AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

September 8, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS 1631-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS 163 - P Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2016.

Dear Administrator Slavitt:

I am writing on behalf of the American Psychological Association Practice Organization (APAPO), the companion organization to the American Psychological Association (APA). APA has over 129,000 members and affiliates engaged in the practice, research, and teaching of psychology. APAPO promotes the interests of psychologists in a wide variety of practice settings. APAPO wishes to take this opportunity to provide the Centers for Medicare and Medicaid Services (CMS) with comments on the proposed rule on the revisions to the payment policies under the physician fee schedule for CY 2016.

Psychologists provide Medicare beneficiaries with critical mental and behavioral health services including psychotherapy, testing, and health and behavior assessments and interventions. Psychologists are the leaders in assessing mental health and pioneered the development of health and behavior services to assist patients struggling with physical health problems.

Medicare's payment formula does not properly value the work of psychologists

We are relieved that the repeal of the Sustainable Growth Rate (SGR) eliminates the uncertainty regarding each year's payment rates. Unfortunately the modest 0.5% increase for 2016 is consumed by the 2% loss for sequestration, leaving psychologists with a loss of 1.5%. It cannot be overlooked that the culmination of losses for sequestration are considerable, reducing psychologists' Medicare reimbursement by 20% over 10 years.

Medicare payments to psychologists have declined significantly since 2001. For example, the Medicare payment for a 45-minute psychotherapy session, the service most commonly billed by psychologists, has been reduced by more than 30% since then, when adjusted for inflation.

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Medicare beneficiaries are increasingly at risk of losing access to these valuable services as more psychologists choose not to continue as Medicare providers. A 2013 APAPO member survey found that 26 percent of responding psychologists were previously Medicare providers but left the program, primarily due to low reimbursement rates.

The problem is that Medicare's current payment formula is not working to ensure that psychologists are paid appropriately and fairly. Under the formula, Medicare increasingly pays more for higher-cost, technology-driven services with high overhead—services which therefore have a high "practice expense" (PE) component within the Resource-Based Relative Value Scale (RBRVS) methodology. Because Medicare is subject to budget neutrality, services with relatively low overhead and PE costs, like psychologists' services, are being unfairly reduced to offset increases in services with higher PE costs. As we have stated before in both letters and meetings with CMS, Medicare's payment formula must be changed so that psychologists are appropriately and fairly compensated for treating Medicare beneficiaries.

Proposal to exclude certain non-physician specialties from the Value-Based Payment Modifier

In the final rule on the 2015 Medicare fee schedule CMS stated it was delaying the application of the value-based payment modifier (VM) for certain non-physician specialties, including psychologists, from 2017 to 2018. CMS reiterated that payment adjustments for such providers in their first year of eligibility under the VM could only be neutral or positive, thus holding them harmless from any negative effects of the VM in 2018.

Now that Congress has repealed the sustainable growth rate (SGR) factor and added the new Merit Incentive Payment System (MIPS), CMS is proposing that it not add psychologists and the other remaining specialties to the VM for 2018. CMS provides no discussion of its rationale for this proposal nor does it indicate what mechanism, if any, will apply to these specialties in 2019.

We question both the rationale for this current proposal and the long-term consequences for the specialties that would be affected if the proposal is adopted. Specifically, we are asking CMS:

- Will the agency bring the excluded specialties under the VM in 2019 or later?
- If so, will they be afforded protection against negative adjustments in the first year?
- Will the excluded specialties later be added to MIPS?
- By not being under the VM, these specialties are unable to earn a positive adjustment in reimbursement for 2018. What steps will CMS take to make up for this lost opportunity?

The Physician Quality Reporting System (PQRS)

APAPO welcomes the adoption of additional PQRS individual measures related to mental and behavioral health. Currently mental and behavioral health professionals such as psychologists have relatively few measures to choose from and most find it difficult, if not impossible, to report on nine measures across three domains. We specifically support the adoption of the following proposed measures:

- Depression Remission at Six Months
- Documentation of a Health Care Proxy for Patients with Cognitive Impairment
- Evaluation or Interview for Risk of Opioid Misuse
- Prevention Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (Replaces PQRS measure #173 on alcohol use)

We have concerns that none of the proposed measures may be reported via claims. While we understand that CMS intends to eliminate claims-based reporting in the future we question why these measures will not be available to eligible professionals who currently report via claims.

We have additional concerns about the reporting mechanism for the proposed measure, Cognitive Impairment Assessment Among At-Risk Adults. We object to the fact that this measure requires documentation in an electronic health record which not all providers are currently required to use. APAPO recommends revising the measure by removing the reference to an electronic health record.

Collaborative Care Models

APAPO agrees with CMS that the care and management of Medicare beneficiaries with multiple chronic conditions often requires extensive discussion, information-sharing, and planning between primary care physicians and other healthcare professionals such as psychologists. APAPO supports the idea of separate payment for collaborative care services that involve interprofessional consultation so long as such payments are structured so that psychologists may bill for collaborative care services that fall under their scope of practice.

Psychologists play a critical role by assessing patients and providing both mental and behavioral health interventions. Although best known for treating mental illness psychologists also use their skills to improve patient adherence to medical treatment, symptom management, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to physical illness. Below is just one example demonstrating how integrating psychologists into primary care benefits patients and can lead to significant reductions in healthcare costs and utilization.

The integration of psychologists throughout primary care and across the care spectrum has been an integral part of experiments in Oregon that have shown real savings throughout the state. In 2010 St Charles Health System deployed a child neuropsychologist in their Neonatal Intensive Care Unit (NICU) Follow-up Clinic (the Clinic) which serves neonates born 37 weeks and younger as well as children who require significant medical intervention(s) or have a genetic syndrome. Since inception of this program, the NICU has experienced a consistent reduction in the length of stay. The NICU's currently averaging 4.5 fewer days per patient than in 2010—saving nearly $3.6 million in 2014 alone. Adding the psychologist to the care team has strengthened the model, and created increased engagement in the Clinic, supporting the continuation of a lifetime of benefits.

This Clinic model is replicated around the country, in health systems like Mayo, the Cleveland Clinic and many other places. Other studies have shown that integrating behavioral health treatment by psychologists and social workers into pediatric treatment improves outcomes over conventional primary care (Asarnow et al. 2015).

Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions

APAPO is pleased that CMS is considering a collaborative care model for treating beneficiaries who have common behavioral health conditions. As CMS works on this issue, we encourage the agency to give equal consideration to care models that were developed and evaluated with psychotherapy as a core component of treatment (Arean et al. 2013; Hegel et al. 2002). APAPO also wishes to point out that collaborative care is a broad health system model that applies to all chronic illnesses, both physical and mental. Psychologists have played many crucial roles in

collaborative care models, such as developing and evaluating the models, training the staff, providing direct patient services, and functioning as consultants. APAPO notes that while the proposed rule makes reference to the AIMS Center at the University of Washington it fails to point out that in programs implemented via AIMS it is psychologists who have trained the care managers and served as consultants.

There are many reasons why non-pharmacological treatments should be the first option for older adults. Risks associated with polypharmacy (i.e., the concomitant use of multiple medications) include increased morbidity and mortality (Espino et al., 2006, Goulding 2004, Straand et al., 2006, Kennerfalk et al., 2002). Older adults are more likely to experience drug toxicity because of reduced metabolism of medications, which can lead to other health problems (e.g., lethargy, confusion, falls, delirium, and death) along with increased healthcare costs and service utilization (Arnold 2008).

In addition, many studies have been conducted on older patients' views and preferences for treatment for depression, a frequently diagnosed mental illness. When asked to choose between psychotherapy, medication, or a combination of the two, in every study patients preferred psychotherapy or a combination to medication alone. Some studies also showed that the effect of treatment varies as a function of preference, meaning those who received their preferred treatment had better treatment outcomes. One study found depressed elderly patients seen in primary care preferred therapy over medication, 57% to 43% (Gum et al. 2006).

Psychologists play a unique role in the collaboration, management, and evaluation of treatment for older adults and can help reduce the adverse consequences related to the use of medication by implementing psychologically-based interventions. We look forward to working with CMS to develop appropriate models of collaborative care for Medicare beneficiaries.

<u>Interprofessional Telephone/Internet Consultations</u>

In the CY 2016 proposed rule, CMS states, *"We believe that the care and management for Medicare beneficiaries with multiple chronic conditions, a particularly complicated disease or acute condition, or common behavioral health conditions often requires extensive discussion, information-sharing and planning between a primary care physician and a specialist.… Because Medicare pays for telephone consultations with or about a beneficiary as a part of other services furnished to the beneficiary, we currently do not make separate payment for these services."*

APAPO supports the separate reimbursement of specialists' telephone consultations (CPT codes 99446-99449). Psychologists frequently provide this consultation service to primary care physicians who are treating Medicare beneficiaries, but do not have codes for reporting the service. APA recommends that CMS consider separate payment for consulting specialists (i.e., psychologists) who cannot report their services with any of the E/M billing codes and who are unlikely to be in "incident to" arrangements with a physician. As a suggestion, CMS could mirror the interprofessional telephone/internet consultation codes with interim HCPCS codes, so that they could be reported by non-physician specialists. We would also want CMS to work with us and the American Medical Association to later relocate the services described in CPT codes 99446-99449 to the (non-Evaluation and Management) Medicine section of CPT.

The interprofessional consultations should be tied to a beneficiary encounter, such as a psychotherapy or psychological testing or neuropsychological testing session. To ensure that beneficiaries are fully aware of the involvement of, and associated benefits from, the specialist in their care, the beneficiary should be provided with a written notification.

Medical Team Conferences

Although not specifically referenced in the proposed rule, APAPO recommends that CMS begin reimbursement for medical team conferences (CPT codes 99366-99368). The CPT codes were constructed for reporting *"Medical team conferences include face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the patient), with or without the presence of the patient, family member(s), community agencies, surrogate decision maker(s) (e.g., legal guardian), and/or caregiver(s)."* [CPT Professional Edition, 2015; American Medical Association]

As with the interprofessional telephone/internet consultation codes, we urge CMS to mirror CPT codes 99366-99368 with interim HCPCS codes, so that non-physicians who cannot bill E/M codes—and who are not likely to be in "incident to" arrangements with physicians—can report their services.

Potentially Misvalued Codes

In the CY 2016 proposed rule, CMS states that listed codes were identified by the High Expenditures screen, and were chosen because they "…account for the majority of spending under the PFS."

We note that the combined, total allowable amount for the three psychological testing and neuropsychological testing codes (96101, 96116, and 96118) is a very small portion of the total fee schedule spending. Further, although each of the three has more than $10 million in allowable charges during each year since 2010, the yearly change is quite small. The 2010 – 2013 claims data show that for the CMS-nominated psychological testing and neuropsychological testing codes, the average yearly change in allowable charges is less than 1%. This seems to indicate that the codes' utilization is stable.

APAPO has considered the codes (96101, 96116, and 96118) on the Potentially Misvalued Services list. We will review the valuation factors relevant to the RBRVS.

Advance Care Planning Services

CMS is taking steps towards instituting payment for advance care planning services furnished by a physician or other qualified health professional under new CPT codes 99497 and add-on code 99498. While APAPO applauds CMS for recognizing the importance of having health professionals discuss topics such as advance directives, internal CMS policy will unnecessarily limit beneficiary access to such services. Specifically, psychologists, who are eminently qualified to help patients deal with end of life issues, will be prohibited from billing Medicare for these services because the codes fall under the evaluation and management (E/M) section of CPT.

For patients with potentially terminal illnesses, making thoughtful decisions about end of life care can be an extremely emotional process. Psychologists are experts at understanding human behavior throughout the lifespan and have had years of training in family dynamics. Advance care planning gives patients an opportunity to retain some degree of control over the remainder of their lives and reduce the decision-making burden that often falls on family members. Psychologists are well-prepared to assist patients in identifying, working through, and resolving their thoughts and feelings on end of life issues.

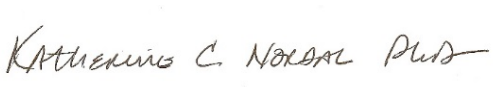
Despite many examples furnished by APAPO showing that psychologists are authorized to furnish numerous E/M services under their scope of practice, including transition care management and chronic care management, CMS refuses to allow psychologists to bill for any E/M services. This decades old policy has not evolved, even as psychologists increasingly use their skills and training to assist patients with co-morbid conditions and physical health issues. Developing new codes for services such as transition care management and chronic care management shows that today many different health care professionals play important roles in treating Medicare beneficiaries. Providers such as psychologists, however, are not being treated fairly if the services they are qualified to provide will not be reimbursed simply because the services' billing codes are placed in one section of the CPT Manual rather than another.

APAPO requests that CMS allow psychologists to assist beneficiaries facing end of life issues by reimbursing them for advance care planning services under CPT codes 99497 and 99498.

Conclusion

APAPO thanks CMS for this opportunity to provide comments on the proposed rule on the CY 2016 Medicare fee schedule. We look forward to working with the agency to address the issues raised in this comment letter. Should you have any questions please contact our Director of Regulatory Affairs, Diane M. Pedulla, J.D., by telephone at 202-336-5889 or by email at dpedulla@apa.org.

Sincerely,



Katherine C. Nordal, Ph.D.
Executive Director for Professional Practice

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