



AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

September 6, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attn: CMS-1600-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1600-P Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014.

Dear Ms. Tavenner:

I am writing on behalf of the American Psychological Association Practice Organization (APAPO), the companion organization to the American Psychological Association (APA). APA is the leading scientific and professional society representing psychologists in the United States and is the world's largest association of psychologists, with more than 134,000 members and affiliates. Through its 54 divisions in subfields of psychology and its affiliations with 60 state, provincial and territorial psychological associations, APA works to advance psychology as a science, as a profession, and as a means of promoting health and human welfare. APAPO also promotes the interests of psychologists in a wide variety of practice settings.

We have concerns with, and will provide later in this letter, comments regarding issues within the proposed 2014 physician fee schedule, specifically with regard to adjustments to the Medicare Economic Index (MEI) and the Physician Quality Reporting System (PQRS). Before addressing these issues, however, I want to first bring to your attention broader Medicare payment concerns for our members that are tied to the proposed rule and which are endangering beneficiary access to mental, behavioral and substance use disorder services within the program.

We begin with a discussion of the precipitously steep decline in clinical psychologist reimbursement under the payment formula and a request that CMS avoid further adjustments in Practice Expense (PE), which if implemented will devastate reimbursement for our members

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next year and ultimately impact beneficiary access to the services they provide. Specifically, we urge CMS to adopt an interim solution that will maintain the 2012 PE values for the new psychotherapy codes until we can find a way to resolve this problem. This interim approach is necessary to prevent further payment losses that will harm both psychologists and the Medicare beneficiaries who need their services.

We met with Jonathan D. “Jon” Blum, Deputy Administrator, CMS, on August 28th in an effort to address both our concerns with the underlying payment formula, and its failure to appropriately reimburse clinical psychologists for the services they provide to Medicare beneficiaries, as well as a request to continue the 2012 PE values since new values would potentially significantly lower payment for key diagnostic and psychotherapy services. We appreciate that the agency will closely consider these concerns for purposes of psychologists’ payment in 2014.

Clinical psychologists are major providers of Medicare mental and behavioral services.

Clinical 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 school. 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.

Clinical psychologists are a primary if not *the* major providers of mental, behavioral and substance use disorder services to Medicare beneficiaries. According to the AMA Specialty Society RVS utilization data, clinical 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 clinical social workers, clinical psychologists provide the vast majority of the mental health benefit to those elderly and disabled persons enrolled in Medicare.

Plummeting reimbursement means a corresponding loss of Medicare beneficiary access to clinical psychologists’ services.

Clinical psychologist services’ reimbursement rates under Medicare are plummeting, and despite the complexity of their valuable services for beneficiaries, reimbursement for psychologists in Medicare now is woefully inadequate. Adjusted for inflation, psychologists have lost more than 37% in payment over the past 12 years for the most commonly provided mental health service, the 45-minute psychotherapy session.

An August 2013 survey of our membership reveals that clinical psychologists’ participation in Medicare is drastically declining. The survey reveals that 26% of responding psychologists, who were previously 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 that nearly 5,200 psychologists are no longer providing the mental, behavioral and substance use disorder services that Medicare beneficiaries need.

Plummeting reimbursement places Medicare 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. Clinical 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. A 2012 study, conducted by Healthcare Visions, Inc., found that Medicare reimbursement rates are 15% below private indemnity market rates for the services that clinical psychologists provide. 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 tell us that they simply cannot remain in Medicare or have to limit the number of their Medicare patients in order to make a living.

Mental health access for Medicare beneficiaries living in rural areas is probably far worse. While clinical psychologists and social workers provide the great majority of mental, behavioral and substance use disorder services to beneficiaries, clinical social workers cannot substitute for psychologists as they do not have as extensive training in assessment or testing and they typically do not provide health and behavior services.

In addition, the only other major Medicare provider of these services, psychiatrists, are simply not as available in rural and frontier areas. For example, a 2007 Density Survey of Psychologists and Psychiatrists found that psychologists far outnumber psychiatrists across the United States and are far more available than psychiatrists in rural and frontier states. For example, psychologists outnumber psychiatrists 9 to 1 in Wyoming, a state where the seniors comprise about one-fifth of the population. In many states, such as Michigan, Vermont, and New Hampshire, psychologists outnumber psychiatrists by 4 to 1, and in others, such as California, Texas, and Pennsylvania, by 3 to 1. CMS and Congress must act now to stem these steep reductions in clinical psychologists' reimbursement or clinical psychologists will simply leave Medicare. As a result, beneficiaries will not have access to the mental, behavioral, and substance use disorder services that they need.

The payment formula is failing to appropriately and fairly reimburse clinical psychologists.

The Medicare payment formula is not succeeding in appropriately and fairly valuing clinical psychologists' services. As has been mentioned, payment rates for clinical psychologists' services have been plummeting in the program and are no longer competitive with private market indemnity rates. At the crux of this problem is the relative value system. Under the payment formula Medicare increasingly has had to pay more for high-overhead, technology-driven services relative to services like those that clinical psychologists' provide, with low and stable overhead costs. As a result, clinical psychologists' services are losing their value with payment rates that are now artificially and drastically low.

Much of the loss in payment for psychological services over time, and particularly recently, has been due to various adjustments in PE. In fact, since 2007, CMS adjustments to PE in the fee schedule have resulted in a 24% reduction in clinical psychologists' payments. Psychological services are cognitive-based and heavily weighted towards their work value under the formula. As changes in PE are made to address the growth in technology and equipment costs for many services, the cognitive-based services that clinical psychologists provide have lost value and corresponding reimbursement levels. Recent emphasis on PE increases to pay for higher-overhead services has shifted payment away from the mental, behavioral, and substance use disorder services that clinical psychologists provide.

As Medicare providers, our members acutely feel these payment reductions, since they can bill only a limited number of procedure or service codes. The Medicare payment formula may work for providers who bill a substantial number of codes. Much like diversification for an investment portfolio, having the payments spread over a variety of services increases the likelihood that in any given year the rates for some services will rise while others fall. The Medicare provider billing a substantial number of codes is somewhat insulated from a sharp decrease in overall reimbursement when reimbursement for some services drastically declines. By contrast, clinical psychologists are reimbursed for very few codes, since their work is focused on three main areas: psychotherapy, health and behavior, and testing. In fact, many clinical psychologists focus their practice in just one of these areas, billing only two or three codes. As such, psychologists are not afforded the same element of protection from payment cuts that many other healthcare professionals enjoy under Medicare's payment formula.

The current payment formula is designed for a different type of healthcare practice, one that provides more services, invests in expensive equipment, and requires administrative and clinical staff. In contrast, clinical psychologists are highly efficient, with low over-head costs, typically working solo or in small group practices with few to no administrative or clinical staff. Under the current payment formula clinical psychologists are penalized rather than rewarded for doing so much with less. It is incumbent upon CMS and Congress to soon find a way to adequately pay for the services that clinical psychologists provide, or Medicare beneficiaries will simply not have access to these needed services.

In a July 2013 study Avalere Health, LLC, identifies three recent changes by CMS that have caused declines in reimbursement for clinical psychologists. First, switching the PE relative value unit (RVU) methodology from a "top-down" to a "bottom-up" approach in 2007 through 2010 was problematic. When CMS used a "top-down" approach the agency would allocate to each individual service the aggregate direct and indirect costs for each specialty. Under a "bottom-up" approach CMS adds up the various resource costs (i.e., clinical staff, equipment, and supplies) typically required for each service. CMS calculates the cost of the resources using the PE inputs recommended for each CPT code by the RUC. Because psychological services have few direct cost inputs and low overall costs it was more beneficial for psychologists to have the PE calculated using a "top-down" approach.

Second, in 2010, new data obtained through the Physician Practice Information Survey separated psychology's PE from psychiatry's for the first time. Psychologists reported having lower practice costs. When combined with the "bottoms-up" methodology this further reduced their

overall payment. Lastly, when the MEI was rebased and revised in 2011, more emphasis was given to PE, a disadvantage for psychology whose codes are more heavily weighted towards the work value. While these changes may make sense for overall payment, they have greatly lowered reimbursement for mental, behavioral and substance use disorder services, again shifting an emphasis in payment toward services with higher PE.

Clinical psychology reimbursement for key mental health services will be devastated if CMS implements new PE inputs.

To understand how large a threat the current payment formula poses for psychological services CMS need only to look at the prospective PE values for the new psychotherapy codes. PE inputs put forward by the Resource-Based Relative Value Update Committee (RUC) in 2012 for the new psychotherapy codes are lower than the PE inputs for the previous set of psychotherapy codes. CMS “cross-walked” the pre-2012 RUC inputs for most of the psychotherapy family of codes with the rationale that until the entire valuation of the family of codes was completed mental health professionals should not suffer a loss in payment for 2013. However, those codes which were not cross-walked, such as family and group psychotherapy, received new PE inputs and as a result experienced sharp declines in reimbursement rates. For example, even though the work and malpractice expense values were unchanged in 2013, the payment for code 90846, family psychotherapy with the patient, is 14% lower than last year while payment for 90853, group psychotherapy, has dropped by 20%.

Fortunately, as mentioned, the old PE inputs for the primary mental health codes, namely the 45-minute, 30-minute and diagnostic evaluation codes were cross-walked and did not experience these sharp declines. However, if CMS does not continue to use the 2012 PE values for these codes then clinical psychologists and clinical social workers will suffer significant additional losses as the new PE inputs will more than offset any potential increases to the work values. In its report Avalere notes that the three most commonly used psychotherapy codes will experience significant reductions. Specifically, the 45-minute psychotherapy (90834), the 30-minute psychotherapy (90832) and the psychiatric evaluation (90791) codes are projected to incur losses of 4%, 17.4%, and 21% respectively.

As CMS stated in the final rule on the 2013 Medicare physician fee schedule (77 Fed Reg 69075), assigning lower PE values for the new psychotherapy codes would mean a substantial loss in payment for non-physicians who are unable to bill for evaluation and management services:

The AMA RUC submitted direct PE input recommendations for codes in this family that included significant reductions in the direct PE costs associated with the predecessor codes. For most of the new codes, we believe that accepting these recommended reductions in direct practice expense conforms to our general approach of maintaining the current values for these services since many practitioners who furnish these services will now report concurrent medical evaluation and management services with PE values that will offset the differences in total PE values between the new and old psychotherapy codes.

However, for practitioners who do not furnish medical evaluation and management services, there are no corresponding PE value increases to offset the recommended reductions in the direct PE inputs for these codes. Therefore, instead of accepting the recommended direct PE inputs for the new CPT codes that describe services primarily furnished by practitioners who do not also report medical evaluation and management services, we will crosswalk the PE RVUs from the CY 2012 codes that describe the same services. We believe this crosswalk will effectively maintain the total value of the services, pending a comprehensive review of the code family.

The CPT codes with CY 2013 PE RVU crosswalks are: 90791 (Psychiatric diagnostic evaluation), 90832 (Psychotherapy, 30 minutes with patient and/or family member), 90834 (Psychotherapy, 45 minutes with patient and/or family member), and 90837 (Psychotherapy, 60 minutes with patient and/or family member). For CY 2013, we are crosswalking the PE RVUs developed for the predecessor codes for CY 2012.

CMS disallows clinical psychologists from providing evaluation and management (E&M) services. While clinical psychologists typically provide coordination of care services, these are not recognized in any of the codes. The APA has requested several times that CMS reexamine its position that because E&M are “medical” codes, they may not be provided by clinical psychologists. In the absence of a change in this position, the APA strongly urges CMS to continue to maintain the 2012 PE values on an interim basis until a solution is found to prevent further catastrophic declines in reimbursement for both clinical psychologists and social workers, the two provider classes who furnish the vast majority of mental health services for Medicare beneficiaries.

Another reason that CMS should use this discretion is to avoid devaluing the RUC process. The RUC agreed with the multi-specialty society workgroup that the psychotherapy codes were undervalued. Therefore, the RUC recommended work values that better reflect the delivery of psychotherapy services today. Hundreds of mental health professionals contributed their time and effort by participating in a survey to furnish the data that allowed the RUC to reach this conclusion. If payment rates fall, even if the new codes are given higher work values, then providers will believe their efforts were worthless and lose all confidence in the RUC process.

While APA urges CMS to adopt the RUC’s recommended work values for 2014, it is clear that if PE values are based on the new inputs for these codes they will almost certainly obliterate any payment increases that would normally result from having higher work values. Thus, despite having successfully revised the psychotherapy family of codes through the *Current Procedural Terminology* (CPT®) process and then producing solid survey data attesting to the need for higher work values, the end result will be a substantial loss in payment for psychotherapy and other mental health services delivered by non-physician providers who cannot bill for E&M, unless action is taken to address the lower PE values.

As mentioned, the APA believes that further reductions in payment for their services will force more clinical psychologists to leave the Medicare program. Some will seek to privately contract

with Medicare beneficiaries, thus creating a situation where beneficiaries incur a cost that could have been avoided. Others will simply no longer see Medicare beneficiaries, leaving them to seek care from a diminishing pool of mental health providers. Even those who remain in the Medicare program are likely to reduce the number of hours they allot for Medicare patients or refuse to add new ones.

If clinical psychologists are forced to make such difficult choices it will become even harder for Medicare beneficiaries to access critically needed mental health services. As mentioned, clinical psychologists provide more psychotherapy services to Medicare beneficiaries than any other specialty. To avoid reducing psychologists' payments and putting beneficiaries at risk, we urge CMS to keep the PE values for the new psychotherapy codes the same as they were under the 2012 predecessor codes until a way to address the PE problem has been identified.

Having provided an overview of problems with the payment formula for clinical psychologists and urging CMS to retain the PE values assigned to the 2012 psychotherapy family of codes, we now turn to matters within the proposed physician fee schedule.

The Medicare Economic Index (MEI)

We note that in accordance with recommendations of the MEI Technical Advisory Panel CMS is proposing changes to the calculation of the MEI. One particular adjustment will shift a portion of the weight for practice expense to the work component. We support this specific change to the MEI as it will assist mental health professionals whose work mainly involves cognitive services. While the modest gain from this adjustment is helpful, additional changes as noted above are needed to ensure that cognitive-based specialties do not continue to fall behind in payment due to their limited need for the use of technology and equipment.

The Physician Quality Reporting System (PQRS)

APA objects to the idea of eliminating claims-based reporting in calendar year 2017 for purposes of the 2019 PQRS payment adjustment. We understand that there are advantages to reporting measures through registries and electronic health records (EHR) but wish to remind CMS that not all eligible healthcare professionals can readily utilize these options. Clinical psychologists and social workers, who combined provide the overwhelming majority of psychotherapy services for Medicare beneficiaries, are not eligible for the EHR incentives they need to invest in this type of technology. Among the numerous registries, few focus on or are even familiar with mental health services. Thus, most mental health providers must rely on claims-based reporting, a method that is both readily available and relatively uncomplicated to use. Therefore we strongly recommend that CMS retain claims-based reporting for PQRS.

We also object to the proposal to eliminate measure #9, Major Depressive Disorder: Antidepressant Medication during Acute Phase, based solely on a low threshold of reporting. Clinical psychologists and other mental health professionals have not participated in PQRS in large numbers to date, but this year we expect to see a significant increase. Many psychologists have told APA they decided to start PQRS reporting upon learning that participation in 2013 would help them avoid the penalty in 2015. The program is challenging because psychologists

do not provide as many different services as other healthcare professionals and thus have a harder time finding measures that fit their practice. Since CMS wants to increase the number of measures required for satisfactory participation from three to nine, it is critical that mental health professionals not lose any of their existing measures. Accordingly, we ask that measure #9 be retained in PQRS.

Lastly, we strongly object to the proposal by CMS to allow reporting for several new mental health measures under EHR only. Imposing this requirement will be prejudicial against clinical psychologists and clinical social workers who are not housed in institutions with EHRs. For those in small or solo independent practices or those employed in small specialty clinics, there is a dearth of acceptable EHR systems even available. And, neither clinical psychologists nor clinical social workers are currently eligible for EHR incentives so even if there was a system available, the cost would likely be very prohibitive at this time. Therefore we are asking CMS to allow claims-based reporting for the following proposed new measures:

82v1 Maternal Depression Screening
155v2 Depression Remission at Twelve Months
160v2 Depression Utilization of the PHQ-9 tool
177v2 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

In closing, we thank the agency for this opportunity to submit comments. We look forward to resolving these issues with CMS to preserve Medicare beneficiaries' access to psychological services. If you have any questions or require additional information please contact our Director of Regulatory Affairs, Diane M. Pedulla, J.D., by telephone (202-336-5889) or email (dpedulla@apa.org).

Sincerely,



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