



August 28, 2012

Marilyn Tavenner
Acting Administrator,
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS 1590-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: File code CMS 1590-P; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2013; Proposed Rule (July 30, 2012)

Dear Administrator Tavenner:

I am writing on behalf of the American Psychological Association (APA), the organization representing over 137,000 members in the practice, research, and teaching of psychology. APA wishes to take this opportunity to provide the Centers for Medicare and Medicaid Services (CMS) with comments on the proposed rule on the 2013 Medicare physician fee schedule.

Transitional Care Management

In the proposed rule, CMS projects that psychologists will suffer on average a 3% loss in their Medicare payments. Two percent of this reduction is due to practice expense adjustments, the minimal redistribution of payments, and other factors while the remaining one percent loss is to offset the anticipated costs of a proposed new evaluation and management (E/M) code for post-discharge transitional care management (TCM) services. As occurred in 2007 when payments were raised for other E/M visit codes, reimbursement for psychologists' services will be reduced in order for the program to pay for new TCM services, a situation made worse by the fact that Medicare will not reimburse psychologists for these services, even though they provide them.

Clinical psychologists are the principal providers of mental health services to Medicare beneficiaries, providing more than 70% of the inpatient and about 40% of the outpatient psychotherapy that beneficiaries receive. Clinical psychologists provide 95% of Medicare behavioral health services, and nearly all psychological and neuropsychological testing services. Medicare coverage of psychological services is central to public access to critical mental health services.

Unfortunately, Medicare reimbursement rates for clinical psychologists' services have precipitously declined over the last decade. For example, Medicare reimbursement for a 50-minute psychotherapy

service (the most common service provided) has declined by 37% since 2000. In real dollars, the average national payment for this service in 2000 was \$98. Today payment is only \$82.

CMS is proposing to create a HCPCS G-code, GXXX1, to describe post-discharge transitional care management services. The code would describe all non-face-to-face services related to the transitional care management furnished by the community physician or qualified nonphysician practitioner within 30 calendar days following the date of discharge from a hospital, SNF, or CMHC partial hospital program to community-based care.

GXXX1 would be payable only once in the 30 days after the patient is discharged to a single community physician or qualified nonphysician practitioner (or group practice) who assumes responsibility for the patient's post-discharge transitional care management. The physician or practitioner must have had an E/M visit with the patient 30 days prior to or 14 business days after the transition in care.

Psychologists routinely provide TCM services for patients who are transitioning from a facility stay to the community. Code GXXX1, however, is specifically limited to physicians and healthcare professionals who bill Medicare for E/M services. By reimbursing these services only when they are linked to an E/M visit CMS is systematically excluding psychologists.

When a patient has been hospitalized for a psychiatric condition, post-discharge is a high risk period and it is critical to establish care as soon as possible. A psychologist providing care to a patient following a psychiatric admission must collaborate with hospital staff to facilitate the transition and contact the patient about moving forward with treatment. During the first appointment, the psychologist would assess the patient by documenting symptoms, psychiatric diagnoses, medical needs, functional status, pain control, and psychosocial needs following the discharge. The psychologist would engage family members in the care planning process, contact local support agencies if necessary, and communicate with the patient's primary care provider regarding the patient's mental health needs.

By making access to GXXX1 dependent upon use of the E/M codes, CMS fails to recognize the work of psychologists in providing TCM for their patients. Excluding psychologists from TCM services is contradictory to CMS's statement in the rule's preamble that the patient's mental health is of equal importance to the patient's physical condition for successful re-entry into the community.

We propose that CMS add a second HCPCS G-code without the E/M visit requirement for use by psychologists and other non-physician practitioners who provide transitional management services but are not allowed to bill for E/M. Another type of patient visit, such as a diagnostic psychiatric interview, psychotherapy, or a health and behavior service, could substitute for the E/M visit required in GXXX1.

PQRS – Coordination of Care for Patients with Adult Major Depressive Disorder (MDD)

We have strong concerns that the language in two of the proposed new individual measures for 2013 fails to recognize psychologists' scope of practice and threatens their ability to successfully participate in PQRS. Both measures involve timely follow-up to the coordination of care of adult MDD patients who have co-morbid conditions. The first measure suggests that communication about the patient can only occur between two physicians. Even more offensive, the second measure reads as if only a physician can treat adult MDD. These measures overlook the work of psychologists and other non-physician practitioners, who combined provide the vast majority of psychotherapy services in Medicare, in treating this serious condition.

In a 2008 survey, seventy-nine percent of psychologists responding said that care is more complex now due to patients' existing co-morbid mental health disorders or a mental health disorder and a major / chronic physical disorder. Fifty percent of the respondents reported that at least a quarter of their patients have major or chronic physical health disorders. Forty- two percent reported an increase in the number of patients with co-morbid physical and mental health disorders. Respondents also indicated that on average forty percent of their patients had co-morbid mental health disorders.

For psychologists and other non-physician practitioners to successfully participate in PQRS it is imperative that measures applicable to the services they provide under their scope of practice are not physician-exclusive. To remedy this situation we believe CMS must amend the two measures as follows:

Adult MDD: Coordination of Care of Patients with Co-Morbid Conditions - Timely Follow-Up.

Percentage of medical records of patients aged 18 years and older with a diagnosis of MDD and a diagnosed co-morbid condition being treated by another ~~physician~~ **healthcare professional** with communication to the other ~~physician~~ **healthcare professional** treating the comorbid condition.

Coordination of Care of Patients with Co-Morbid Conditions - Timely Follow-Up (Paired Measure). Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a diagnosed co-morbid condition with communication to another ~~physician~~ **healthcare professional** treating the co-morbid condition who have a response from the other ~~physician~~ **healthcare professional** within 45 days of original communication OR who have a follow-up attempt within 60 days of original communication by the ~~physician~~ **healthcare professional** treating MDD to elicit a response from the other physician.

Less Stringent Criteria for Eligible Professionals New to PQRS

We applaud CMS for making it easier for eligible professionals who have yet to participate in PQRS to begin reporting in 2013. Because the 2015 adjustment will be tied to reporting in 2013 it is critical that eligible professionals who have to report begin participating next year. As many specialties may have few measures available to match the different practice patterns of their members, reducing the number of measures required in 2013 for new participants to just one is a significant action by CMS.

We thank you for this opportunity to share our thoughts on these proposals for the 2013 Medicare fee schedule. If 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