American Psychiatric Association

1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209
Telephone 703.907.7300
Fax 703.907.1085
E-mail apa@psych.org
www.psychiatry.org

Board of Trustees
2012-2013
Dilip V. Jeste, M.D.
President
Jeffrey A. Lieberman, M.D.
President-Elect
Roger Peele, M.D.
Secretary
David Fassler, M.D.
Treasurer

John M. Oldham, M.D.
Carol Ann Bernstein, M.D.
Alan F. Schatzberg, M.D.
Past Presidents

Molly K. McVoy, M.D.
Jeffrey L. Geller, M.D., M.P.H.
James E. Nininger, M.D.
Brian Crowley, M.D.
Judith F. Kashtan, M.D.
James A. Greene, M.D.
Marc David Graff, M.D.
Jeffrey Akaka, M.D.
Alik S. Widge, M.D., Ph.D.
Eric R. Vanderlip, M.D.
Trustees

Assembly
2012-2013
R. Scott Benson, M.D.
Speaker
Melinda L. Young, M.D.
Speaker-Elect
Jenny L. Boyer, M.D.
Recorder

Staff
James H. Scully Jr., M.D.
Medical Director and CEO

Paul T. Burke
Executive Director,
American Psychiatric Foundation

April 16, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Means
House of Representatives
1102 Longworth H.O.B.
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives
2125 Rayburn H.O.B.
Washington, D.C. 20515

Dear Chairmen Camp and Upton,

On behalf of the American Psychiatric Association, the national medical specialty society representing over 34,000 psychiatric physician members, I am writing in response to your recent solicitation for stakeholder input on the second iteration of your framework proposal to permanently repeal and replace the flawed Medicare Sustainable Growth Rate (SGR) physician reimbursement formula. We remain hopeful that with the recently decreased cost of repeal estimated by the Congressional Budget Office, and the early interest and action shown by your committees, that permanent repeal and replacement of SGR can occur this year. APA appreciates the opportunity to share our thoughts on how your proposal will affect the practice of psychiatry and access to high quality mental health services for our nation's elderly and disabled population.

<u>Phase I: Stable, Predictable Updates</u>

Reform of Medicare fee for service (FFS) and the Medicare physician reimbursement system at large will be a complicated endeavor, and the stability period suggested in your framework – providing its length is ultimately suitable – is necessary for both the continued development of private and public quality initiatives as well as for testing of innovative payment models that physicians may be participating in on a significantly larger scale. Regarding positive updates in this period, APA notes that Medicare physician payment rates have increased by just four percent since 2001 and are practically stagnant when compared to the inflation of practice cost. We recommend that payment updates be based on the Medicare Economic Index (MEI), and be stabilized for not less than four years in order to allow adequate time for development of alternative payment models (APMs).

We note that your second iteration more specifically states that "updates will apply to all providers," but it is unclear if this suggests that the updates will be *uniformly applied* to all providers. In its June 2011 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that SGR repeal and replacement presented an opportunity to introduce needed payment reforms, one of which included "increasing payments for cognitive (or nonprocedural) services relative to procedural services" in order to incentivize the management of patients with chronic conditions. There is clear evidence that co-occurring mental disorders and other medical ailments add to patient complexity and increase costs, both to the patient and to taxpayers. Assuring access to treatment for elderly and disabled Americans suffering from mental disorders, as well as incentivizing medical students to enter cognitive specialties like psychiatry, is necessary to reduce the overall cost of care in this country. For example, bipartisan legislation to repeal and replace SGR introduced by Representatives Allyson Schwartz (D-PA) and Joe Heck, M.D. (R-NV) allows for increased payments for medical evaluation and management services during its suggested stability period. More recently, the National Commission on Physician Payment Reform, chaired by former Senate Majority Leader Bill Frist, M.D., and Steven Schroeder, M.D., recommended that "updates should be increased for evaluation and management codes, which are currently undervalued". Failure to address the relative imbalance for cognitive specialties will miss a major opportunity to address undue medical costs associated with mental health comorbidities. APA asks you to consider these points in your determination for how updates should be structured during the aforementioned stability period.

Phase II: Portion of Payment Based on Quality through Update Incentive Program (UIP)

APA appreciates the greater specificity in this section regarding the determination of a physician's variable performance rate, the elaboration on what the committees feel constitutes a clinical improvement activity, and that you have specified that quality measures implemented by HHS in consultation with specialties will include either process or outcomes measures. We refer you to our first committee framework iteration comments on quality initiatives, attached to this document, which go over APA activities related to clinical quality measure (CQM) and practice guideline development, the need for federal investment in quality improvement, and the importance of addressing the administrative burden of measure reporting by streamlining incentive programs and addressing the disparate ability of psychiatrists to participate in the HITECH incentive program in order to become 'meaningful users' of electronic medical records.

On the need for federal investment with regard to quality improvement (QI) activity occurring in specialty societies and other collaborative organizations, your updated framework suggests an annual update process between HHS and the relevant specialty society. We would take this opportunity to reiterate to the committees that maintenance and annual review of performance measurement and QI tools is a resource-heavy proposition for physician associations, and federal support for this private/public partnership would be essential for the product of the collaboration as well as the ultimate

success of the reforms sought by both your committees and the physician community. We believe the feasibility of an annual review should be explored further.

Document question: Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

Rewarding for improved care over time is a way of assisting those who may not have top scores on measures but are still providing quality care despite resource limitations and challenging patient populations. Since risk adjustment remains difficult and unreliable, there is a real prospect of penalizing those clinicians who take on the most medically complex or sickest patients. Both of these methods for rewarding quality are only appropriate when quality measures have evidence based risk adjusters attached. The failure to risk adjust and base payment on anything less will incentivize physicians to select against more medically ill and complex patients and exacerbate the attendant cost issues. This is a critical area where sufficient resources must be committed to meet the ultimate goals of the committee framework.

Document question: Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?

Yes, there are sufficient clinical practice improvement activities (CPIAs) relevant to psychiatry. However, progress on the conceptualization, development, and implementation of these activities varies. As articulated in our previous commentary (attached to this document), APA is engaged on the development of CQMs that are meaningful to the practice and efficacy of psychiatry, we have put considerable effort into the creation of comprehensive evidence-based practice guidelines, and we are in the early stages of exploring the potential of patient registries and national collection of clinical data. APA also develops QI tools for use in maintenance of psychiatric board certification that may provide a foundation for collaboration with the Secretary for a qualifying CPIA. However, as your document notes, these efforts take time and an appropriate stability period is clearly necessary. These efforts also take considerable resources, and the prospect of facing either an unfunded mandate or inelegant implementation of the proposed framework will be cause for concern for some specialties.

Phase III: Reward for Efficient Resource Use

With regard to psychiatry and the treatment of the elderly and disabled Medicare population, much of the problem pertains to under-diagnosis, under-treatment, and underuse of services, due in large part to the unavailability of resources (e.g. coverage access issues like the disparate mental health coinsurance that is currently phasing out, and provider access problems driven by various federal policies). This impacts the efficiency of healthcare as a whole; undermanaged mental health leads to poor medical health outcomes. For example, co-occurring mental and other medical illness is associated with

elevated symptom burden, functional impairment, decreased length and quality of life, and increased overall costs to the health system. Appropriate reimbursement policy and funding for innovative evidence based collaborative care approaches for behavioral health are essential if efficient resource use is to be achieved.

A significant product of the efficiency extracted from a high quality psychiatric practice is realized by the system as a whole. That is why the prospect of innovative payment models that actually enable and incentivize integrated, team-based care holds great promise for the future of mental illness treatment and service delivery in America. Moreover, psychiatrists are not heavy referrers for potentially expensive tests or imaging. We caution that little can be gleaned from stratifying all Medicare FFS psychiatrists into a "risk-adjusted relative ranking system" to compare individuals' episode-based and per capita costs of care. In terms of resource use there may be little difference between outliers on both sides of the spectrum besides prescription patterns, which may be largely variable and based primarily on the characteristics of a psychiatrist's patient population.

In general, we feel it would be wise to apply the same philosophy that the committees have adopted for your Phase II approach (i.e. flexibility and specialty/Secretary collaboration) to your Phase III approach regarding efficiency measure for specialties. For example, rather than deducing practice efficiency from the relative ranking of total or episodic care cost, the actual cost effects of specific best practices (for example, avoiding improper polypharmacy) should be explored as an available option. In this pursuit, in addition to our ongoing evidence based practice guideline development, APA is currently examining procedures and aspects of care that are overused in cooperation with the American Board of Internal Medicine's Choosing Wisely Campaign.

Furthermore, as medical and Medicare policy evolves to more strongly emphasize and encourage the development and implementation of coordinated care models, it is important to recognize that current Medicare payment policy would seem to inhibit such activity. For example, CMS' decision to not pay for consultations or team meetings limits the communication that must occur among treating clinicians for effective integrated care. Lack of coverage for necessary extended telephone calls and email communication with the patient and/or guardian does the same. A reversal of CMS's decision to not cover the new complex chronic care coordination codes would be a step in the right direction and a recognition of the value of appropriate and adequate care coordination. In brief, Medicare codes need to be better aligned with the reality of the elements that comprise coordinated care and the necessity for consultations among multiple caregivers. The available CPT codes for Medicare providers should recognize that coordinated care may take a considerable amount of time and that providers should be compensated for that time.

Provider Opt-Out for Alternative Payment Model (APM) Adoption and Improvements Upon Current Law

Document question: What do you believe will be necessary to support provider participation in new payment models?

Document question: What improvements upon current law do you believe will be required to support alternate payment model adoption?

Please see previous commentary about the need for psychiatric participation in the HITECH meaningful use incentive program and the problems that psychiatrists are facing with unreasonable and inapplicable measure requirements. Adoption of advanced electronic health records is critical to the future of these alternative payment models and innovative system designs. We would take this opportunity to also note that a large number of facility settings that psychiatrists practice in (specifically: psychiatric hospitals, community mental health centers, and addiction facilities) are currently ineligible for the HITECH meaningful use incentive program. To address that oversight APA has supported legislation to extend the HITECH incentive to these facilities. Reducing other barriers to HIT adoption including clarifying potential liability issues and providing HIT liability protection within future Medicare reform legislation should be considered by the committees of jurisdiction.

It will also be necessary to structure incentives for APM participation in a meaningful way such that the potential reward actually motivates practitioners, and the administrative burden or uncompensated time to achieve them is marginal. There is a growing body of services research which explores these issues, and we would urge the committees to base your policy on the evidence that would assist in this achievement.

Document question: Should providers be able to participate in more than one payment model?

APA feels that the flexibility should exist for providers to participate in more than one alternative/innovative payment model for a number of reasons including potential multiple practice settings for psychiatrists.

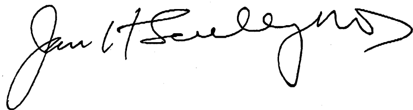
It has been brought to our attention that while statute and implementing regulations permit specialists to participate in more than one Accountable Care Organization (ACO), specialist physicians have encountered administrative obstacles that have precluded them from collecting payment from participation in more than one ACO. This is a cause for concern that requires remedy.

Document question: What is a reasonable time frame for CMS to approve and adopt APMs?

Assuming that there is researched evidence that the APM makes clinical and fiscal sense, many major federal programs have adopted a four year phase in approach (e.g. Diagnosis-related Groups) and we would think that is a minimum for providers to transition.

APA appreciates the opportunity to submit these comments on your collaborative work to repeal and replace the flawed Medicare SGR system. The members and leadership of the American Psychiatric Association look forward to working with Congress to ensure that any reform of the system meets the needs of our patients and psychiatric physicians now and in the future. If you have any questions please contact the APA Department of Government Relations at advocacy@psych.org or by calling 703-907-7800. Thank you again.

Sincerely,



James H. Scully Jr., M.D.
Medical Director and C.E.O., American Psychiatric Association

Attachment: APA Feedback on SGR Repeal and Replacement Framework to House Committees on Energy and Commerce and Ways and Means, 2/26/2013

American Psychiatric Association

1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209
Telephone 703.907.7300
Fax 703.907.1085
E-mail apa@psych.org
www.psychiatry.org

Board of Trustees
2012-2013
Dilip V. Jeste, M.D.
President
Jeffrey A. Lieberman, M.D.
President-Elect
Roger Peele, M.D.
Secretary
David Fassler, M.D.
Treasurer

John M. Oldham, M.D.
Carol Ann Bernstein, M.D.
Alan F. Schatzberg, M.D.
Past Presidents

Molly K. McVoy, M.D.
Jeffrey L. Geller, M.D., M.P.H.
James E. Nininger, M.D.
Brian Crowley, M.D.
Judith F. Kashtan, M.D.
James A. Greene, M.D.
Marc David Graff, M.D.
Jeffrey Akaka, M.D.
Alik S. Widge, M.D., Ph.D.
Eric R. Vanderlip, M.D.
Trustees

Assembly
2012-2013
R. Scott Benson, M.D.
Speaker
Melinda L. Young, M.D.
Speaker-Elect
Jenny L. Boyer, M.D.
Recorder

Staff
James H. Scully Jr., M.D.
Medical Director and CEO
Paul T. Burke
Executive Director, American Psychiatric Foundation

February 26, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Means
House of Representatives
1102 Longworth H.O.B.
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives
2125 Rayburn H.O.B.
Washington, D.C. 20515

Dear Chairman Camp and Chairman Upton,

On behalf of the American Psychiatric Association, the national medical specialty society representing over 35,000 psychiatric physician members, I am writing in response to your recent solicitation for stakeholder input on a framework proposal to permanently repeal and replace the flawed Medicare Sustainable Growth Rate (SGR) physician reimbursement formula. APA appreciates the opportunity to share our thoughts on how this proposal will affect the practice of psychiatry and access to high quality mental health services for our nation's elderly and disabled population. Today it is our intention to share these preliminary comments on the development and implementation of quality improvement initiatives in Medicare fee for service (FFS) as it related to your proposal. We plan to submit further comments in the near future.

It is clear that the elimination of SGR is essential to moving forward with a stable, predictable, and high quality Medicare program. APA is heartened by several recent developments in this arena. First, we are encouraged that your committees have clearly shown this effort to be a top priority and have worked collaboratively to put out this substantive proposal, with a stated goal of moving legislation before the August district work period. Second, and notably, the cost of SGR repeal was recently revised down by the Congressional Budget Office to $138 billion, a drop of more than $100 billion from previous estimates. The reduced price tag makes SGR repeal even more feasible.

<u>Clinical Quality Measure (CQM) Development, Specialty Endorsement, and Performance</u>

APA has for many years been closely engaged in meaningful quality measure development through a variety of partnerships and collaboration with the physician community and beyond. We have participated in relevant workgroups of the American Medical Association's Physician's Consortium for Performance Improvement (PCIPI) and engaged with the National Quality Forum (NQF) and other public and private quality improvement

ventures in order to guide the development of measures that are relevant to the practice of psychiatry and accompanying tools that will likely be nationally endorsed and/or utilized in national programs. A variety of applicable mental health-specific and cross cutting medical measures are available currently for use by our members, including measures concerning conditions such as major depressive disorder, bipolar disorder, and substance use disorders. APA has made this effort a priority in order to improve the care our patients receive and provide the coordination of clinical expertise that our members deserve. Over the next several years we will continue a process of deriving meaningful, vetted, and nationally recognized CQMs from APA's comprehensive practice guidelines - resources that provide evidence-based recommendations for the assessment and treatment of psychiatric disorders. In the near term, new psychiatric CQMs currently in development include sets concerning psychiatric evaluation of adults (including suicide assessment and screening for underlying medical illness), and the off-label prescription of anti-psychotic medication. Information on the full range of APA practice guidelines, which are freely available in order to promote dissemination, can be found at http://psychiatryonline.org/guidelines.aspx.

As your Committees move forward with exploring a mechanism for a standard process for medical societies to develop measures and clinical improvement activities, APA encourages you to build on what is an established infrastructure and track record in the community. Because measures are often cross cutting through multiple specialties and primary care applicability, particularly measures related to mental health and addiction, physician led collaborative efforts like the PCPI should be relied upon to foster and test quality improvement initiatives. Along with this recognition, it is important to understand that collaborative work and efforts from individual societies in measure development is both time consuming and costly. Additional federal support toward tangible quality improvement goals to medical specialties, physician collaborative organizations, and other quality improvement outlets should be considered as needed. The complexity and cost of measure development should also be taken into consideration as the Committees explore the appropriate length of the suggested immediate grace period for stable updates, which APA believes should be long enough to both make comfortable progress on measures as well as to draw meaningful conclusions and incorporate what is learned from the nascent Medicare Physician Quality Reporting System (PQRS) and other measures currently in place.

APA is also in the process of studying the promise of national patient clinical registries. While their application may be less systematic with psychiatrists and physicians who predominantly treat chronic conditions over other medical specialties (e.g. surgical specialties), national clinical registry data may hold great potential for both public health and psychiatric clinical treatment research and it is important that this potential is explored.

Relative Performance Ranking and Efficiency/Economy Measures

Once measures are approved that meet the established bar of the processes that have been either laid out by your proposal or have yet to be determined, the committees' outline suggests "relative ranking amongst physician specialty peer groups and improvement on quality over time". While it may be necessary to separate specialties to judge the advancement of quality improvements by FFS participants within, relative ranking could create a scenario where the gulf between 'higher performing' individuals to 'lower performing' individuals may be significantly different between specialty groups. For that reason APA suggests the establishment of more predictable or concrete thresholds over relative ranking within specialties, which we are concerned could serve as an artificial cap on reimbursement bonuses in relatively high performing specialties.

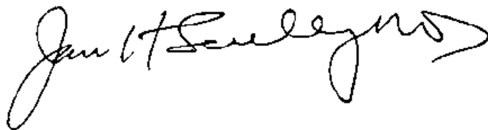
As we understand it, the Committees' draft proposal envisions a fee-for-service system in which a portion of a physician's reimbursement is withheld pending successful compliance with efficiency and economy measures. We are concerned that, if the withhold percentage is set too high, the compliance burden will be so onerous that many physicians, including psychiatrists, will be unable to "recoup" to enable them to receive their baseline fee, let alone qualify for bonus payments on top of their baseline fee. While some physicians may be willing to accept this enforced discount, others will undoubtedly respond by limiting the portion of their patient population insured through Medicare or declining to take on new Medicare patients. This would be particularly disadvantageous for medically complex psychiatric patients being treated for multiple comorbid medical conditions including psychiatric and non-psychiatric medical illness.

Administrative Burden of Measure Reporting and Challenges Concerning HIT Adoption

The future of data collection, quality improvement, addressing preventable conditions, and valuable medical research necessitates the adoption of electronic medical records by psychiatrists and a secure regional or nationwide sharing apparatus. The benefits of health information technology (HIT) adoption and coordinated care are particularly pronounced for Americans suffering from mental illness and substance use disorders, as our typical patient population consists of those that are most at risk for co-morbid medical conditions whose care must be coordinated across multiple settings and clinicians. In order to efficiently report and receive feedback on the types of quality initiatives the Committees are studying for FFS medicine, it is crucial that psychiatrists from solo and small group practice to large integrated health systems transition to 'meaningful users' of HIT. As physicians eligible for the HITECH Act adoption incentive, psychiatrists can serve as a beachhead into the meaningful use program for the mental health community. Unfortunately, both anecdotal evidence and CMS data show that psychiatric participation in the meaningful use program lags behind primary care and other medical specialties. We believe this is due to a number of reasons, most notably unreasonable and inapplicable measurement requirements and the lack of outreach and technical assistance resources to specialists including psychiatrists. It is our hope that an effort addressing these problems can be taken up by your Committees in conjunction with SGR repeal and replacement.

APA appreciates opportunity to submit these preliminary comments on your collaborative work to repeal and replace the flawed Medicare SGR system. The members and leadership of the American Psychiatric Association look forward to working with Congress to ensure that any reform of the system meets the needs of our patients and psychiatric physicians now and in the future. If you have any questions please contact the APA Department of Government Relations at advocacy@psych.org or by calling 703-907-7800. Thank you again.

Sincerely,



James H. Scully, Jr., M.D.
Medical Director & CEO

CC:

The Honorable Sander Levin
The Honorable Henry Waxman
The Honorable Joe Pitts
The Honorable Kevin Brady
The Honorable Jim McDermott
The Honorable Frank Pallone
The Honorable Michael Burgess