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Submitted electronically

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-P
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Re: Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy (85 FR 50074, August 17, 2020)

**Assembly
2020-2021**

Joseph C. Napoli, M.D.
Speaker

Mary Jo Fitz-Gerald, M.D., M.B.A.
Speaker-Elect

Adam Nelson, M.D.
Recorder

Dear Administrator Verma:

The American Psychiatric Association (APA), the national medical specialty society representing over 38,800 psychiatric physicians and their patients, would like to take this opportunity to comment on the proposed rule on the 2021 Medicare Physician Fee Schedule and Quality Payment Program. Our comments focus specifically on issues that affect the care of patients with mental health and substance use disorders (MH/SUDs).

Our country is facing an unprecedented COVID-19 crisis with the days, weeks, and months ahead at best uncertain and for many crippling. We appreciate the work of CMS to reduce barriers to care throughout this crisis, especially using telehealth. As the country begins to explore what the new normal will be there will continue to be an increased need for services for individuals with mental health and substance use disorders. Due to the scope and severity of the pandemic, we anticipate that mental health and SUD impacts will continue well after the public health emergency period. Telehealth expansion has enabled millions of Americans to receive much-needed mental and substance abuse care, some of them for the first time. It is also critical to ensure continuity of care.

Administration

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

We urge CMS to maintain a number of the telehealth flexibilities implemented during the public health emergency permanently. We also support Congressional action to remove the geographic restrictions and allow mental health patients to be seen in the home; flexibilities currently in place for those with substance use disorders through the Support Act. These changes would ensure a smooth transition to in-person care and increase access via telehealth and telephone to necessary care. It is especially important for mental health and substance use care, where the ability to establish and maintain a strong, uninterrupted therapeutic alliance with patients is critical to effective interventions.

Telehealth and Other Services Involving Communications Technology (Section II.D)

a. Adding Services to the Medicare Telehealth Services List

We commend CMS for their responsiveness in ensuring timely access to care during the public health emergency through temporarily expanding the number of services that could be provided by telehealth. CMS is proposing to add a number of these same services to the list of telehealth services. **APA supports the addition of those proposed as Category 1 Telehealth Services, and in particular group psychotherapy (90853), neurobehavioral status exam (96121), prolonged office visit (99xxx), and assessment of and care planning for patients with cognitive impairment.** These services meet the criteria for Category 1 telehealth services as they are similar to services currently on the list.

c. Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services from the Medicare Telehealth Services List.

APA also supports the inclusion of psychological and neuropsychological testing (96130-96133) as Category 3 telehealth services. **We also recommend that CMS include the following services on the Category 3 list as well: developmental testing codes (96112 & 96113), Psychological & Neuropsychological Test Administration & Scoring (96136, 96137, 96138, and 96139), and the Adaptive Behavior codes (97151, 97152, 0362T, 97153, 97154, 97155, 97156, 97157, 97158 and 0373T).** There are similarities between these services and other services currently on the Category 1 list and the newly proposed Category 3 list.

Finally, we agree that in those instances where existing telehealth services are being replaced with new codes describing the same service, the new codes should automatically be included on the telehealth list.

3. Furnishing Telehealth Visits in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS has proposed to make permanent some of the flexibilities around visit frequency in specific settings. While we appreciate the proposal to increase access to telehealth services in nursing home settings we are troubled that frequency limitations are placed on any setting, including those proposed to be maintained for inpatient settings, but which were lifted during the public health emergency. While APA understands the concern that many inpatient medical conditions require or would otherwise benefit from seeing a physician in-person as opposed to via telehealth. However, many patients benefit from regular telehealth encounters with psychiatrists. This is true for a number of psychiatric diagnoses, and also because, oftentimes, a hospital in a rural/remote area may not have an attending psychiatrist and may rely on telehealth to bridge this gap in care.

These are arbitrary barriers to care, which should be driven by medical necessity, with supporting documentation in the record, regardless of the modality with which the care is provided. **We recommend**

CMS remove all frequency limitations and use medical necessity as the rationale for payment uniformly across the fee schedule.

6. Comment Solicitation on Continuation of Payment for Audio-only Visits

According to a recent APA survey, approximately 60 percent of respondents stated that between 1-25% of their patients cannot access care via audio/video platforms due to technical issues (lack of broadband), financial constraints (cannot afford video technology) or inability to use technology due to lack of knowledge or as a result of their impairment (e.g. paranoia). **Flexibility regarding how care is provided is key to ensuring everyone, especially the most vulnerable, has access to care.**

CMS understood this need and rapidly responded during the public health emergency by approving coverage for audio-only services. CMS worked with the physician community to cover telephonic services and then modified this code-set to create a workable coding solution that captured the time and effort spent providing audio-only services to Medicare beneficiaries during the public health emergency.

We support the continuation of coverage for audio-only services after the public health emergency ends. Audio-only should be considered as an alternative for in-person or video-telehealth services for all beneficiaries when there lacks a reasonable alternative and it is medically appropriate. Given the geographic and numeric maldistribution of psychiatrists and other mental health professionals within the United States, there are areas of the country that have too few providers and/or insufficient broadband internet infrastructure necessary to connect patients to providers via telehealth. Also, there are many patients that either lack the technology or who cannot operate the technology required to access care via synchronous audio/video sessions. Moreover, many patients living in remote and urban areas alike spend significant time and effort traveling to appointments who rely on audio-only telehealth as an option for treatment, as they otherwise might miss their appointment. Patient preference in terms of modality, informed by medical necessity, also drives patient satisfaction, which positively impacts patient engagement and results in better outcomes.¹

CMS has recognized the value of having an audio-only option by granting this flexibility during the public health emergency. Psychiatrists have been able to provide effective, quality services, including evaluations, E/M services, and psychotherapies during the emergency, and should be able to continue to bill for them at the same rate as in person services, after the emergency ends. We recommend CMS retain the current codes identified as audio only for all sites of service when provided to patients with MH/SUD diagnoses.

In lieu of what has been proposed, we recommend CMS create an audio-only approved list of services and implement a new modifier for use with existing E/M and psychiatric evaluation and psychotherapy services that indicates the service was provided via audio-alone. This would create uniformity in the coding, documentation, and payment of services regardless of how the service was provided. The work performed and the practice expenses incurred are the same regardless of the modality. **We strongly encourage CMS to maintain coverage for those services currently approved for audio-only care, and develop an audio-only coding solution through the use of an audio-only approved category, the**

1 Hilty DM, Ferrer DC, Parish MB, et al. The Effectiveness of telemental health: A 2013 review. *Telemed J E Health* 2013;(19):444-454.

standard billing code at the payment rate of an in-person visit, and the use of a modifier that ensures uniformity in the coding, documentation and payment of the service provided.

Care Management Services and Remote Physiologic Monitoring Services (Section II.E)

4. Psychiatric Collaborative Care Model (CoCM) Services (HCPCS code GCOL1)

In response to feedback from the field, CMS has proposed to establish a G-code to describe a shorter (30 minute) psychiatric collaborative care management service with same service elements and time rules currently in place for the other services in the family of codes. **We support this addition which provides primary care practices with additional flexibility in billing for care.**

CMS has also proposed to increase the payments for the CoCM family of codes to align with the increase in payments for outpatient evaluation and management (E/M) services. While we enthusiastically support increasing the values, we are concerned that the CoCM family of codes still remain undervalued and as a result primary care practices are not utilizing them.

A recent APA survey indicated that more than one-third of Americans (36%) say coronavirus is having a serious impact on their mental health. Almost a third of Americans in urban areas and over half in rural areas receive their mental health care through their primary care physician. These primary care physicians often serve as the sole providers treating the mental and physical health needs of children, adolescents, and adults. As sole providers, primary care practices – including pediatric and OB/GYN practices - are the front-line for mental health and substance use care.

Many more Americans are experiencing mental health problems due to the increasing anxiety associated with COVID 19. These anxieties, coupled with the economic stress on families as they struggle to maintain employment, including employer sponsored healthcare coverage, and income, further exacerbate mental health and substance use issues. The urgent need to address access to mental health and substance use care will continue well beyond the period of recovery from the crisis and must be dealt with now. CMS must ensure that Americans have access to timely and effective mental health and substance use care.

CMS has recognized the significant body of evidence behind the CoCM model and the cost savings shown over time. Implementation of CoCM is a significant lift for primary care practices both in terms of financial resources and changes in workflow. The uptake of the CoCM codes within Medicare has been limited. As the need for mental health and substance use treatment increases, we need to encourage and support primary care practices in implementing the CoCM model. The increase as currently proposed is still not sufficient. To encourage practices to begin to start implementing the CoCM in their practice, **we respectfully ask CMS to increase the current Medicare payment for each code in the CoCM family of codes by a minimum of 75% for the first year, 50% for the second year and 25% for the third year to help these practices expand access to cover the escalating demand for evaluation and initiation of treatment for mental health and substance use disorders.**

Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic (Section II.F)

1.b Overview of Policies Finalized in CY 2020 for CY 2021

APA commends CMS for recognizing the need to review and refine payment policies and documentation requirements associated with E/M services. **We fully support CMS' decision to adopt the RUC recommended values and the new documentation guidelines for outpatient E/M services. We also encourage CMS to adopt the RUC recommended times which were derived from the robust survey responses representing the breadth of medicine.** These changes will more accurately reflect the work and resources required to provide care in the outpatient setting. The documentation requirements will be less burdensome, more intuitive, and will focus care and documentation on what is clinically relevant on the date of the service.

We urge CMS to adopt these recommendations across all CMS payment programs for implementation beginning on January 1, 2021. We are also supportive of Congressional action to waive the budget neutrality requirement to limit the reductions set to occur once these policies are finalized.

2.b. (including 2.b.3, 3.b.5, 3.b.8-9) Revaluing Services that are Analogous to Office/Outpatient E/M Visits

In general, we support CMS' proposal to extend the increases that have been approved for the outpatient evaluation and management (E/M) to other services that are closely tied to evaluation and management services visits. The office/outpatient E/M codes were used as building-blocks in valuing many of these services. Specifically, we support the proposed increases to transitional care management (TCM) services (CPT codes 99495, 99496); and cognitive impairment assessment and care planning (CPT code 99483) [See discussion of psychiatric collaborative care management (CPT codes 99492, 99493 and 99494) above].

Absent Congressional action, we urge CMS to extend increases to E/M services provided in other settings (i.e., inpatient, nursing facilities, domiciliary care, home care etc.) as well to mitigate the drop in payments due to the reduction in the conversion factor. These settings treat patients requiring higher levels of care and who are most often the most vulnerable patients. Reductions in payments could further exacerbate access to care in settings that struggle to meet current needs. Much of the work performed is similar in nature to the outpatient services. **We recommend CMS mitigate the loss by increasing the payments equivalent to the reduction on the conversion factor until the codes can be reviewed as part of the ongoing work of the CPT/RUC E/M workgroup.**

We also support CMS' proposal to increase the values associated with the psychiatric diagnostic evaluation with medical services (CPT code 90792) which is analogous to the new patient E/M codes. We are however, concerned about CMS' proposal to increase the (stand-alone) psychotherapy codes (90832, 90834, 90837) without a corresponding increase to the (add-on) psychotherapy codes (90833, 90836, 90838). Unlike the other services CMS proposes to increase, psychotherapy is a procedure that is distinct from the work described by E/M services. There are already separate CPT codes for psychotherapy add-on codes (CPT codes 90833, 90836, 90838) that are billed when done in conjunction with an E/M service with values that are virtually identical to the stand-alone codes. CMS has posited that an increase in values of the stand-alone psychotherapy codes will maintain current relativity however there is no established relativity between psychotherapy and E/M services. If approved as proposed, the

relativity between the two sets of psychotherapy services will be lost. There will be two distinct code-sets that describe the exact same work but are valued differently. This lack of relativity will not only impact Medicare beneficiaries but will likely be carried forward by commercial payers who adopt the Medicare Physician Fee Schedule as the basis for their fees. This will further compound the disparity that already exists for psychiatric care in commercial payments where it has been shown that primary care reimbursement rates for E/M services are 23.8 percent higher than those paid to psychiatrists.² **We recommend that CMS maintain relativity within the psychotherapy family of codes and apply the increase to all psychotherapy services including those billed in conjunction with an E/M service.**

Scope of Practice and Related Issues (Section II.G)

1. Teaching Physician and Resident Moonlighting Policies

During the PHE, CMS allowed for the supervision of resident physicians via telehealth, which helped to ensure the health and wellness of residents, their supervisors, and patients alike. APA supports CMS' proposal to extend supervision via telehealth through the end of PHE calendar year, in which the PHE expires. APA understands that CMS is concerned that direct supervision through virtual presence may not be sufficient to support PFS payment on a permanent basis due to patient safety and the NPRM lists several examples for why extending this option permanently might be a concern. However, APA contends that these examples are more germane to other medical disciplines than to psychiatry, and that, in most cases, psychiatry residents can still be successfully and safely supervised via telehealth. **As discussed in the NPRM, over the course of the PHE, clinicians used their clinical judgment to decide whether they wanted to supervise residents in-person or virtually. The APA contends that, upon the expiration of the PHE, clinicians should still be able to rely on their clinical judgments to make this decision.**

2. Supervision of Diagnostic Tests by Certain NPPs

We are concerned about the specific change to increase the capacity and availability of practitioners who can supervise diagnostic tests. As noted in the proposal, "there is a wide range of diagnostic tests, from a simple strep throat swap to more sophisticated and/or invasive tests such as x-rays and cardiology procedures". More information is needed to understand who could potentially provide these tests safely. **We urge you against making any changes, especially before stakeholders can review information submitted as part of your request to understand the how the proposal would be impacted by applicable state laws, scope of practice, and facility policies.** Given the importance of diagnostic testing to ensure patients receive the correct diagnosis, and, thus treatment, we encourage you to make available the information gathered and allow time for comment before finalizing the proposal.

3. Pharmacists Providing Services Incident to Physicians' Services

Pharmacists are valued members of the care team with an important role helping with medication management and coordinating care with a patient's physician. Thus, we appreciate the focus on physician supervision and coordination. We have been concerned with state laws that allow for pharmacists to

² Melek, S., Davenport, S, Gray, TJ. (2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. Milliman Research Report. <https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p>

make a therapeutic interchange of psychoactive medication, including the interchangeability of generic and brand medications, without the express consent of the prescribing psychiatrist. It is essential to acknowledge that individual drugs within the therapeutic classes used to treat psychiatrically ill patients have very different clinical indications, mechanisms of action, and side effect profiles. Drug prescribing is therefore complicated given the nature of a drug in the classes for the treatment of psychiatric disorders. These drugs are not clinically interchangeable. No two psychotropic medications have the same therapeutic effect or identical duration and intensity characteristics.

We urge you to specify that such changes may not be made without the consent of the physician under Medicare.

Valuation of Specific Codes (Section II.H)

[\(52\) Evaluation and Management, Observation and Provision of Self-Administered Esketamine \(HCPCS Codes G2082 and G2083\)](#)

CMS has proposed to increase payments paid for services performed in the administration of Esketamine and maintain the current bundled services as originally proposed and billed using HCPCS codes G2082 and G2083. APA supports the increased payments and acknowledges CMS' recognition of the clinical staff time that is inherent in the provision of these services.

We remain concerned that the current structure fails to account for higher level E/M work that could occur in the course of the administration of the medication. The 99212 is a low-level E/M service that is for minor procedures. The side-effects of administering these medications may on occasion necessitate a higher level of effort from the physician. **We encourage CMS to provide the ability to bill a separate E/M service on those occasions where medical necessity dictates a higher level of service.**

As we have stated previously, by approving coverage and payment CMS has clearly indicated their interest in making available this evidence-based treatment. It is important to provide the mechanisms to enable all psychiatrists and other payers to do the same. We ask that CMS 1) **reduce the barriers by issuing a J-code specifically for Esketamine treatment which would remove communication barriers between provider and payer, and 2) create a HCPCS code that separates the clinical work of the service from the cost of the medication.** There are psychiatrists that, for a variety of reasons, do not "buy and bill" the medication. As a result, they are currently forced to bill for services using existing CPT codes that do not clearly describe the work performed. Providing a HCPCS code for the services alone (subtracting the portion to cover the cost of the medication) would be beneficial and would ensure equity in payment whether or not the psychiatrist purchases the medication. While it would seem that this could be addressed through the CPT process, the service itself has to achieve some stability/uniformity and uptake to ensure that the codes developed appropriately describe the service being performed. This service is not yet there. The use of a HCPCS coding structure with both the bundled and unbundled option enables psychiatrists to provide the service for any patient regardless of payer.

[\(53\) Bundled Payments under the PFS for Substance Use Disorders \(HCPCS codes G2086, G2087, and G2088\)](#)

As an organization that represents front-line physicians who treat patients with substance use disorders, including opioids, **APA commends CMS for expanding coverage for services provided to patients to include all substance use disorders.** As we recommended in our comments last year, it is important

that CMS take steps to address gaps in care for all substance use disorders, including dependence on tobacco, marijuana, and alcohol. This includes advancing solutions that will improve access to effective evidence-based treatment, reduce the stigma associated with substance use disorders, and protect safety net programs that offer valuable coverage for individuals and families in need of treatment. Expanding coverage to include all substance used disorders a good first step and one we wholeheartedly support. **Additionally, we support adding these services to the telehealth list as it is critically important to provide the ability to seek treatment via a variety of modalities.**

As with other medical conditions, treatment for substance use disorders should be individualized and comprehensive, based on patient need and severity of illness. The range of services and levels of care vary over the course of the episode and do not always correlate to additional time. It is important to maintain the ability to bill for additional services not currently captured in the bundle. A comprehensive assessment (and re-assessment as needed) as indicated for co-occurring mental health disorders or other physical health conditions is important in establishing and refining a treatment plan and ongoing management of conditions. Studies have demonstrated the effectiveness of medication for treatment of OUD, especially when combined with counseling and other psychosocial therapies.³⁴⁵ Thus, medication for OUD should be prescribed as part of a comprehensive treatment plan that includes counseling and participation in social supports.

(54) Initiation of Medication Assisted Treatment (MAT) in the Emergency Department (HCPCS code GMAT1)

CMS proposes to add a new G-code, GMAT1 (*Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services (List separately in addition to code for primary procedure)*) to provide payment for Medication Assisted Treatment in emergency room settings. **APA supports the proposed code and see it as an opportunity to ensure the initiation of evidence-based treatment and referral to specialty care occurs as soon as possible.**

Modifications related to Medicare Coverage for Opioid Use Disorder (OUD) Services Furnished by Opioid Treatment Programs (OTPs) (Section II.I)

APA applauds the ongoing support CMS has provided through increased coverage of and access to evidence-based services for patients with opioid use disorders. We support CMS' proposal to add naloxone to the definition of OUD treatment services, and to provide coverage in OTPs to dispense the medication. We also encourage CMS to initiate coverage for injectable naloxone in addition to that for nasal naloxone and auto-injector naloxone. This would afford access to all FDA-approved naloxone products.

³ Substance Abuse and Mental Health Services Administration. Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63, Executive Summary. HHS Publication No. (SMA) 18-5063EXSUMM. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

⁴ Substance Abuse and Mental Health Services Administration. Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide. HHS Publication No. (SMA) 14-4892R. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

⁵ NIDA (2009). Principles of drug addiction treatment: A research-based guide (2QPP pnd ed.).

Patient and Family Education

We support reimbursement for patient and family education as this is an essential component of care but recommend a higher level of payment. Patients ending treatment are at a higher risk of overdose, even when treated for 18 months. According to a study from Columbia University Vagelos College of Physicians and Surgeons, among people who were treated with buprenorphine continuously for 6 to 18 months, about 5% needed medical treatment for an opioid overdose in the 6 months after ending buprenorphine treatment. The true rate is likely higher as the study was unable to account for overdose events that did not present to healthcare settings. It is essential to help patients and their families understand and manage the risks of reduced tolerance to drugs as a result of treatment. We recommend increasing the payment to incentivize programs to provide information to patients and their families/caregivers. CMS has suggested 96161, paid at \$2.53 which describes the work of clinical staff to provide instructions on and score a standardized health risk assessment tool as a potential benchmark for the valuation of the patient/family education component. We think the clinical activities are more aligned with 98960 (*Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient*) currently paid at \$27.75. In this scenario, the staff are not passively administering the test, they are actively engaged with the family, educating them as to the risks and signs of an opioid overdose, as well as the actions to take (administering the naloxone) to stabilize the patient until assistance can arrive. It is important that families comprehend the actions that they need to take in a life or death situation. We suggest the value is a percentage of the 98960, falling above the 96161.

Proposal to Remove Selected National Coverage Determinations (NCD) (Section III.J)

CMS is proposing to remove nine NCDs that they believe no longer contain pertinent or clinically relevant information and are rarely used by beneficiaries. The NCDs are Extracorporeal Immunoabsorption (ECI) using A Columns; Electrosleep Therapy; Implantation of Gastroesophageal Reflux Device; Apheresis (Therapeutic Pheresis); Abarelix for the Treatment of Prostate Cancer; Histocompatibility Testing; Cytogenetic Studies; Magnetic Resonance Spectroscopy; and FDG PET for Inflammation and Infection. Eliminating an NCD means that coverage decisions for that particular item or service revert back to the local Medicare Administrative Contractors (MACs). APA has no objection to the removal of electrosleep therapy.

Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a prescription drug plan or an MA_OD plan (Section III.K)

The APA recognizes that the use of electronic prescribing has become more commonplace as technology has evolved and clinical workflows have adapted. However, federal mandates for adopting the electronic prescribing of controlled substances often place undue burden on psychiatrists practicing within solo and small group settings. These burdens are administrative and financial, as these providers may not have the IT or other support staff to aid in implementation of new software and psychiatric workflows, or the financial resources to maintain e-prescribing software that may require frequent updates.

APA therefore supports CMS' delaying the Part D EPCS mandate from January 2021 to January 2022. Further, APA recommends that CMS develop certain exclusions or other considerations—similar to the

MIPS “low-volume threshold” or other hardship exceptions that have been used within various CMS quality programs—for providers who may be negatively impacted by the Part D e-Rx mandate.

Proposal to Establish New Code Categories (Section III.N)

CMS is proposing 15 new code categories for use to report all currently marketed buprenorphine/naloxone products, based on strength as well as therapeutic equivalence. These new categories are intended to address variability in bioequivalence between the products and permit physicians and clinics to accurately bill insurers for the drug and dose utilized and will not change Medicare coverage or payment policies for oral or sublingual buprenorphine codes. **We do not support this change. We are concerned that new coding categories will cause confusion and are unnecessary.**

CY 2021 Updates to the Quality Payment Program (Section IV)

Promoting Interoperability Performance Category

APA appreciates CMS’ commitment to reducing administrative burden through many of its initiatives, including the various iterations of the QPP over the last several years, as well as through its Patients Over Paperwork initiative. As the 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 QPP. As such, the APA appreciates the current proposed rule’s emphasis on using EHRs to promote interoperability, as well as the overall reduction of mandatory reporting thresholds, and the flexibility for solo and small group providers inherent within the construct of the “low-volume threshold.”

First, the APA supports the performance-based approach to determining eligible professionals’ scores on Promoting Interoperability. While questions remain about the direct correspondence of these activities with improved patient outcomes, the revised scoring methodology originally established for reporting year 2020 (RY 2020), which CMS has proposed to retain for RY 2021, will allow psychiatrists to pick-and-choose among measures that best meet their strengths with a focus on health-data exchange, patients’ access to their records, and open Application Programming Interfaces (APIs) to facilitate the movement of patient data across systems. Many CEHRT systems used by psychiatrists do not directly mirror psychiatric care workflows, so offering psychiatrists some the ability to select those measures most germane to them is appreciated.

Similarly, the APA also appreciates the efforts of CMS over the past several reporting years to reduce administrative burdens within MIPS that have been time-consuming or otherwise not truly aligned with the meaningful use of EHR systems in general. **The APA appreciates that the scoring methodology in this proposed rule again takes into consideration that eligible professionals are not always able to have their patients engage with the EHR, thereby allowing for the scoring of the different objectives and embedded measures to be weighted accordingly.** The APA also appreciates how CMS, over the last two PFS rules, has eliminated many of the arbitrary thresholds and administrative burdens associated with reporting activities that rely on patient engagement with the record.

The APA supports CMS’ decision to keep the “Query PDMP” measure as optional for RY 2021, as it did for RY 2020. Integration between PDMPs and EHRs still has not been achieved across the healthcare landscape, and so making this measure mandatory would be burdensome for physicians. However, hopefully as various features of the 21st Century Cures Interoperability and Information Blocking Final Rule (released May 2020) are implemented, software vendors—using a common standard, like the Fast Healthcare Interoperability Resources (FHIR)—will begin to address this issue. With respect to scoring of the “Query PDMP” measure, **APA also supports CMS’ decision to increase the bonus from 5 to 10 points for RY 2021.**

The APA also supports CMS’ decision to include a new, optional measure, “Health Information Exchange Bi-Directional Exchange” for RY 2021, as alternatives to the “Support Electronic Referral Loops by Sending Healthcare Information,” and “Support Electronic Referral Loops by Receiving and Incorporating Healthcare Information” measure under the “Health Information Exchange” Objective. This option would give physicians added flexibility under the Promoting Interoperability performance category, and an opportunity to shift the weighting of their score around completing interoperability activities within the EHR at which they might be successful.

More broadly, APA thanks CMS for recognizing the challenges faced by the healthcare system as a result of the COVID-19 public health emergency. Delaying implementation of significant new initiatives such as the MIPS Value Pathway (MVP) program is prudent given the demands on clinicians to respond to the pandemic and to adjust to new modes of providing care. Moreover, APA continues to have concerns about the approach to measuring costs as part of the MIPS program, particularly regarding application of the Medicare Spending Per Beneficiary (MSPB) measure. It is not clear that clinicians can control the costs that are attributed to them as part of this measure, especially those costs that are incurred after hospital discharge, and we are not convinced that holding individual providers accountable for these costs is appropriate. **For these reasons, APA recommends that, rather than continuing to increase the weight of cost measures in relation to the weight of quality measures, CMS should maintain the current weighting of performance categories through the end of 2021, or until practices begin to normalize.**

Thank you again for the opportunity to comment. The APA welcomes the opportunity to further discuss any of the issues raised in this letter. Please contact Rebecca Yowell, Director of Reimbursement Policy and Quality, at byowell@psych.org.

Sincerely,



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CEO and Medical Director
American Psychiatric Association