AMERICAN PSYCHIATRIC ASSOCIATION

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September 11, 2017

Seema Verma, M.P.H.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1676-P
P. O. Box 8016
7500 Security Boulevard
Baltimore MD 21244-8013

Dear Administrator Verma:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,000 psychiatric physicians and their patients, would like to take the opportunity to comment on the 2018 proposed rule for the Medicare Physician Fee Schedule. Our comments focus specifically on issues that impact the care of patients with mental health and substance use disorders (MH/SUDs), particularly expansion of coverage for evidence based clinical services, reduction of administrative burdens through revision of documentation guidelines for evaluation and management (E/M) services, and improvements in 2018 payment adjustments under the expiring Medicare quality programs, as considered in this proposed rule. We particularly urge the Centers for Medicare and Medicaid Services (CMS) to address the following top priorities:

- Implement the correction to the allocation of indirect practice expense (PE) relative value units (RVUs) to more accurately reflect resource costs incurred by psychiatrists providing services to patients with mental health and substance use disorders;
- Collect/implement appropriate professional premium liability insurance rates for non-physician practitioners in the calculation of the malpractice RVUs;
- Support expanding access to care via expanding telehealth services;
- Support patient access to the Collaborative Care Model through appropriate valuation in all (facility and non-facility) settings and separate payment in federally qualified health centers (FQHCs) and rural health centers (RHCs);
- Adopt Medicare coverage for services for patients with Opioid addiction;
- Provide relief from burdensome E/M documentation requirements while at the same time developing audit criteria that can be applied reliably and consistently;

- Finalize the proposal to adopt quality reporting requirements for 2018 payment adjustments under the Physician Quality Reporting System (PQRS) that are consistent with the Merit-based Incentive Payment System (MIPS) program;

- Finalize proposed improvements to assessment of 2018 payment adjustments under the Value-Based Payment Modifier which would reduce the application of unfair penalties; and

- Implement the patient relationship categories in a measured way with appropriate educational support.

PROVISIONS OF THE PROPOSED RULE FOR THE PHYSICIAN FEE SCHEDULE (PFS)

Adjustment to Allocation of Indirect Practice Expense (PE) for Some Office-Based Services

APA commends CMS for proposing to correct an anomaly in the allocation of indirect PE relative value units (RVUs) to a number of services for which these have been unusually low. If finalized, this will more accurately reflect the resource costs incurred by psychiatrists providing services for patients with mental health and substance use disorders in non-facility settings. CMS is proposing to establish a minimum non-facility indirect PE RVU based on the indirect PE RVU to work RVU ratio for the most commonly furnished office-based, face-face service, CPT® (Current Procedural Terminology®) 99213, *Office or other outpatient visit for the evaluation and management of an established patient; usually the presenting problems are of low to moderate severity*, as a marker. This proposal would increase the allocation of indirect PE RVUs to codes for services that currently fall below that ratio. As a result, this proposed change would more accurately reflect the resource costs, such as office space, administrative labor and records management, necessary to providing these services. **We concur with CMS's proposal, including the plan to base the ratio on that of the most commonly billed CPT® code, 99213, which is billed by a wide range of clinicians. We also support the agency's proposal to exclude the codes directly impacted by this proposal from the mis-valued code target calculation as this is a change to the methodology to account for a longstanding anomaly.** Many APA members have told us that these PE expenses were undercounted in their services. This proposal is a step in the right direction for improving psychiatrists' reimbursement under Medicare.

Determination of Malpractice Relative Value Units

APA concurs with the concerns expressed by the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) that the proposal to crosswalk non-physician practitioner (NPP) specialties to the lowest physician risk factor specialty (Allergy/Immunology) for which their contractor collects premium rates. This would result in some NPP specialties being overcompensated. CMS has data from the 2006 AMA Physician Practice Information (PPI) survey, which shows a substantial difference (roughly twenty percent less) in the premium rates between Allergy and Immunology, and seven out of the eight NPP groups listed. In the event the CMS contractor is unable to gather the rates for allied health professionals from state filings as they do with physicians, a quick search of the Intranet will produce rates for a variety of NPP specialties. Sites such as: NSO.com, HPSO.com, trustinsurance.com, and americanprofessional.com, have information on rates publicly available and in many instances, breaks them down by state. **As the APA has stated in previous comments, CMS should collect premium data**

for the NPP specialties from those states where it is readily available. If this is found to be insufficient, CMS should use the PPI data from 2006.

Medicare Telehealth Services

APA supports CMS's interest in expanding access to telehealth services. Most psychiatric treatments can be delivered through telepsychiatry, which provides an already vulnerable mental health population improved access to care in a variety of settings. Case studies and empirical data have revealed that telepsychiatry has no known absolute exclusion criteria, nor contraindications for any specific psychiatric diagnoses, treatments, or populations. Specifically, APA supports CMS's proposal to add three CPT® codes from the psychiatry section of CPT® to the list of covered Medicare telehealth services. These are: 90839 (Psychotherapy for crisis, first 60 minutes); 90840 (Psychotherapy for crisis, each additional 30 minutes); and 90875 (Interactive complexity); APA also supports addition of: 96160 (Administration of patient-focused health risk assessment instrument); 96161 (Administration of caregiver-focused health risk assessment instrument); and G0506 (comprehensive assessment of and care planning for patients requiring chronic care management services).

With regard to providing psychotherapy for crisis (90839 and 90840) via telehealth, CMS has asked for feedback on "whether the remote practitioner will be able to 'mobilize resources at the originating site to defuse a crisis and restore safety,' which is a current requirement of the code." Telemedicine requires particular cautions regarding emergency management. In order to practice remotely, clinicians may need to make the extra effort to learn about local resources or consult with services in that area to ensure adequate care.[1] Reasonable and appropriate measures that address patient safety in the event of a medical emergency, while paramount to the standard of care around telepsychiatry, should not preclude access to timely treatment via telepsychiatry."

The APA echoes the AMA in strongly urging CMS to issue a call for new and expanded demonstration projects which waive Medicare's current geographical and originating site restrictions for telehealth. This would benefit the patients served in those demonstrations and also help develop data on whether expanded access to telehealth may increase (or even decrease) overall health costs.

Proposed Valuation of Specific Codes

(53) Psychiatric Collaborative Care Management Services (CPT® codes 994X1, 994X2, 994X3, and HCPCS code G0507)

As we have noted previously, APA strongly commends CMS for its decision to provide Medicare coverage for psychiatric collaborative care management services. This is a significant advancement in health policy for the population that suffers with behavioral health conditions, which are largely underdiagnosed and/or undertreated in the primary care sector. As we noted in our September 8, 2015 letter to CMS, "the lack of reimbursement for key components of this model has been the principal barrier

[1]APA Resource Document on Telepsychiatry and Related Technologies in Clinical Psychiatry, 2014 APA Council on Psychiatry & Law, 2014. https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/resource-documents.

to its widespread implementation. Although there may be other treatment models that engage primary care clinicians and behavioral health specialists, the specific Collaborative Care Model [CoCM] that CMS refers to in the July 15 [2015] Federal Register is the only model that has compelling scientific data supporting its effectiveness."[1]

APA supports CMS's proposal to remove the furniture (one couch and two chairs) from among the equipment costs for 994X1, 994X2, and 994X3 in the facility setting, given that the provider will typically be seeing the patient for face-to-face services in the facility setting rather than their private office. However, we disagree with CMS's proposal to not include the minutes of clinical staff time when these services are done in a facility setting. We appreciate that CMS recognizes some physicians will not be appropriately compensated for the services provided to patients in a facility setting should this proposal be finalized. CMS acknowledges there are circumstances where the patient who is receiving the services is located in a facility but the bulk of the services, in this case non-face-to-face care management services, occurs in the private office of the billing physician rather than in the facility itself. As currently constructed, if CMS finalizes this proposal, those physicians would be paid at the facility rate, which would not adequately compensate them for the costs associated with the services they have provided. This anomaly occurs with all care management codes, which have substantial amounts of clinical staff time devoted to non-face-to-face services, when provided to patients located in a facility.

We appreciate CMS's willingness to consider other means to address the appropriate valuation of these services in the facility setting. Like CMS, we are open to separate billing for the professional, technical, and global components of these services to allow practitioners to appropriately bill the component of the service, which they furnish.

Another option may be to reconsider how place of service (POS) codes are used with psychiatric collaborative care management, chronic care management, and other such services. As CMS notes in the March 2013 MLN Matters (MM7631), "At the time a POS code is developed, CMS determines whether a MPFS facility or non-facility payment rate is appropriate for that setting and Medicare contractors are required to make payment at the MPFS rate designated for each POS code. Under the MPFS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to beneficiaries."[2] In the case of the monthly care management services, much of the care is provided non-face-to-face by clinical staff and the practice expenses are driven by where the physician is rather than where the patient is located. By enabling physicians to report their place of service rather than using the facility where the patient is located, physicians would be "selecting the most appropriate POS code." This would ensure that CMS would include the minutes or not as defined by the physician's POS.

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[1] Archer, J., et al. Collaborative care for depression and anxiety problems. *Cochrane Database Systems Review*, 2012. 10: CD006525.

[2] MLN Matters® Number: MM7631; March 29, 2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf.

There are multiple ways in which CMS could address the issue of not including clinical staff time in the facility setting. APA looks forward to working with CMS and other stakeholders to identify a mutually agreeable solution before the final rule on the 2018 Fee Schedule is issued.

CMS expressed interest in understanding how the general behavioral health intervention (BHI) code (99XX5) is being used. At this point, the code has been in place for less than a year and there has not been sufficient billing activity to understand exactly how this code is being used.

CMS stated that professionals who cannot report E/M services to Medicare have expressed interest in serving as a primary hub for behavioral health services, citing that stakeholders have suggested that a clinical psychologist might serve as the primary practitioner that integrates medical care and psychiatric expertise. CMS seeks comments on the circumstances under which this model of care is happening and whether additional coding would be needed to accurately describe and value other models of care.

While there are a number of models of care that are identified as "collaborative" or "integrated" care, none have the level of evidence and demonstrated effectiveness as the Collaborative Care Model (CoCM), which utilizes the unique combinations of medical and behavioral health training for which the expertise of a psychiatric physician is a necessary element.

The suggestion that a clinical psychologist could "integrate medical care and psychiatric expertise" runs counter to CMS policy. CMS has stated in previous rulemaking "that Medicare does not recognize clinical psychologists to bill E/M services because they are not authorized to furnish those services under their state scope of practice (62 FR 59057). While clinical psychologists have been granted prescribing privileges in Louisiana and New Mexico, [under specifically defined circumstances] they are not licensed or authorized under their State scope of practice to furnish the full range of traditional E/M services."[3] Stated simply, psychologists lack the medical training and expertise necessary to serve in this role. Integration of medical and psychiatric care requires the ability to advise and make medical recommendations, as needed, for psychiatric and other medical care (of physical health conditions), including psychiatric and other medical differential diagnosis, treatment strategies regarding appropriate therapies, medication management, and medical management of complications associated with treatment of psychiatric disorders.

Clinical psychologists currently serve important roles in the care of patients in an integrated care model. In addition to providing direct patient care (i.e., psychotherapy, psychological testing, health and behavioral assessment and interventions), they can also serve as trainers for behavioral health care managers, teaching them brief interventions. Psychologists "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."[4]

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[3] Federal Register / Vol. 77, No. 222 / Friday, November 16, 2012 / Rules and Regulations 69062

[4] American Psychological Association Practice Organization. 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. September 8, 2015. http://www.apapracticecentral.org/update/2015/09-10/proposed-rule.pdf

(55) Physician Coding for Insertion and Removal of Subdermal Drug Implants for the Treatment of Opioid Addiction (HCPCS Codes GDDD1, GDDD2, and GDDD3)

APA supports Medicare coverage for HCPCS codes GDDD1, GDDD2, and GDDD3 which describe the insertion and removal of subdermal drug implants provided to patients with Opioid addiction. This is just one part of a complete treatment program that should include counseling, psychosocial support, and routine follow-up. **APA commends CMS for its ongoing efforts to ensure that patients with substance use disorders have access to medically necessary care.**

Evaluation and Management (E/M) Guidelines and Care Management Services

APA supports CMS's proposal to review and revise the existing documentation requirements for E/M services. APA members report that the documentation guidelines as they currently exist are overly burdensome and impede clinical care. It appears that results of Medicare contractor audits are widely variable, reflecting what appears to be an inconsistency in the application of audit criteria. We support CMS's proposal to conduct a comprehensive reform of the documentation guidelines. This process should be iterative with multiple opportunities to comment, transparent, and allow for the involvement of all interested stakeholders that offer a range of perspectives. The current valuation of all E/M services should be presumed correct. The goal is to reform the E/M documentation guidelines to make them consistent with current medical practice, rather than to change the nature of the services provided.

APA supports halting the review of documentation of the history and physical exam as part of the audit process, however we encourage interim revisions to the audit criteria for medical decision-making documentation to ensure it is reliable and consistent. Psychiatrists routinely provide evaluation and management services to Medicare beneficiaries. We welcome the opportunity to participate in the comprehensive reform process.

OTHER PROVISIONS OF THE PROPOSED RULE

New Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

APA commends CMS and supports the proposal to establish HCPCS codes (GCCC1 and GCCC2) to allow RHCs and FQHCs to bill separately for these increasingly essential care management and behavioral health integration services. As CMS is aware, there is a strong evidence base[5][6] in support of the Collaborative Care Model (CoCM) for use in all settings. As with the adoption of any new model of care, identifying and reducing obstacles to implementation (i.e., financial, organizational) is critical to the long-

[5] Unützer, Jürgen, Henry Harbin, Michael Schoenbaum, and Benjamin Druss. "The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes." *HEALTH HOME, Information Resource Center* (2013): 1-13.

[6] "Aims.uw.edu,", accessed August 30, 2017, https://aims.uw.edu/sites/default/files/CollaborativeCareEvidenceBase_0.pdf

term success of the model.[7] It is difficult at this point to project whether or not the proposed rates are appropriate and to discern whether or not the increased rate for the general BHI code will negatively impact the adoption of the one model (CoCM) with a significant evidence base. **APA encourages CMS to monitor the use of the codes and related feedback with regard to the financial sustainability of the model, and address any challenges and concerns in future rulemaking.**

Physician Quality Reporting System (PQRS) Criteria for Satisfactory Reporting for Individual Eligible Professionals (EPs) and Group Practices for the 2018 PQRS Payment Adjustment

CMS is proposing to adjust the criteria it applies to the PQRS data already submitted for the 2016 reporting period, in determining who is a successful PQRS reporter and therefore avoids a two-percent PQRS penalty in 2018. The prevailing minimum PQRS standard has, for several years, required the reporting of at least nine PQRS quality measures across three National Quality Strategy "domains" – including one cross-cutting measure (for claims and qualified registry reporting) and one outcome or "high-priority" measure (for reporting by a qualified clinical data registry). PQRS high-priority measures relate to resource use, patient experience of care, efficiency/appropriate use, or patient safety.

CMS is now proposing to lower the 2016 PQRS minimum standard to six measures, also the minimum standard for full reporting of MIPS quality measures. However, CMS does not plan to apply the MIPS requirement to report at least one outcome or high-priority quality measure, saying it wants "to revise the satisfactory reporting criteria for the last year of PQRS to be less complex for individual EPs and groups to understand." If an EP submitted less than six PQRS measures for 2016, they may still be able to avoid 2018 PQRS penalties, if the "measure application validity" (MAV) process finds they had no other applicable quality measures available.

APA commends CMS for overhauling the quality measure applicability process by making it a deliberative process that includes the eligible clinician as a collaborative partner, rather than a determination, which is based on codes and lacks consideration for therapeutic appropriateness. Psychiatrists are challenged to find six quality measures relevant to their practice and their patients, given the significant gaps in quality measures for mental health and substance use disorders. The higher PQRS standard of nine measures has been a significant barrier to their successful participation in PQRS, even with the application of the of the MAV process. **This proposal will lead to fewer PQRS penalties for psychiatrists and other EPs, which could encourage greater participation in the MIPS program. We strongly urge CMS to finalize this proposal, and we offer our assistance to CMS administrators in identifying a measure applicability process that provides meaning to psychiatrist EPs and their patients.**

Value-Based Payment Modifier (VM)

The Value-Based Payment Modifier (VM) is a payment adjustment imposed by Congress and designed to measure physicians' relative resource use. In 2015, CMS applied VM payment adjustments to physicians in groups of 100 or more EPs. In 2016, the VM was also applied to physicians in groups of 10 or more EPs.

[7] Goodrich, David E., Amy M. Kilbourne, Kristina M. Nord, and Mark S. Bauer. "Mental Health Collaborative Care and its Role in Primary Care Settings." *Current Psychiatry Reports 15*, no.8 (2013). Doi:10.10007/s11920-013-0383-2.

Under the MACRA, in 2017 the VM was applied to all physicians. And in 2018, VM adjustments will also apply to physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.

CMS is proposing three beneficial proposals regarding VM 2016 reporting and 2018 payment adjustments.

- First, for individuals and groups that successfully avoid 2018 PQRS penalties, CMS no longer plans to apply a VM "quality tiering" or cost analysis that could subject them to 2018 VM penalties. All successful PQRS reporters (including successful reporters of Shared Savings ACO quality data) would also avoid VM penalties.

- Second, for unsuccessful PQRS participants, CMS plans to lower the automatic VM penalty from two to one percent for small practices (of up to 9 EPs), and from four to two percent for large practices (of 10 or more EPs). This would bring the 2018 total maximum penalties under PQRS and VM to four percent, the same as the highest MIPS penalties in 2019. Since VM adjustments are budget-neutral, less funds would be available for upward adjustments, and these would be lower than in the past.

- Third, CMS is no longer planning to include VM data on EPs' performance data (for 2016 reporting/2018 adjustments) that publicly reported on its consumer website, Physician Compare. The VM information would soon be supplanted by MIPS performance data, in just one year.

The APA applauds these proposed improvements. These would add a much-needed element of fairness to the VM and avoid subjecting psychiatrists to unfair penalties for costs and analyses beyond their control. Psychiatrists who are successful PQRS reporters should be held harmless from VM penalties. The VM has been fraught with difficulties from the start, including ever-changing, incomprehensible methodological issues lacking in transparency, and problematic quality and resource use reports (QRURs) that EPs cannot understand and often attribute costs beyond their control. Many psychiatrists do not understand why they are now receiving VM penalties (or bonuses), or how these were calculated. Congress recognized these flaws and redefined cost measurement under the MIPS program in the MACRA. Significant efforts are already under way to develop a more accurate approach, with input from psychiatrists, physicians, and other clinicians. VM penalties should be as low as possible, and including EPs' performance under this flawed analysis on Physician Compare would not help consumers.

MACRA Patient Relationship Categories and Codes

For the MIPS cost performance category, CMS has created an operational list of the following "patient relationship categories" -- and is proposing related modifiers – to accurately attribute a patient's costs to the correct MIPS eligible clinician(s).

Proposed HCPCS Modifier	Patient Relationship Category
X1	Continuous/Broad Services
X2	Continuous/Focused Services
X3	Episodic/Broad Services
X4	Episodic/Focused Services
X5	Only as Ordered by Another Clinician

The proposed Level II HCPCS (Healthcare Common Procedure Coding System) modifiers would be reported on Medicare claims starting on January 1, 2018, as required under the MACRA. However, CMS plans to "work with clinicians to educate them about the proper use of the modifiers," anticipates a significant learning curve, and "time would be needed to work with clinicians to ensure they gain experience in using these modifiers." Therefore, at least initially, reporting of the modifiers would be voluntary. In addition, the use of modifiers would not change the meaning of the procedure codes, and would also not affect the reported intensity of services such as evaluation and management services. CMS also plans to resubmit the patient relationship modifiers to the CPT® Editorial Panel to consider future inclusion into the CPT® modifier code set.

The APA appreciates this gradual approach in easing into the use of these modifiers – as well as CMS' commitment to educate clinicians in their proper use. This represents an entirely new requirement when filling out Medicare claims. Psychiatrists and other clinicians, as well as coders and other supporting personnel who fill out Medicare claims, will need time to learn these modifiers and their significance. In addition, CMS will need to provide detailed guidance on how to select the correct modifier that most accurately reflects each patient's relationship with the clinician during the provision of the service(s) in that claim. For psychiatrists, the relationship may vary considerably from patient to patient and from claim to claim.

Conclusion

Thank you for your consideration of our comments on these important issues. We look forward to working with you to develop and implement these policies. If you have any further questions or would like the opportunity to discuss our comments, please contact Becky Yowell, APA Deputy Director of Coding and Reimbursement, at byowell@psych.org or 703-907-8593.

Sincerely,

Saul Levin, MD, MPA

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