American Psychological Association
Services, Inc.

September 18, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
CMS-1715-P
7500 Security Blvd.
Baltimore, MD 21244-8016

Re: Medicare Program: CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma:

The American Psychological Association (APA) thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to provide comments on the proposed rule on the 2020 Physician Fee Schedule. APA is the largest scientific and professional organization representing psychology in the United States. APA's membership includes over 118,700 clinicians, researchers, educators, consultants, and students. APA seeks to promote the advancement, communication, and application of psychological science and knowledge to benefit society and improve lives.

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. At a time when the country is faced with an epidemic misuse of opioids, psychologists can fill the enormous gap in providing care and offer evidence-based nonpharmacological treatments to patients suffering from chronic pain. More needs to be done to expand the role of psychologists to meet the needs of individuals and communities across the country.

In summary, APA asks for the following actions by CMS:

- Exclude psychologists' services from the projected 7% payment reduction in 2021.
- Adopt the revised health behavior assessment & intervention CPT® codes with proposed values.
- Add coverage for health behavior assessment & intervention services without the patient present.
- Adopt the new online digital assessment codes with RUC-recommended values.
- Adopt the new cognitive function intervention codes with proposed values.
- Allow additional psychotherapy services for beneficiaries receiving treatment for Substance Use Disorder/Opioid Use Disorder.
- Re-weight Promoting Interoperability in MIPS to zero for psychologists.
- Engage specialty societies in updating the Quality Payment Program.

Proposed 2021 Evaluation and Management Payment Increases Will Harm Beneficiary Access to Psychologists' Services

APA is gravely concerned about the significant reimbursement cuts that the majority of physician and non-physician specialties will sustain in 2021 should CMS finalize its proposal on evaluation and management (E/M) value increases without modification. While we acknowledge that CMS must maintain budget neutrality with the fee schedule, we strongly object to the severe impact the agency's proposal will have on reimbursement for psychologists, who don't have access to bill E/M services.

CMS' proposal to fund E/M code value increases through redistribution across the fee schedule is projected to result in a 7% decrease in payments to clinical psychologists. When coupled with the 2% decrease already incurred due to sequestration, a mandatory reduction created by Congress that has applied to all Medicare providers since 2013, it amounts to a 9% cut in reimbursement in 2021. This would be devastating for psychology practices, and we unfortunately predict a mass exodus of psychologists who currently provide important care for Medicare beneficiaries such as neuropsychological testing for dementia and behavioral pain management for opiate addicted peoples. The mental health needs of older adults are unique and challenging, and most physicians do not have the training required to adequately address the current and rising demand for mental health treatment of our aging population that psychologists provide.

Because psychologists cannot bill E/M codes, they cannot fill their days with additional patients by working faster. For example, a 45-minute psychotherapy session typically takes 45 minutes, plus time between patients to finish up one appointment and prepare for the next.

Further, there are already too few psychologists across the country to meet beneficiary demand, especially in rural and frontier states. According to the Health Resources and Services Administration, 113 million Americans live in federally designated Mental Health Professional Shortage Areas.[1] If/when psychologists choose to opt out or leave the Medicare program altogether, beneficiaries will be faced with even poorer access to mental health services, and could be forced to choose between searching for a new mental health provider, undertaking the financial burden of paying out of pocket for all treatment costs, or foregoing treatment entirely. With fewer psychologists in Medicare beneficiaries will be forced to wait longer between appointments and travel further to receive treatment.

We implore CMS to find another way to address the impact of redistributing the E/M code value increases, so they do not disproportionately harm non-physicians such as psychologists and the most vulnerable older Americans. Additionally, we request that CMS provide more explanation so that we might gain a better understanding of how costs would be distributed across the fee schedule, particularly with regard to the data analysis and policies utilized to determine the impact on each specialty type as well as discuss why the impact is greater for certain specialties, especially those who don't have access to billing or being reimbursed for E/M services.

APA welcomes the opportunity to discuss alternative proposals and/or provide any information that would be helpful to CMS to more fully understand and mediate the projected negative reimbursement impact of the existing proposal.

[1] https://data.hrsa.gov/topics/health-workforce/shortage-areas

Valuation of New/Revised Health Behavior Assessment and Intervention Services

We commend CMS for fully accepting the recommendations of the American Medical Association (AMA) / Specialty Society Resource-Based Relative Value Update Committee (the RUC) for the new/revised billing codes and values for Health Behavior (H&B) Assessment and Intervention services. Increasing reimbursement for H&B services acknowledges the importance of addressing the psychosocial factors that impact patients' physical health problems. APA was actively involved in the CPT and RUC process to revise and revalue the H&B codes. We are very pleased to see that CMS supports the RUC's recommended values for these codes.

H&B services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. This is the first time H&B services have been reviewed and revalued since their inception in 2002. The proposed work RVUs for the new H&B codes are:

H&B services covered by Medicare

961X0 Assessment / Reassessment	2.10
961X1 Individual Intervention, first 30 minutes	1.45
961X2 Individual Intervention, each additional 15 minutes	0.50
961X3 Group Intervention, first 30 minutes	0.21
961X4 Group Intervention, each additional 15 minutes	0.10
961X5 Family Intervention with patient, first 30 minutes	1.55
961X6 Family Intervention with patient, each additional 15 minutes	0.55

H&B services not covered by Medicare

We strongly recommend that CMS add coverage for H&B family intervention services without the patient present. Although the patient is not an active participant in the services under these two codes, the time the psychologist spends with family members directly benefits the patient.

961X7 Family Intervention without patient, first 30 minutes	1.50
961X8 Family Intervention without patient, each additional 15 minutes	0.54

We believe that the proposed work RVUs accurately represent the intensity and complexity of physician work involved in providing H&B assessment and intervention services. Adopting the new values will incentivize more psychologists to offer H&B services and ultimately benefit patients by increasing access to behavioral health and promoting integrated care with providers in both primary and specialty care settings. Additionally, the proposed revisions will bring H&B code values closer to psychotherapy services and reestablish relativity between parallel mental and physical health services. *APA strongly recommends that CMS finalize its proposal to accept the RUC-recommended work RVUs and direct PE inputs for all of the CPT® codes in this family without refinement.*

New Online Digital Assessment Codes

CMS is proposing three new codes, GNPP1, GNPP2 and GNPP3, for use by non-physicians to capture online digital assessment services initiated by patients that require a clinical decision. The codes capture online digital assessment services provided for 5 to 10 minutes (GNPP1), 11 to 20 minutes (GNPP2) and 21 minutes or more (GNPP3) over a 7-day period. CMS is

proposing the following work RVUs for these codes: GNPP1 = 0.25, GNPP2 = 0.44 and GNPP3 = 0.69. Below we provide examples to show how psychologists would assess patients, engage in clinical decision making, and direct services under the new online digital assessment codes.

CMS has proposed to make changes to the RUC/HCPAC recommended values for GNPP2 = 0.44 and GNPP3 = 0.69.

CPT / HCPCS Code	RUC/HCPAC Recc. Value	CMS Recc. Value	Difference
9X0X1	0.25 RVUs	0.25 RVUs	No Change
GNPP1	0.25 RVUs	0.25 RVUs	No Change
9X0X2	0.50 RVUs	0.50 RVUs	No Change
GNPP2	0.50 RVUs	0.44 RVUs	**-0.06 RVUs**
9X0X3	0.80 RVUs	0.80 RVUs	No Change
GNPP3	0.80 RVUs	0.69 RVUs	**-0.11 RVUs**

We do not support the proposal to decrease the RUC-recommended work RVUs for GNPP2 and GNPP3. This code set was developed for practitioners who cannot independently bill E/M services and were intended to be equivalent to CPT codes 9X0X1-9X0X3 describe the same services but will be used by practitioners who can independently bill E/M services. The intent of developing two separate code sets was to provide physicians and nonphysicians a mechanism to report and be reimbursed for equivalent services and decreasing the RUC-recommended work RVUs for GNPP2 and GNPP3 does not support consistency between these parallel services. Therefore, we recommend that CMS to accept the RUC recommended values of 0.50 RVUs for GNPP2 and 0.80 RVUs for GNPP3 to maintain consistency and support the original intent of developing these new codes.

In CMS' proposal related to the codes GNPP1-GNPP3, it is not clear which non-physician specialties will be eligible to provide and bill for these services. Based on APA's review of the new codes and descriptions of service, we have identified instances when it would be appropriate for psychologists to provide these services to Medicare beneficiaries. Below we provide examples to show how psychologists would assess patients, engage in clinical decision making, and direct services under the new online digital assessment codes.

Example 1: For GNPP1. a mother submits an online query through her child's psychologist's Electronic Health Record (EHR) portal about her 12-year old son who is being treated for Generalized Anxiety Disorder with concerns that her son's anxiety is worsening. Upon assessing the symptoms outlined on the patient query, the child's psychologist responds via the EHR portal and requests that the mother upload the patient's daily anxiety ratings and activity log through the portal and also asks several other pertinent questions related to the patient's social, school, and family functioning and interactions.

Upon review of the mood ratings, activity log and the additional clinical history, the psychologist determines the patient's anxiety is stable and not interfering with daily functioning. The

psychologist saves the clinical documentation in the Electronic Medical Record (EMR) as an eVisit encounter to support reporting a professional claim. Total cumulative time spent by the psychologist for the entire service is 10 minutes.

Example 2: For GNPP2, a 65-year old patient with a Pain Disorder submits an online query through her psychologist's EHR portal about her increase in pain and having to miss work. Upon assessing the symptoms outlined on the patient query, the patient's psychologist queries on-line about current pain rating and depressive symptoms needing in-person office or ED visit. Subsequent to the patient's reassuring response, the psychologist follows-up on-line regarding use of cognitive/behavioral techniques the patient has been previously taught and instructs patient to use these techniques. Several hours later subsequent to the employing the cognitive/behavioral techniques, the patient provides her psychologist with a symptoms update along with pre-and post-treatment pain and functioning ratings.

The next day, the patient forwards via the portal a status update that reflects reduced pain but reluctance to go to work for fear of aggravating pain. The psychologist then sends the patient a pain/physical activity/catastrophic thoughts handout with a request for the patient to complete a pain/activity/cognitions tracking form for the day. On the third day, the patient provides the psychologist with a follow-up portal message stating that symptoms are improving and that the patient was able to go to work. The psychologist saves the clinical documentation in the EMR as an eVisit encounter to support reporting a professional claim. Total cumulative time spent by the psychologist for the entire service is 15 minutes.

Example 3: An example of a longer session under GNPP3 would be when a mother submits an online query through her child's psychologist's EHR portal about her 10-year old son who has ADHD with increased behavioral difficulties. Upon assessing the symptoms outlined on the patient query, the child's psychologist responds via the EHR portal and requests that the mother upload a completed parent follow-up ADHD standardized assessment scale. The psychologist reviews the standardized score and also queries the mother via the EHR portal several questions related to her son's behavior at home and school, as well as interactions with peers and other adults. With the additional clinical history received from the mother, the psychologist assesses that the ADHD is well-controlled at home but not at school.

The psychologist provides mother with a list of behavioral strategies the mother can discuss with the child's teacher and instructs mother to follow-up via the portal within 5 days and to provide a teacher-completed ADHD assessment scale during that time. Five days into the eVisit, the mother and psychologist re-connect to assess the child's symptoms, assess a follow-up parent-completed assessment scale, and review the teacher's assessment scale. Through both portal and phone communication, the psychologist and mother agree that symptoms are better controlled at school with the implementation of behavioral strategies at school and increased communication between mother and teacher. The psychologist instructs mother to schedule a follow-up office visit in one month for ADHD reassessment. The psychologist saves the clinical documentation in the EMR as an eVisit encounter to support reporting a professional claim. Total cumulative time spent by the psychologist for the entire service is 25 minutes.

New Cognitive Function Intervention Codes

We fully support CMS' proposal to accept the AMA RUC/HCPAC recommendations for the new/revised CPT codes 971XX and 9XXX0 to describe cognitive function intervention services.

The proposed work RVUs for the new/revised cognitive function intervention codes are:

971XX Therapeutic intervention, first 30 minutes	0.50
9XXX0 Therapeutic intervention, each additional 15 minutes	0.48

Further, now that Category III CPT codes have been established, we would like to respectfully remind CMS to delete HCPCS G-code G0515; *Development of cognitive skills to improve attention, memory, problem solving, direct patient contact, each 15 minutes*, established in the CY 2018 PFS final rule.

We greatly appreciate CMS' acceptance of the recommended values and are pleased that for calendar year 2020 and beyond, a single coding option for cognitive therapy will exist and be consistently implemented by all payer types.

Bundled Payments for Substance Use Disorders

CMS is proposing to establish bundled payments for the treatment of Substance Use Disorders (SUDs), including Opioid Use Disorders (OUDs), outside of established treatment programs. Services involving management, care coordination, psychotherapy, and counseling activities would be covered under the bundled payments. Although CMS starts with the assumption that patients will need two individual psychotherapy sessions per month and four group psychotherapy sessions, the agency acknowledges that the number of sessions will vary among patients and fluctuate over time.

As stated in the preamble, creating a separate bundled payment for these services should incentivize providers to furnish counseling and care coordination for patients with SUD/OUD in the office setting and give these patients more opportunities to seek help outside of a treatment program. CMS is proposing three new codes to capture these bundled services:

GYYY1 for at least 70 minutes of office-based treatment in the first month,

GYYY2 for at least 60 minutes in a subsequent calendar month, and

GYYY3 for each additional 30 minutes, beyond the first 120 minutes.

While we support the proposal to add these three new codes to Medicare's telehealth list, we have serious concerns about the agency's position that a practitioner may not report 90832, -34, -37 or -53 in the same month as GYYY1, GYYY2 and GYYY3 for the same beneficiary. This prohibition will harm beneficiaries with SUD/OUD who have co-occurring mental health conditions that require psychotherapy. This would mean that a psychologist seeing a patient for psychotherapy services to address a mental health problem like Panic Disorder would not also be able to provide psychotherapy for that patient to address SUD/OUD in the same month. This would be problematic, as many patients with SUD/OUD misuse substances to self-medicate symptoms of another condition, like panic or others. As such, requiring services to be non-coordinated would significantly harm beneficiaries from receiving coordinated, whole-person care. Further, in rural or frontier states there may not be enough mental and behavioral health providers for a patient to be seen by one for SUD/OUD and another for mental health issues.

Restricting patients to a limited number of hours of psychotherapy under a bundled payment treatment program may prevent them from receiving sufficient psychotherapy services needed to address their underlying issues and ultimately hinder their SUD/OYD treatment. <u>We ask CMS to allow providers to furnish additional psychotherapy services to address co-occurring mental health issues of patients receiving treatment for SUD/OUD.</u>

Quality Payment Program Updates

Promoting Interoperability Category

Psychologists were added to the Merit-based Incentive Payment System (MIPS) for the first time in 2019. While many psychologists are exempt from MIPS reporting under the low volume threshold others are actively participating to demonstrate quality and increase their Medicare reimbursement through bonus payments in MIPS. To assist the psychologists and other mental health professionals reporting under MIPS, APA created the Mental and Behavioral Health Registry, the first qualified clinical data registry focused on mental and behavioral health.

We thank CMS for recognizing that eligible clinicians (ECs) who were not eligible for incentives to adopt electronic health record (EHR) technology or subject to Meaningful Use may not be able to report on the Promoting Interoperability category in MIPS. We support the proposal by CMS to continue making psychologists automatically eligible for a zero weighting in the Promoting Interoperability category.

MIPS Value Pathways

We read with great interest the future changes proposed by CMS for the MIPS reporting program. Starting in 2021, ECs will no longer choose from a wide array of quality measures and improvement activities. Instead a new MIPS Value Pathways (MVPs) program will direct ECs to subsets of quality, cost, and improvement measures (known as MVPs), possibly based on a specialty type or health condition. It is CMS's intention that reporting the MVPs will be less burdensome than the current MIPS reporting.

In the proposed rule CMS asks for input on several key concepts regarding the MVP. Our concern is that these concepts, designed without the participation of the specialty societies, are already under consideration by the agency. In essence, the specialty societies are being asked to choose among options that may not be relevant or appropriate for their members.

We ask that the specialty societies have a role in designing the reporting options within the Quality Payment Program (QPP) to ensure their relevance to clinicians. This should include changes to existing programs like MIPS as well as integrating possible future programs such as MVPs. Having gone from PQRS to MIPS, many clinicians are wary of Medicare's ever-changing quality reporting programs. Before CMS tries to create yet another new reporting program, we believe there needs to be more discussion with the specialty societies to ensure not only the relevance of the program but also the likelihood that it will be accepted by clinicians. We look forward to working with CMS as the agency continues to update the QPP.

Qualified Clinical Data Registry (QCDR) Measures

CMS is proposing to add the following requirements in performance period 2021:

1. QCDRs must identify a linkage between their QCDR measures and the following, at the time of self-nomination: (a) cost measure; (b) Improvement Activity; or (c) CMS developed MVPs.

2. QCDR measures must be fully developed with completed testing results at the clinician level and must be ready for implementation at the time of self-nomination.
3. QCDRs must collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period.

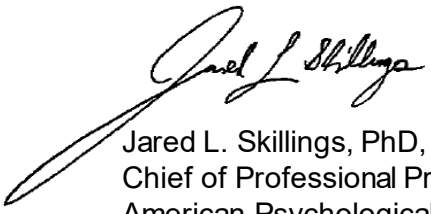
For requirement 1, we request that CMS clarify how this would this work for specialties that do not have any cost measures and/or CMS developed MVPs.

We ask that CMS drop requirements 2 and 3. Most specialty societies simply do not have the financial resources to support both the QCDR hosting and maintenance fees and then provide incentives for providers to use measures in a testing phase when they cannot be submitted to MIPS. We fear these requirements would prevent QCDRs from ever adding new specialty-based, meaningful measures, thereby making the point of having a QCDR moot. If specialties cannot maintain their QCDRs, their members will end up back where they started, i.e., without meaningful measures to report.

Conclusion

We thank CMS for its consideration of our comments and look forward to seeing our recommendations adopted when the final rule is issued in November. If we can be of any further assistance please contact Diane M. Pedulla JD, Director of Regulatory Affairs, by email at dpedulla@apa.org or by telephone at 202-336-5889.

Cordially,



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