



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION  
PRACTICE ORGANIZATION

September 10, 2018

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8016  
Baltimore, Maryland 21244-8016.

**Re: CMS-1693-P Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program**

Dear Administrator Verma:

I am writing on behalf of the American Psychological Association (APA)'s Practice Organization (the Practice Organization). APA is the professional organization representing more than 115,700 members and associates engaged in the practice, research, and teaching of psychology. The Practice Organization advocates on behalf of psychologists engaged in the practice of psychology in all settings. The Practice Organization is providing the Centers for Medicare and Medicaid Services (CMS) with comments on the proposed rule on the 2019 Medicare physician fee schedule released on July 12, 2018.

**Summary of Key Recommendations**

Psychological and Neuropsychological Testing Codes

We urge CMS to adopt the proposed values for the newly revised family of testing codes.

We request clarification about the lack of a facility fee for codes 963X9, 963X10 and 963X12.

Communication Technology-Based Services

We urge CMS to either revise proposed code GVCII or create a new code so that providers who cannot furnish evaluation and management (E/M) services in Medicare will be able to bill for brief check-in services.

Management and Counseling Treatment for Substance Use Disorders

We urge CMS to recognize different treatment methods for opioid and other substance use disorders including psychotherapy and health and behavior services.

750 First Street, N.E.  
Washington, DC 20002-4242  
(202) 336-5800  
(202) 336-5797 Fax  
(202) 336-6123 TDD

*An affiliate of the American Psychological Association*

## Quality Payment Program

We thank CMS for proposing to add psychologists as eligible clinicians in the Merit-Based Incentive Payment System (MIPS) for 2019.

We strongly support CMS's proposal to weight the Promoting Interoperability (PI) Performance Category to zero for providers such as psychologists who were not part of meaningful use and never received incentives to adopt electronic health information technology.

We request that CMS add a Pick-Your-Pace option for providers being added to MIPS in 2019 to allow them the same opportunity that physicians had to avoid a penalty by submitting minimal data in their first year of reporting.

### **Background**

Psychologists provide Medicare beneficiaries with critical mental, behavioral, and substance use disorder services including psychotherapy, psychological and neuropsychological testing, and health and behavior assessments and interventions. Our members are among the most highly educated healthcare professionals with an average seven years of graduate education. They are the leaders in the diagnosis and assessment of mental health problems and pioneered the development of health and behavior services to assist patients struggling with physical health problems. Their work commonly involves treating patients with co-morbid conditions. Since 1970, an increasingly larger percentage of patients with mental illness are being treated by psychologists in outpatient rather than inpatient settings.

Psychologists are primary, if not the major, providers of mental, behavioral, and substance use disorder services to Medicare beneficiaries. According to Medicare's utilization database, psychologists provide 40% of the outpatient and 70% of the inpatient psychotherapy services that beneficiaries receive, and they provide most of the mental health diagnostic services. Along with licensed clinical social workers (LCSWs), psychologists provide most of the mental health benefit to elderly and disabled persons enrolled in Medicare.

America cannot afford to let the mental and behavioral health needs of the elderly and disabled go unmet. According to the Center for Medicare Advocacy about 26% of all Medicare beneficiaries (more than 13 million Americans) experience some mental disorder, including cognitive disorders like Alzheimer's disease, every year.<sup>1</sup> With the aging of the baby boom generation this number will grow significantly over the next decade. According to the Medicare Payment Advisory Commission (MedPAC) the Medicare population, currently about 59 million, will rise to over 80 million beneficiaries by 2030.<sup>2</sup> To help the elderly and disabled lead the best lives they can it is critical that Medicare beneficiaries have access to psychological services.

While we are pleased to see that CMS is projecting an overall 2% increase in payments to psychologists in 2019 it cannot be overlooked that reimbursement rates have been falling for years. Despite the complexity of their valuable services, reimbursement for psychologists in Medicare remains inadequate. Adjusted for inflation, psychologists have lost more than 37% in payment over the past 15 years for the most commonly provided mental health service, the 45-

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<sup>1</sup> <http://www.medicareadvocacy.org/medicare-and-mental-health/>

<sup>2</sup> Medicare beneficiary demographics, Section 2, Page 24; MedPAC Data Book: Health care spending and the Medicare program, June 2017

minute psychotherapy session. Declining reimbursement means a corresponding loss of Medicare beneficiary access to psychologists' services.

An internal survey of our membership reveals that psychologists' participation in Medicare is drastically declining. The survey found that 26% of responding psychologists, who were once Medicare providers, have left the program primarily due to low reimbursement rates. Half of the respondents indicate that they have left since 2008. This means over 5,000 psychologists no longer provide the mental, behavioral and substance use disorder services that Medicare beneficiaries need.

Losing psychologists from Medicare places beneficiaries in need of mental, behavioral and substance use disorder services in an increasingly dire situation, where they cannot get access to a provider of these services. Psychologists are dropping out of the program, and those who remain are more likely to limit the number of Medicare beneficiaries they see in favor of patients who privately pay or whose insurance provides more competitive reimbursement. Since most psychologists work in solo or small group practices, continuing to participate in Medicare while having their payments repeatedly cut puts their entire practice at risk. Our members say they cannot remain in Medicare or must limit the number of their Medicare patients to make a living.

### **Psychological and Neuropsychological Testing Services**

For key services Medicare beneficiaries must have access to psychologists. Although LCSWs provide many of the mental health services in rural areas they cannot substitute for psychologists as they are not trained in assessment and they typically do not provide health and behavior services. Only psychologists can furnish vital psychological and neuropsychological testing services. Such services are critical when assessing patients for potential brain damage, dementia, and functionality.

In 2015 CMS flagged the growing usage of the professional psychological and neuropsychological testing services (CPT® codes 96101, 96116, and 96118). These codes capture services provided by a psychologist or physician. Concern over the codes being misvalued led to the current family of testing codes being sent to the AMA CPT® Editorial Panel for revision.

Because of the changes adopted by the CPT Panel, psychologists and other health care professionals will need to learn new codes and employ a more complicated billing structure in 2019. Designed to put testing in line with other health care services, the new codes vary by the type of service provided (testing administration vs. testing evaluation), the individual providing the service (a psychologist or physician vs. a technician) and the length of the testing battery (the initial 30 minutes of testing administration or 60 minutes of testing evaluation vs. additional "add-on" time required to complete the service).

After CPT the family of testing codes was sent to the Resource-based Relative Value Update Committee (RUC) for surveying. The RUC approved recommended values for the codes in October 2017.

Because psychologists play such a prominent role in testing APA was an active participant in both the CPT process to revise the codes and the RUC surveys. Looking at the RUC's recommended values for the new testing codes we anticipated significant work value reductions of 13-18% for a typical psychological or neuropsychological test battery, in the 2019 physician fee schedule.

To avoid this, the APA Practice Organization met with CMS earlier this year and respectfully requested that the agency increase the RUC recommended values for several of the codes to offset the anticipated reductions. Payments for psychological services in Medicare have been

falling for years due to payment adjustments, ongoing sequestration cuts, and penalties under the former Physician Quality Reporting System (PQRS). Additional reductions in payment for testing services would have driven many psychologists out of the program entirely, leaving beneficiaries unable to access such critical services.

Recognizing the importance of psychological and neuropsychological testing services to the health of Medicare beneficiaries CMS is taking a proactive stance to protect testing services in Medicare. In addition to accepting the RUC's recommendations for test administration by the professional (963X7 and 963X8), CMS is proposing higher work values for the four professional evaluation codes (963X3, 963X4, 963X5 and 963X6) than the values the RUC recommended. CMS is also proposing to reinstate PE costs that APA had recommended but were eliminated by the RUC. Based on the information in the proposed rule the APA Practice Organization projects that many psychologists and neuropsychologists performing testing services will see a modest increase for a standard battery of tests in 2019. Adjustments proposed by CMS still allow for work neutrality within the family of testing codes.

On behalf of both psychologists and their Medicare patients, the APA Practice Organization thanks CMS for its leadership on this issue. Realizing that the RUC recommendations would result in a loss of value under the new billing structure, even though the professional work involved in these services remains the same, CMS found this reduction was unwarranted. We support the adoption of the values proposed by CMS for the family of testing codes in 2019.

We are requesting clarification regarding the lack of a facility fee for codes 963X9, 963X10, and 96X12. The current testing codes for services comparable to those covered by these three new codes all have facility fees. We are asking CMS to explain in the final rule why the facility fee values were eliminated for these services.

In response to the agency's request for clarification on code 96X12, we note that since 2006 there has been significant increase in technology driven, computer-based psychological and neuropsychological assessments using desktop computers and tablets for administration. In APA's October 2017 submission of PE recommendations for 96X12, we suggested that CANTAB Mobile (per single automated assessment) was a representative example of a new automated supply item. We submitted documentation that a CANTAB Mobile software license cost \$2,800 and could be used for up to 100 assessments (\$28.00/administration) but were unable to obtain a paid invoice prior to the presentation. We also included 10 minutes of equipment time for the patient's use of an iPad to complete the test.

During our presentation of the recommendations, the PE Subcommittee determined that because CANTAB Mobile was a software license, it would be more appropriately classified as equipment. The time that the item is in use, which is not directly related to the clinical activity time, is typically for 10 minutes while the patient takes the test. As directed by the PE Subcommittee, the \$28.00 supply item, CANTAB Mobile, was removed, as was the 10 minutes of equipment time for the iPad. The PE Subcommittee then included 10 minutes of CANTAB Mobile equipment time and requested that APA submit additional examples of automated instruments that may be used when performing 96X12.

After the October meeting, APA staff and members of its expert panel identified and submitted examples of two (2) additional software license-based automated instruments that are also typically used when performing the service described 96X12. The first instrument, a license for locally installed software application, allows for computer-based administration of a neurocognitive test that typically takes the patient 30 minutes to complete, and produces automatic result. The

cost is \$350.00 per 10 tests administered, or \$35.00 per test administered. The second instrument is a computer-based online test license that produces an automatic result and takes an average 20 minutes for the patient to complete (15-20 minutes for cognitively intact individuals and 20-30 minutes for those who are cognitively impaired). It costs \$425.00 per 25 tests administered, or \$17.00 per test. APA submitted paid invoices for these two (2) additional tests to AMA staff for their consideration, and we can arrange to provide those to CMS upon request.

### **Recognizing Communication Technology-Based Services**

We commend CMS for its efforts to recognize innovations in the active management and ongoing care of chronically ill patients. We agree that many communication technology-based services are not the same as telehealth and consequently should not be subject to the telehealth requirements but should be eligible for reimbursement.

We see the value of having a new HCPCS code, GVCII, to capture brief communication technology-based services for routine non-face-to-face communication before or after a patient visit. We agree with CMS that having a brief check-in service can be an effective way to address patient concerns and mitigate the need for potentially unnecessary office visits.

We are frustrated, however, by the restriction that GVCII can only be used by physicians and other qualified health care professionals who can report E/M services. Since psychologists, as well as licensed clinical social workers (LCSWs), cannot bill for E/M this restriction by CMS means brief check-in services will not be an option for Medicare beneficiaries who are receiving psychotherapy or health and behavior (H&B) services furnished by psychologists or LCSWs.

Restricting the use of code GVCII to only providers who can report E/M services will disproportionately impact beneficiaries struggling with mental and/or behavioral health issues as psychologists and LCSWs provide most of the psychotherapy and H&B services in Medicare.

To afford these beneficiaries the same opportunities as those who are dealing with physical health problems we are asking CMS to expand the requirements for GVCII so that a provider who is treating a patient with psychotherapy or H&B services can also furnish and bill for a brief check-in service regardless of whether the provider can report E/M services. If CMS is not willing to revise GVCII we ask that the agency create a new, essentially identical G code that can be billed for brief check-in services furnished by providers who cannot report E/M.

### **Creating a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders**

We commend CMS for continuing to look for ways to address the nation's drug problem, not only involving opioids but also other forms of substance use disorders. As experts in dealing with human behavior psychologists are a valuable addition to any team attempting to help patients free themselves from the ravages of addiction. Through interventions such as psychotherapy psychologists provide patients with alternatives to medication-based treatment.

The Medicare population has among the highest and fastest-growing rates of diagnosed opioid use disorder. Older adults are at risk for opioid use disorders due to several factors including chronic pain, which affects the elderly more than any other age group. Even though older adults experience age-related decline in drug metabolism, the use of multiple prescriptions—including opioids, benzodiazepines, and other central nervous systems drugs—is especially common in this population, and rates of polypharmacy appear to be rising. Consequently, even beneficiaries prescribed moderate amounts of opioids may be placed at risk because of interactions between

opioids and other prescriptions. Unfortunately, a significant proportion of psychotropic drugs are prescribed for older adults in the absence of a diagnosed mental illness.

Effectively addressing the opioid epidemic among the Medicare population will require improving beneficiaries' access to both substance use and mental health treatment services, as unaddressed mental health issues frequently contribute to and complicate addictive behaviors. As an example, patients with chronic non-cancer pain and comorbid depression are more likely than those without depression to receive opioids, be on them for longer periods of time, and to misuse or abuse opioids. At the same time, use of opioids is associated with an increased risk of depression, even in patients who were free of depression prior to taking opioids.

Psychologists are experts at furnishing non-opioid alternatives for pain treatment and management. As explained in the article *Managing Chronic Pain: How Psychologists Help with Pain Management*<sup>3</sup>, chronic pain is not just physical. Patients suffering from chronic pain may also experience feelings of sadness, anger and hopelessness. Psychologists routinely help people cope with the thoughts, feelings and behaviors that accompany chronic pain and other physical health problems. Psychologists can address behavioral health issues through H&B interventions and treat mental health disorders with psychotherapy.

Unfortunately, several barriers exist that hinder access to psychologist services. Low Medicare reimbursement rates discourage many psychologists from becoming or remaining Medicare providers. Many of the services they provide, such as chronic care management and transitional care management, are not reimbursed by Medicare because CMS limits these services to providers who can report the E/M codes.

Bundled payments may present a risk of boxing out independent practitioners such as psychologists who are not recognized by CMS as being able to lead treatment team and do not provide services "incident to" that of a physician. Accordingly, the APA Practice Organization urges CMS to recognize different treatment models for opioid and other substance use disorders, including individual and group psychotherapy and health and behavior services.

### **Quality Payment Program**

For 2019 CMS is proposing to add clinical psychologists, along with LCSWs, physical therapists and occupational therapists, to the definition of eligible clinicians (ECs) under the Merit-based Incentive Payment System (MIPS). The APA Practice Organization thanks CMS for adding psychologists as MIPS ECs and for making other revisions to the program as discussed below.

CMS is proposing to expand the low volume threshold (LVT) exemption by adding a third criterion for covered services. For 2019 CMS the LVT would exempt ECs or groups that:

- Bill Medicare for \$90,000 or less in allowed charges for covered services,
- Treat 200 or fewer Medicare beneficiaries, or
- Provide 200 or fewer covered professional services under the Physician Fee Schedule.

A MIPS EC or group meeting all three elements of the LVT would be included in MIPS.

Under the LVT criteria the APA Practice Organization believes many, if not most, psychologists will be exempt from MIPS reporting. For purposes of determining if a MIPS EC is exempt under the

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<sup>3</sup> <http://www.apa.org/helpcenter/pain-management.pdf>

LVT CMS will examine claims for the 12-month period that began on October 1, 2017 and concludes on September 30, 2018.

In addition to adding covered services to the criteria for the LVT exemption, CMS is also proposing to apply the payment adjustments to only covered professional services under the Physician Fee Schedule, rather than to all Medicare Part B services.

Thanks to another new CMS proposal in the rule, those who meet at least one of the three LVT criteria will be able to opt-in to MIPS if they wish to participate. Deciding to opt-in will be an irrevocable decision. We previously asked CMS to give all clinicians the chance to opt-in to MIPS and therefore view this proposed expansion of the opt-in as a step in the right direction.

CMS is taking other steps to reduce the burden of reporting. We support the addition of 3 bonus points for MIPS ECs who are in small (15 or fewer) practices who submit data on at least 1 quality measure.

For psychologists and the other clinicians who are being added to MIPS in 2019 a critical element of the proposed changes to MIPS can be found in the Promoting Interoperability (PI) Performance Category. Formerly known as Advancing Care Information, PI is the category that involves certified electronic health record technology (CEHRT). This category will be 25% of the composite MIPS score in 2019 and requires a 90-day reporting period.

PI is the most challenging part of MIPS for psychologists and many other non-physician providers who were never part of meaningful use and never received financial incentives to invest in CEHRT. Recognizing this, CMS is proposing to reweight the PI category to zero for psychologists and other non-physician MIPS ECs in 2019. We applaud CMS for taking this approach and not holding the non-physician providers responsible for the use of a product they were never incentivized to invest in.

We are, however, disappointed to see that CMS is not offering the newest MIPS ECs a “pick-your-pace” option for 2019. In the first year of MIPS physicians could choose to simply avoid a negative payment adjustment by reporting as little as one measure for one patient. They also had the option of reporting for just a 90-day period rather instead of the entire year. We believe both choices should be available to psychologists and the other non-physicians being added to MIPS in 2019.

## **Conclusion**

We believe if adopted our recommendations will not only benefit psychologists and their Medicare patients but will also help strengthen the program. With the growing number of American senior citizens, and the many mental and behavioral health challenges that they face, it is critical that as many psychologists as possible join and remain in Medicare. We thank CMS for the steps it is taking in the proposed rule to strengthen beneficiary access to psychological and neuropsychological testing by raising the relative values of these services. We also thank CMS for adding psychologists to MIPS and by simultaneously proposing adjustments to MIPS that will allow providers who were left out of meaningful use to successfully demonstrate quality. We appreciate that CMS has set the LVT criteria high enough to exclude many solo and small practice ECs while giving them the chance to opt-in to MIPS if they wish to do so.

We look forward to seeing these proposals adopted by CMS in the final rule. If you have any questions or need additional information please contact our Director of Regulatory Affairs, Diane M. Pedulla, J.D., by telephone (202-336-5889) or by email ([dpedulla@apa.org](mailto:dpedulla@apa.org)).

Sincerely,

A handwritten signature in black ink, appearing to read "Jared L. Skillings". The signature is fluid and cursive, with a long, sweeping underline that extends to the left.

Jared L. Skillings, Ph.D., ABPP  
Chief of Professional Practice  
American Psychological Association