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September 24, 2018

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Centers for Medicare and Medicaid Services
Attention: CMS-1695-P
P. O. Box 8013
Baltimore MD 21244-1850

Re: **Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (83 Fed. Reg. 37,046, July 31, 2018)**

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The American Psychiatric Association (APA), the national medical specialty society representing over 37,800 psychiatric physicians and their patients, would like to take the opportunity to comment on the 2018 proposed rule for the Medicare Outpatient Prospective Payment System (OPPS). Our comments focus specifically on issues that impact the care of patients with mental health and substance use disorders (collectively referred to as “behavioral health” disorders), particularly:

- Mental health services composite APC
- Payment changes to the Partial Hospitalization Program
- Controlling unnecessary service volume increases
- Request for Information: Promoting Interoperability

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Proposed Updates Affecting OPPS Payments

Proposed recalibration of APC relative payment weights
Mental Health Services Composite APC

CMS states its belief that the costs involved with delivering Partial Hospitalization Program (PHP) services are the most resource-intensive among all outpatient mental health services. Consequently, the agency believes that mental health services in the Outpatient Prospective Payment System (OPPS) should be valued equal to the PHP maximum per diem payment. In an example of CMS’s attempt to equalize payments for the same services between different treatment settings, this proposed rule states that if one hospital’s sum total of individual, same-day charges for one beneficiary exceeds what CMS would pay as the per diem to a PHP, the “excess” charges would be paid to the hospital under the composite ambulatory payment classification (APC) 8010 *Mental Health Services Composite*; \$216.55, which is equal to APC 5863 *Partial Hospitalization (3 or more services) for Hospital-based PHPs*; \$216.55.¹

Administration

Saul Levin, M.D., M.P.A.
CEO and Medical Director

¹ CY 2019 OPPS and ASC proposed rule. Addendum A. Centers for Medicare and Medicaid Services. July 31, 2018. CMS-1695-P.

The below-the-APC charges would also be paid under composite APC 8010. **APA supports the pricing equalization between these outpatient hospital APC and PHP per diem rates and is pleased that the proposed payment rate is increased from last year's \$205.36.**

Proposed Payment for Partial Hospitalization Services

In last year's rule, CMS considered and then rejected the idea of revising its "3 or more services per day" policy for PHPs. APA is encouraged that there are no proposed changes to said policy, and that it will remain in place for at least another year.

CMS proposes to maintain the payment methodology used in the CY 2018 final rule, meaning that its PHP payment would be based on the APC geometric mean per diem costs as reflected in the most recent claims and cost data.

The APA supports Partial Hospitalization Programs (PHPs) and the important role they play in the continuum of psychiatric care. Both patients who are transitioning out of inpatient hospital treatment and patients who may otherwise be at risk of inpatient hospitalization (absent the intensive care provided in PHPs) can greatly benefit from this type of care. PHPs meet the needs of patients who require comprehensive, highly structured, and multimodal treatments, because their mental illness and/or substance use disorders severely interfere with multiple areas of daily life. Because of the importance of maintaining access to this option for care and the significant impact Medicare policies governing the PHP benefit can have, these proposals have important implications for psychiatrists and their patients.

APA continues to emphasize the importance of CMS being vigilant in monitoring the effects of these changes to the reimbursement rates to ensure they do not cause or contribute to any unintended consequences, particularly: 1) reducing the number of operational PHPs; or 2) incentivizing an otherwise unwarranted or inappropriate reduction in the number of services reimbursed in a site-neutral manner.

Proposed Nonrecurring Policy Changes

Proposal and Comment Solicitation on Method to Control for Unnecessary Increases in the Volume of Outpatient Services

CMS summarizes the changes it has made to the outpatient hospital payment program since 1966—evolving from cost-based payments to the current prospective payment system. In this proposed rule, CMS aims to slow the growth of program spending by matching outpatient hospital reimbursements to Medicare fee schedule reimbursement levels. CMS proposes to use its authority to apply the physician fee schedule payment amounts to the clinic visits provided at off-campus provider-based departments (PBD) that are excepted from §1833(t)(21) of the Social Security Act. This would equalize the clinic and office visits at excepted and at nonexcepted off-campus PBDs. All PBD clinic visits (billed with HCPCS code G0463) would be paid roughly equivalent to fee schedule-valued evaluation and management (E/M) office visits. This would remove the site differential payment and reduce beneficiaries' cost-sharing amounts, but it would also discourage PBDs from drawing patients to their sites for clinic visits when office visits would be appropriate.

APA appreciates that CMS is beginning to reconsider the disparate payment systems for outpatient hospitals and physician offices. We understand that the goal is to make the payments site-neutral, to reduce the number of hospital visits that could have occurred in the physician office, and to reduce beneficiaries' cost-sharing. However, we question the appropriateness of matching hospital-based

payments to office-based payments. Hospitals and physician offices are currently reimbursed according to two completely different payment systems, with the most obvious difference being that the outpatient hospital payments are “ambulatory payment classifications” created around the geometric mean of bundled services, while the physician fee schedule values services based on wide-ranging professional work surveys of physicians and other clinicians, and on CMS-calculated professional liability insurance rates

CMS is exploring ways to control unnecessary increases in volume and is soliciting comments on the use of prior authorization and utilization management techniques as potential cost-containment strategies, citing their use by private payers. APA has concerns about the implementation of prior authorization and utilization management techniques which have been shown to create both barriers to care and delays in accessing appropriate treatment. This is especially problematic for those patients with chronic disorders requiring long-term treatment and care management. A recent AMA study² reports that 92% of survey participants report care delays for those patients whose treatment requires prior authorization. Not only can management techniques lead to suboptimal care, they can also lead to harmful care. In addition, a move in this direction would increase the administrative burden faced by physicians and their staff who have to comply with these management protocols on behalf of their patients.

If management of mental health and substance use benefits becomes more aggressive as resources become more limited, the problem of access to services may be exacerbated. Patient safety and quality of care must be evaluated if restrictions are imposed. **APA recommends studying the impact of the implementation of management techniques to better understand the overall impact on patient care and cost. We urge CMS to work with key stakeholders to identify alternative ways to reduce—where appropriate—overuse of outpatient hospital services without jeopardizing access to care for our patients.**

Promoting Interoperability

APA acknowledges the success of the Health Information Technology for Economic and Clinical Health (HITECH) Act and the original Meaningful Use program in incentivizing the adoption of electronic health record (EHR) systems into practice, especially among hospitals. APA also appreciates CMS’s commitment to reducing administrative burdens associated with EHR adoption and utilization with respect to the MIPS program and supports CMS’s commitment to do so for eligible clinicians in the 2019 reporting year Quality Payment Program proposed rule.

As APA has detailed extensively in previous letters, the focus on true interoperability—rather than on arbitrary, measure reporting thresholds with respect to EHR use—should remain the cornerstone of the Medicare EHR Incentive Program. **As such, APA appreciates the current proposed rule’s emphasis on using EHRs to promote interoperability, the overall reduction of mandatory reporting thresholds, and the elimination of many burdensome, patient-driven measures, all of which represent progress toward implementing the aims of the Office of the National Coordinator for Health Information Technology (ONC) MyHealthEData initiative.**

First, APA supports the performance-based approach to determining eligible clinicians’ scores on the Promoting Interoperability performance category. While questions remain about the direct correspondence of these activities with improved patient outcomes, the proposed scoring methodology

²2017 AMA Prior Authorization Physician Survey (2017). Retrieved from [https://www.ama-assn.org/prior-authorization-research-reports#Prior Authorization Physician Survey](https://www.ama-assn.org/prior-authorization-research-reports#Prior%20Authorization%20Physician%20Survey)

would allow eligible clinicians to pick-and-choose among measures that best meets their strengths with a focus on health-data exchange, patients' access to their records, and open APIs to facilitate the movement of patient data across systems. Unfortunately, however, there are still too few CEHRT options specifically tailored for behavioral health, and psychiatry specifically, that will allow for successful participation of psychiatrists in MIPS. While there are general CEHRT options that psychiatrists *could* use to participate in the Quality Payment Program, these often do not directly mirror psychiatric care workflows; however, the APA is hopeful that the performance approach in the 2019 reporting year proposed rule will offer psychiatrists some degree of leniency in selecting from among measures most germane to their practice.

Second, APA also appreciates the efforts of CMS in this proposed rule to reduce administrative burdens within the EHR Incentive Program that have been time-consuming or otherwise not truly aligned with the meaningful use of EHR systems in general. The removal of patient-driven measures that proved particularly challenging for psychiatrists (e.g., Patient-Specific Education, Secure Messaging, Patient-Generated Health Data, View, Download, or Transmit) and the consolidation of others (e.g., Request/Accept Summary of Care, Clinical Information Reconciliation) is especially appreciated, given the amount of administrative burden endured by clinicians in adopting these activities into workflows and subsequently tracking successful incidences of their use. Additionally, successful reporting on these measures is based on whether patients engage with their own record, something beyond the control of clinicians. The APA anticipates that psychiatrists will continue to endure challenges on the new measures that consolidate the features of some of the removed ones (e.g., Support Electronic Referral Loops—Receiving and Incorporating Health Information). This is because psychiatrists often work with patient populations whose diagnoses make it extremely difficult to regularly and meaningfully engage with the EHR in the interest of their own care coordination.

Some psychiatrists may also find the 2 renamed/re-envisioned measures (e.g., Supporting Electronic Referral Loops by Sending Health Information; Provide Patients Electronic Access to their Health Information) challenging due to the unique nature of psychiatric workflows. APA appreciates the proposed rule's elimination of many of the arbitrary thresholds and administrative burdens associated with these types of reporting activities required under the current reporting program; however, attaining the maximum, combined 60 points under the proposed performance score methodology for the "Provider to Patient Exchange" and "Health Information Exchange" Promoting Interoperability measures might still prove challenging for many psychiatrists due to the unique nature of psychiatric workflows and the limited capacity for some psychiatric patients to engage with their electronic record. **The APA recommends that the final rule follow previous rulemaking in allowing "one permissible..." activity to count toward full participation in the various measures under the Promoting Interoperability category (e.g., "at least one permissible prescription written by an eligible clinician...").**

Health Information Exchange Across the Care Continuum (Health Information Exchange Objective): This measure, if introduced into the Promoting Interoperability performance category, has the potential to "close the referral loop," which would be beneficial for psychiatrists and their patients. **The APA recommends that this not become a required measure for reporting year 2019, but instead be introduced as a potential bonus of up to 5% for the Improving Interoperability performance category.**

Transition to sole use of 2015 CEHRT

In the current proposal, CMS states that it will require eligible professionals to use 2015 Edition CEHRT by the 2019 reporting year. APA understands the drive toward 2015 CEHRT will maximize the potential for interoperability between systems and that including 2014 CEHRT results in a number of drawbacks due to retro-adaptations.

With respect to the CEHRT program overall, psychiatrists still experience challenges in adopting CEHRT into their practices, for multiple reasons, compared to other clinicians. Regardless of CEHRT edition, it is in the interest of Medicare to promote greater engagement of independent and small-group psychiatrist eligible clinicians with larger hospital systems and limiting the type of EHR system that can support said engagement precludes these efforts. The MyHealthEData initiative's focus on interoperability and this proposed rule's use of APIs to connect patients and physicians may eventually bridge this gap; unfortunately, the business case for smaller, psychiatry-focused EHR vendors to adopt CEHRT simply does not exist, often because many solo and small-group psychiatrists have opted-out of Medicare due to increasing demands of reporting requirements. While many larger vendors certified to the 2015 Edition can and do support psychiatry, there is often an added cost in adapting the software to fit psychiatric workflows, including integrating relevant electronic clinical quality measures into the platform. These psychiatrists must also then bear the cost of hiring administrative support staff to aid in adhering to the quality reporting programs.

The APA recommends that CMS allow for a one-time exception for the Improving Interoperability for eligible clinicians for the 2019 reporting year who used CEHRT for the 2018 Quality Payment Program reporting year to ease the transition for those who must purchase and implement new technology.

Hospital OQR Program Quality Measures

CMS states their interest in expanding the current set of quality measures to inform decision making and quality improvement in the hospital outpatient setting. APA supports this effort, specifically the development of patient-centered outcome measures and process measures that are proximally linked to positive health outcomes, especially those that can be aligned across care settings and payment programs. The measures should focus on assessing gaps in care among diverse psychiatric diagnoses and those treated within and outside of specialty behavioral healthcare settings. The measures should assess attributes identified as meaningful to the physicians responsible for carrying out the numerator actions and to the facilities providing care in the outpatient setting. Even more importantly, they should also represent value to patients and/or family members. Right now, the measures in this program do not address meaningful psychiatric care for these parties.

Conclusion

Thank you for your consideration of these comments on these important issues. We look forward to working with you in the future to develop and implement these policies. If you have any further questions or would like the opportunity to discuss our comments, please contact Debra Henley Lansey, M.P.A., APA Associate Director of Reimbursement Policy, at DLansey@psych.org.

Sincerely,



Saul Levin, M.D., M.P.A.
CEO and Medical Director