AMERICAN PSYCHIATRIC ASSOCIATION

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September 2, 2016

Andrew M. Slavitt, M.B.A.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 (81 *Fed. Reg.* 46,162; July 15, 2016).

Dear Administrator Slavitt:

The American Psychiatric Association (APA), the national medical specialty representing over 36,500 psychiatric physicians and their patients, would like to take this opportunity to communicate our comments to the Centers for Medicare and Medicaid Services (CMS) regarding the Medicare Physician Fee Schedule proposed rule for calendar year (CY) 2017.

Improving Payment Accuracy for Primary Care, Care Management Services and Patient-Centered Services: Psychiatric Collaborative Care Model and General Behavioral Health Integration

We appreciate the acknowledgement by CMS that physician work is being done that is consistent with the objectives of reforming service delivery under Medicare, and that work is not currently being reimbursed. We think it is essential to the success of this reform effort that CMS consider how new health care delivery arrangements have changed expectations for clinical care in ways that are not currently described. CMS has taken a significant step through this proposal to remedy that situation.

CMS is proposing a family of four G-codes to facilitate separate payment for services covering behavioral health integration (BHI) in the primary care setting. Three of the codes (GPPP1, GPPP2, and GPPP3) parallel recently approved Current Procedural Terminology® (CPT®) codes describing the work of the CoCM. GPPPX describes services furnished using other approaches to enable care management of patients with behavioral health conditions in the primary care setting. We have nine specific recommendations below regarding these codes.

Psychiatric Collaborative Care Management Services in the Collaborative Care Model

Psychiatric Collaborative Care Management services are based upon the Collaborative Care Model (CoCM) that has been developed over the past 20 years, by entities such as

the AIMS Center of the University of Washington.[1] This evidence based model was designed for the treatment of patients with the most common psychiatric disorders. For patients with common behavioral disorders who are treated in primary care, the CoCM maximizes the effectiveness of current behavioral health treatments (i.e., indicated pharmacotherapies and evidence based psychotherapy) by ensuring that patients are identified, treated, and monitored proactively, with clinical guidance provided by a qualified psychiatric consultant. A recent large study by the Mayo Clinic found that the median time to remission was 86 days for the CoCM group, versus 614 days for those who chose usual care by a primary care provider.[2]

In this model, primary care providers (PCPs) receive extensive support from a team that includes a trained behavioral health care manager and a psychiatric consultant. Patients benefit from the heightened benefits of a collaborative, team-based approach that applies well-established principles of population-based behavioral health care and employs specific behavioral health expertise. More than 80 randomized controlled trials have shown that the Collaborative Care Model achieves the Triple Aim of Health Care Reform: improving access to care, improving health outcomes, and making the most cost-effective use of our existing health care workforce.[3]

Under the CoCM, PCPs identify certain patients with depression or other psychiatric diagnoses (including substance use disorders) and connect them with the behavioral health care manager (BHCM) for inclusion in the program. The program is structured to provide intensive services as early as feasible in the patient's treatment, to more quickly alleviate the severity of symptoms and achieve remission, and avoid the delays in treatment often encountered in standard approaches to care. The psychiatric consultant supports the PCP and BHCM in treating patients with psychiatric disorders, through ongoing case review and recommendations (i.e., pharmacotherapy, referral to specialty care including psychotherapy) for changes in treatment, as necessary. Patients are discharged from the program when their illness can be managed by the PCP, their treatment is no longer managed by the primary care provider, or they decline to continue in the program. The three key elements of the services are:

1. Active treatment and care management using established protocols for an identified patient population;
2. Use of a patient tracking tool to promote regular, proactive outcome monitoring and treatment-to-target using validated and quantifiable clinical rating scales; and
3. Regular (typically weekly) systematic psychiatric caseload reviews and consultation by a psychiatric consultant, working in collaboration with the behavioral health care manager and primary care team. These primarily focus on patients who are new to the caseload or not showing expected clinical improvement. The psychiatric consultant recommends changes in individual treatment plans as necessary, communicating other instructions through the behavioral health care manager and (more rarely) directly to the primary care provider.

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[1] Four professors from the AIMS Center (Anna Ratzliff, M.D., Ph.D.; Jurgen Unutzer, M.D., M.A., M.P.H.; Wayne Katon, M.D.; Kari Stephens, Ph.D.) co-authored a book about the CoCM, Integrated Care: Creating Effective Mental and Primary Health Care Teams. 2016, John Wiley & Sons, Inc.

[2] Garrison, G.M., et al. Time to Remission for Depression with Collaborative care Management (CCM) in Primary Care. *Journal of American Board of Family Medicine,* January-February 2016. 29:1(10-17).

[3] Archer, J., et al. Collaborative care for depression and anxiety problems. Cochrane Database Systems Review, 2012. 10: CD006525. Bower, P., et al. Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. *British Journal of Psychiatry*, 2006. 189: 484-93.

> Recommendations, which can include adjustments in medication and referrals for psychotherapy, are documented in the medical record. The psychiatric consultant generally does not see the patient face-to-face. The primary care provider makes the final decision in regard to changes in treatment and remains the prescriber of all medications, including psychotropic medications recommended by the psychiatric consultant.[4]

This model has been shown to be effective in a variety of settings and for a diverse array of populations – including rural and urban areas, and among veterans. [5]

Coverage for Psychiatric Collaborative Care Services

> **Recommendation 1: We recommend that CMS finalize its proposal to establish coverage of the Collaborative Care Model for any diagnosed behavioral health condition through the creation of and coverage for G-codes that parallel the recently approved CPT codes that describe psychiatric collaborative care management services consistent with the CoCM.**

We strongly commend CMS for its decision to propose coverage for the Collaborative Care Model starting in January 2017. This is a huge 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 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."[6]

We also strongly concur with CMS' proposal to adopt the recently approved CPT descriptors for these codes, as this language has been vetted through the CPT Editorial Panel process. Further, we support the decision not to restrict eligible diagnoses to a subset of behavioral health conditions. There is sufficient experience to demonstrate that a wide range of mental health and substance use disorders can be effectively treated in a primary care setting with the appropriate psychiatric support and care coordination described by this model**.**

Proposed Values for GPPP1, GPPP2, and GPPP

> **Recommendation 2: We recommend an increase in the proposed payment amount, valuing the work of the psychiatric consultant no less than that of the primary care physician. After**

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[4] For further information about the CoCM, see: Raney, L.E. Integrating Primary Care and Behavioral Health: The Role of the Psychiatrist in the Collaborative Care Model. *American Journal of Psychiatry,* August 2015. 172:8.

[5] Unutzer J., et al., Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *Journal of American Medical Association,* 2002. 288(22): 2836-45. Bauer, A.M., et al., Implementation of collaborative depression management at community-based primary care clinics: an evaluation. *Psychiatric Services*, 2011. 62(9): 1047-53. Sanchez, K. and Watt, T.T., Collaborative care for the treatment of depression in primary care with a low-income, Spanish-speaking population: outcomes from a community-based program evaluation. *Primary Care Companion for CNS Disorders*, 2012. 14(6).

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

extensive discussions with experts in the CoCM, we have concluded that the proposed values assigned to the GPPP1, GPPP2, and GPPP3 codes do not adequately reflect the work of the psychiatric consultant and would result in values that are not sufficient to sustain the model.

We sincerely appreciate CMS' proposal to provide coverage for these services and generally support the proposed values as they relate to the primary care physician and behavioral health care manager. Absent a survey by the AMA/Specialty Society Relative Value Update Committee (RUC), we support CMS' proposal to crosswalk the work of the primary care physician to the proposed work values of the complex chronic care management codes, 99487 and 99489, which require similar work and take approximately the same amount of time. Pending the survey results, we also support the values proposed for the behavioral health care manager, including the designated type of clinical staff, which are appropriate given the level of responsibility and specific training required.

However, we believe that the proposed valuation of the psychiatric consultant is not representative of the actual work being performed, and thus requires modification in the final rule. CMS' proposal to crosswalk the work of the psychiatric consultant in codes GPPP1, GPPP2, and GPPP3 to CPT code 90836, *Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service*, for a work RVU of 0.42, is not appropriate. CPT defines psychotherapy as "the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbance, reverse or change maladaptive patterns of behavior, and encourage personality growth and development." Psychotherapy, therefore, does not involve medical decision making. While psychotherapy is an important management option, it is not the work being performed.

The psychiatric consultant's work is inherently medical and is more equivalent to the medical decision making of an evaluation and management (E/M) service.[7] Patients enrolled in the CoCM are

[7] The three key components when selecting the appropriate level of E/M services provided are history, examination, and medical decision making:

- History - Chief Complaint (a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter); History of Present Illness HPI (a chronological description of the development of the patient's present illness), Review of Systems (an inventory of body systems obtained by asking a series of questions to identify signs and/or symptoms that the patient may be experiencing or has experienced); Past, Family, and/or Social History.
- Examination - The levels of E/M services are based on four types of examination:
    - Problem Focused – A limited examination of the affected body area or organ system;
    - Expanded Problem Focused – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s);
    - Detailed – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s); and
    - Comprehensive – A general multi-system examination or complete examination of a single organ system (and other symptomatic or related body area(s) or organ system(s).
- Medical Decision Making - Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:
    - The number of possible diagnoses and/or the number of management options that must be considered;
    - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and

typically those who have not responded to standard care and need additional specialty evaluation and involvement to enable the development of an appropriate and effective treatment plan. The psychiatrist is evaluating the patient's condition based upon the data provided by the PCP and the behavioral health care manager. This includes:

- Prior/current medical history (e.g., co-morbid conditions, including medications);
- Other pertinent bio-psychosocial information;
- Prior mental health/substance use disorder treatment history (including psychotherapy) if applicable; and
- Psychotropic medications prescribed/recommended by the PCP, etc.

"The consulting psychiatrist provides an opinion about diagnosis or differential diagnosis, recommendations about further diagnostic testing that may be helpful, and management options (including providing several medication options when medications are deemed appropriate) that account for the possibility of failed medication trials. . . The results of the consultation can generate diagnostic clarification, targeted medication algorithms complete with dosing and necessary laboratory/medical monitoring, general psychotropic education covering the most common and important side effects, and other behavioral and community referral recommendations. . . The consulting psychiatrist in primary care has a more accurate medical picture of each patient, including comorbid medical problems that may exacerbate psychiatric conditions. Psychotropic medications that can treat active medical conditions and the presenting psychiatric condition can be prioritized while overlapping prescriptions for psychotropic medications can be avoided. This integration can decrease the risk of a patient abusing medications such as stimulants, benzodiazepines, or other hypnotics. Potential medication interactions can be reviewed more accurately and potential additive side effects can be anticipated or avoided."[8] Furthermore, "[b]ecause clinical recommendations often involve management of psychotropic medications, psychiatrists and psychiatric nurse practitioners are the two types of clinicians eligible to provide these services in most settings."[9]

We think the medical work of the psychiatric consultant is <u>at least</u> commensurate with that of the primary care physician This professional work typically requires <u>at least</u> a moderate level of medical decision making (E/M codes 99204, 99214, etc.) based upon the severity of the presenting problems and/or the lack of improvement. This medical evaluation and the derived treatment recommendations are communicated by the behavioral health care manager to the primary care physician and reevaluated by the psychiatrist as necessary depending upon the patient's progress to remission.

- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

Centers for Medicare and Medicaid Services, Medicare Learning Matters. Evaluation and Management Services, August 2015. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764TextOnly.pdf.

[8] Schreiter, E. A. Z., Pandhi, N., Fondow, M. D. M., Thomas, C., Vonk, J., Reardon, C. L., & Serrano, N. (2013). Consulting Psychiatry within an Integrated Primary Care Model. *Journal of Health Care for the Poor and Underserved*, *24*(4), 1522–1530. http://doi.org/10.1353/hpu.2013.0178.

[9] Collaborative Care for Primary/Co-Morbid Mental Disorders Brief for CMS Meeting July 27, 2011 (updated August 4, 2011). http://dhmh.maryland.gov/bhd/Documents/CMS_Brief_on_Collaborative_Care_4Aug11.pdf.

In sum, the proposed crosswalk is based upon a misunderstanding of the work of the psychiatric consultant and would result in values insufficient to sustain the model which would also impede adoption of the CoCM. The work of the psychiatric consultant in all three codes (GPPP1, GPPP2, and GPPP3) should be valued no less than that of the primary care physician (1.17, 1.00, and 0.50 RVUs respectively).

Coverage for and Definition for Billing GPPPX

> **Recommendation 3: We support the creation of GPPPX, "care management services for behavioral health conditions." However, we recommend that CMS provide further clarification regarding the proposed code and we believe the creation of an add-on code would be premature.**

We commend CMS' effort to expand Medicare coverage and payment to additional services involving care for patients with behavioral health conditions based on the recognition that significant time and resources are expended on patients with behavioral health conditions that are not currently compensated. Lacking time-specific data from practitioners themselves (which should be supplied in a future RUC survey), we believe the initial proposal for a BHI code with a time interval of 20 minutes appears to be appropriate. However, it is not clear from the proposed rule precisely which services, practitioners, patients, and circumstances would qualify for the billing of the GPPPX code. We recommend that CMS provide further clarification as discussed below regarding the precise services contemplated for g-code GPPPX.

Billing Requirements for GPPP1, GPPP2, GPPP3, and GPPPX

> **Recommendation 4: We recommend that CMS adopt appropriate requirements for GPPP1, GPPP2, and GPPP3 that reflect the prescribed elements of the CoCM model; delineate practitioners' eligibility, supervision requirements, patient eligibility, patient agreement requirements, and the scope or required elements of GPPX services; and avoid applying unduly restrictive requirements for all four codes.**

Patients eligible for all four of these services (GPP1, GPP2, GPP3, and GPPX) would have a diagnosed psychiatric and/or substance use disorder that requires care management services. Similar to CCM services, we recommend patients be seen for an initiating visit and that general beneficiary consent should be given prior to being enrolled in the program. There should be continuity of care with a designated member of the care team. A written plan of care should be developed and shared with the patient, and a comprehensive assessment of the patient's psychiatric condition as well as any medical, functional, and psychosocial needs should be performed and updated as necessary. At a minimum patient progress should be routinely evaluated using validated rating scales, with progress tracked using a patient tracking system, such as a registry. All services should be documented in the patient's medical record and available to other treating professionals.

We concur with the CMS proposal that if eligible to individually furnish and report services, the behavioral health care manager may report separate services in the same calendar month. These could include: psychiatric evaluation (90791, 90792), psychotherapy (90832, 90833, 90834, 90836, 90837, 90838), psychotherapy for crisis 90839, 90840), family psychotherapy (90846, 90847), multiple family group psychotherapy (90849), group psychotherapy (90853), smoking and tobacco use cessation

counseling (99406, 99407), alcohol or substance abuse structured screening and brief intervention services (99408, 99409). Time spent by the behavioral health care manager on activities for services reported separately may not be included in the services reported using time applied to the GPPP1, GPPP2, GPPP3 and GPPPX codes.

Requirements for the Behavioral Health Care Manager (GPPP1, GPPP2, and GPPP3) and the Care Manager (GPPPX)

> **Recommendation 5: We recommend that CMS allow the behavioral health care manager (BHCM) to work off-site, under the general supervision of the treating physician or other qualified health care professional (QHP), consistent with the evidence base for the CoCM and similar to current requirements for care managers for chronic care management (CCM) services.**

CMS has indicated in the proposed rule that it "expects" that the BHCM would furnish services incident to services of the treating physician/QHP; be a member of the clinical staff of the treating physician/QHP; and work on-site at the location where the treating physician/QHP furnishes services to the beneficiary.

For CCM services, CMS originally proposed requiring that care managers be part of the clinical staff of the treating physician/QHP, and that they also be physically on-site with that physician/QHP. But CMS subsequently decided to allow the care managers to work under general supervision. CMS also specifically allowed the billing physician/QHP to arrange to have CCM services provided by clinical staff "external to the practice," including under arrangements with case management companies—so long as all "incident to" and other rules for billing CCM are met and the individuals providing the services are located in the United States.

The AIMS Center at the University of Washington has trained and consulted with practices of all sizes, including small (1-2 provider) practices and small rural clinics, in the Collaborative Care Model. In small to medium sized practices, a single behavioral health care manager may work for two or more clinics or practices, remaining available to primary care providers in assigned practices via phone, pager and email during all usual work hours. Under ideal circumstances, care managers who work with multiple small clinics will maintain a schedule in which they are physically present in each of their clinics on a regular basis. Even though a higher portion of their patient interventions and contacts may occur by phone, we know from CoCM studies in the VA system and elsewhere that patient outcomes in models more reliant on telephonic care management also surpass those of usual care.[10]

Additionally, practices in rural and some urban/suburban areas may be unable to find a qualified person in their region to fill the position. A number of sites that have successfully adopted CoCM—and demonstrated its effectiveness in improving care—have shared a behavioral health care manager who functions out of one office and visits the other sites on an as needed or regular basis, and/or who works

[10] Fortney, J., et al. Practice-Based Versus Telemedicine-Based Collaborative Care for Depression in Rural Federally Qualified Health Centers: A Pragmatic Randomized Comparative Effectiveness Trial. *American Journal of Psychiatry,* 2012; 00:1–12.

remotely using the telephone and telemedicine/video technology.[11] This model can accomplish all care management work so long as the program is structured to reinforce the primary care providers' role as prescriber and lead in organizing and optimizing the delivery of Collaborative Care. **Thus, it is crucial to the ability of diverse practices to implement evidence-based CoCM that the care manager be allowed to work off-site under general supervision of the treating physician or other qualified health care professional. We believe these considerations should also apply to the care manager for the GPPPX code.**

Initial Visit Required to Bill GPPP1, GPPP2, GPPP3, and GPPPX, Beneficiary Consent, and Coinsurance

> **Recommendation 6: We recommend that CMS finalize its proposal to require an initial visit prior to the initiation of these services. Specifically, CMS should finalize its proposal to allow the same types of services which serve as the initiating visit for chronic care management (CCM) services also be allowed for the behavioral health integration codes (GPPP1, GPPP2, GPPP3, and GPPPX).**
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> **Recommendation 7: We recommend that CMS finalize its proposal to establish a beneficiary general consent standard for BHI services.**

We agree there should be an initial visit with the beneficiary before the behavioral health integration (BHI) codes (GPPP1, GPPP2, GPPP3 and GPPPX) can be billed. We also support allowing the same types of services to serve as the initiating visit for CCM services and the BHI codes. Likewise, beneficiary consent should be consistent for all the BHI codes. We support CMS' proposal to adopt a general consent standard for the BHI codes. Prior to initiating these services, the primary care physician or QHP would be required to obtain and document that the beneficiary has consented to consultation with relevant specialists, which would include conferring with a psychiatric consultant, and was informed of the beneficiary cost-sharing.

> **Recommendation 8: We recommend moving ahead with coverage of GPPP1, GPPP2 and GPPP3 with any cost-sharing that is currently required; while simultaneously urging CMS to establish a Centers for Medicare and Medicaid Innovation (CMMI) demonstration project to assess the impact of requiring cost-sharing for CoCM services on beneficiary participation.**

We acknowledge that the current statutory requirements generally require cost-sharing for BHI services. However, cost-sharing is likely to present a significant impediment to patient engagement in Collaborative Care. We have had numerous discussions with experts who have conducted various studies of the CoCM model and/or provided collaborative care services. While there is no published research on this specific question, the expert consensus opinion is that a cost-sharing requirement has had a negative impact on the utilization of the program and thus merits further study and a formal evaluation. Consequently, while we recommend moving ahead with coverage, we also urge CMMI to consider establishing a demonstration to assess the impacts of requiring cost-sharing for CoCM services on beneficiary participation in order to assess whether a waiver of cost-sharing is in order.

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[11] Butler, M., et al. Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09-E003. Rockville, MD. Agency for Healthcare Research and Quality. October 2008.

Separate payment for the CoCM in RHCs and FQHCs

Recommendation 9: We recommend that CMS provide separate payment for psychiatric collaborative care management services furnished in RHCs and FQHCs.

As noted in the proposed rule, CMS began to provide separate payment for transitional care management (TCM) services furnished in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) starting in January 2013. Likewise, CMS added separate payment for chronic care management (CCM) services in RHCs and FQHCs beginning in January 2016. Payment for CCM services is made when CPT code 99490 is billed alone or with other payable services, at the Physician Fee Schedule national average non-facility payment rate. CMS waived the normal requirement that RHC and FQHC services must be face-to-face. The proposed rule also would allow services furnished "incident to" TCM and CCM services to be furnished under general (versus direct) supervision, because the TCM and CCM codes require 24-7 access in order to bill for these services.

We urge CMS to provide separate payment for GPPP1, GPPP2, GPPP3 and GPPPX services furnished in RHCs and FQHCs. CMS recognized that allowing RHCs and FQHCs to bill separately for TCM and CCM services would benefit patients, improve continuity of care, and preserve resources. These same goals would be served by allowing FQHCs and RHCs to bill for these codes. RHCs and FQHCs play a crucial role in their communities by providing much-needed mental health (and substance abuse) services to patients who may not have any other options. Some of the research demonstrating the validity of the CoCM model centered on Medicaid and other vulnerable populations. Allowing FQHCs and RHCs to bill for these services will ensure that their patients who have been diagnosed with a mental health or substance use disorder have access to high-quality care tailored to their individual condition and circumstances.

Assessment and Care Planning for Cognitive Impairment (GPPP6)

The APA commends CMS for proposing coverage for assessment and care planning for patients with cognitive impairment in CY 2017 and for proposing a G code with the same language as the CPT code recently adopted by the CPT Editorial Panel.[12] However, we disagree with the CMS proposal for physician work (3.30). **We recommend that CMS accept the RUC recommended physician work RVU of 3.44. We think the proposed crosswalks (99204 and G0181) are inappropriate and do not reflect the range, type and intensity of the tasks performed.**

Prolonged Service Without Direct Patient Contact (CPT codes 99358 and 99359)

We strongly support the CMS proposal to make separate payment for 99358 and 99359 and to value these services using the RUC recommended physician work RVUs. However, we recommend that CMS not finalize the proposal to require that the work be performed on the same date of service as the underlying face-to-face E/M. This proposed requirement is contrary to CPT instructions and could be

[12] "Estimates suggest that 5%–10% of individuals over age 65 and 30%–40% of individuals over age 85 in the United States have dementia (Ferri, et al. 2005; Hebert, et al. 2013; Prince, et al. 2013). Data from a nationally representative sample suggested that in 2002 approximately 3.4 million individuals had dementia; Alzheimer's disease was present in about three-quarters of these individuals (Plassman, et al. 2007)." The American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia. May 2016.

confusing which could lead to miscoding. In many instances the work occurs on a subsequent day as in the case of the review of medical records or data that has been requested from another physician or health care provider. We recommend that CMS not finalize this proposal and instead adopt a policy which is consistent with CPT instructions.

Expanded Payment and Improved Access for Chronic Care Management (CCM) (CPT codes 99487, 99489, and 99490)

We recommend that CMS finalize its proposals to make separate payment for CPT codes 99487 and 99489 and to base payment on the RUC recommendations for physician work and practice expense inputs. We believe that the availability of the full range of care management services (99487, 99489 and 99490) will significantly improve access to CCM services and will allow the sickest, most frail beneficiaries access to the complex CCM services they need. We appreciate that CMS is proposing to revise its policies on CCM to make them more consistent with CPT guidelines and instructions. We strongly recommend that CMS finalize all its proposals to facilitate access to CCM services. We remain concerned, however, that the requirements for reporting 99490 are excessive and burdensome. We believe that these requirements are, in part, responsible for the low utilization of this service. While making separate payment for 99487 and 99489 will theoretically allow physicians to report 99487/99489 on months where complex CCM is required and 99490 on those months where complex CCM is not required, we believe that 99490 will continue to be underreported as long as CMS requires all the elements listed in Table 11 of the proposed rule. Finally, we strongly recommend that CMS reduce the required elements for performing 99490.

Determination of Malpractice Relative Value Units (RVUS)

The APA agrees with the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) that CMS should use the most up-to-date and reliable information available regarding malpractice/professional liability insurance (PLI) premiums, in determining the relative value units (RVUs) reflecting those costs. Current CMS policy is to update PLI premium data every five years. However, CMS apparently considers the data in the *Draft Report on CY 2017 GPCI Update*, prepared by Acumen, to be sufficiently reliable for updating the geographical practice cost index (GPCI). CMS should also use the 2014 PLI premium data in that report, to determine PLI RVUs, rather than the outdated 2011 data.

Medicare Telehealth Services

The APA is a strong proponent of telehealth as practiced by psychiatrists – otherwise known as "telepsychiatry." The APA has a very active Committee on Telepsychiatry, which has recently issued a "Telepsychiatry Toolkit" with a number of videos and other materials to educate psychiatrists on this treatment option. The ability to offer telepsychiatry services to patients with mental health and substance use disorders, particularly those in rural and remote areas, can make a real difference in their ability to access the care they need, both long-term for those with chronic conditions and short-term for those facing a crisis.

Although telepsychiatry has been employed in therapeutic settings since the 1950s, recent advances in video technology coupled with widespread, broadband internet access have resulted in a rapid expansion in the number of psychiatrists who regularly engage in telepsychiatry. Early research has demonstrated—and most recent research is elucidating upon—that psychiatry as a medical discipline

appears to be an ideal fit with videoconferencing as a treatment modality. Arguably, most psychiatric treatments can be translated to telepsychiatry. Further, 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. Given the current shortage of psychiatrists practicing in the United States, the use of telepsychiatry is able to increase an already vulnerable mental health population's access to care in a variety of settings.[13]

Access to psychiatric care is fundamental not only to address the whole health of patients utilizing healthcare services, but also because patients with acute and chronic mental health problems have been shown to be at increased risks for suicide, homicide, and accidents. This trend—particularly as it relates to suicidality—is especially pronounced within rural populations, which typically demonstrate higher suicide rates, particularly for men, when compared with urban populations. Telepsychiatry increases access to critical services to patients within rural, remote, and isolated settings, and has the potential to address these public health concerns.[14]

Additionally, the benefits of telepsychiatry in emergency department settings are becoming increasingly more apparent. An estimated 5% of ambulatory-care visits in the United States during 2007–2008 were made by patients with primary mental health diagnoses. (cite AHRQ 2010, Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007) Many patients suffering from acute episodes related to mental health and/or substance use conditions enter the health system by presenting first in an emergency department. Unfortunately, many emergency departments do not have any access to a psychiatrist, not even the ability to consult with a psychiatrist on call. For patients who are in imminent danger to themselves or others, telepsychiatry offers a crucial lifeline. ED physicians can contact an on-call psychiatrist who can then use videoconferencing to conduct emergency psychiatric assessments and offer real time guidance to medical staff within the ED while each patient is there.[15] **The APA strongly supports adding emergency department services to the list of covered Medicare telehealth services, and we urge CMS to reconsider its proposal to deny such coverage.**

CMS is also proposing to recognize the potential benefit of critical care consultation services when performed remotely. The agency's proposal would limit such coverage to services provided by consultants who are specially trained in critical care. While psychiatrists are generally not providing

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[13] Hyler, S., Gangure, D., Batchelder, S. Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies. *CNS Spectrums* 2005; 10:403-413. De Las Cuevas, C., et al. Randomized clinical trial of telepsychiatry through videoconference versus face-to-face conventional psychiatric treatment. *Telemedicine Journal and E-Health* 2006; 12:341-350.

[14] Shore, J., et al. A resident, rural telepsychiatry service: training and improving care for rural populations. *Acad Psychiatry* 2011; 35:252-255. Yellowlees, P., et al. Using e-health to enable culturally appropriate mental healthcare in rural areas. *Telemedicine Journal and E-Health* 2008; 14:486-492. Yellowlees, P., Shore, .J., Roberts, L. American Telemedicine Association: Practice guidelines for videoconferencing-based telemental health: October 2009. *Telemedicine Journal and E-Health* 2010; 16:1074-1089.

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"critical care services," CMS should be aware that psychiatrists are sometimes called upon to provide consultation-liaison services to hospital inpatients. Those services are increasingly being set up using telepsychiatry, and some of these will involve services for patients in critical care units. Critical access hospitals (CAHs) are also relying more on telemedicine for specialist consults in critical cases.[16] Many times this involves a psychiatrist videoconferencing in on a tablet, and some CAHs attach that tablet to a mobile unit that is wheeled around the hospital into patients' rooms. This is also occurring nursing homes.

Moreover, placing additional administrative barriers to telepsychiatric access, such as new place of service codes or originating site restrictions only limits practitioners' ability to address the above, critical needs for psychiatric services in these settings. **Consequently, the APA opposes CMS' proposal to require physicians who provide Medicare telehealth services to report a new telehealth place of service (POS) code.**

The APA also opposes the proposal to pay physicians the (lower) facility practice expense (PE) relative value units (RVUs), instead of the (higher) non-facility rate. CMS contends that many practitioners of telehealth service already use a facility POS and the agency does not anticipate there will be much of a difference for most Medicare telehealth services. We respectfully disagree. As noted above, telepsychiatry is an increasingly important treatment option for many psychiatrists. As CMS itself has indicated in the proposed rule, there are three (unidentified) services for which the difference would be at least a 1.0 PE RVUs, or around $36. This is a substantial difference that can lead to a sizable reduction in overall Medicare payments, particularly for those psychiatrists and other physicians who see a large number of Medicare beneficiaries, some on a frequent basis, year after year.

Valuation of Specific Codes: Parent, Caregiver-Focused Health Risk Assessment (CPT Codes 961X0, 961X1)

We appreciate and support CMS' proposal to accept the RUC recommended values for 961X0. We also urge CMS to reconsider the payment status assigned to 961X1 and to value this service. There are many patients that would benefit from this service including caregivers of children, disabled adults (including Veterans) and the elderly. According to a 2015 report from AARP and the National Alliance for Caregiving, there are approximately 43.5 million [unpaid] caregivers who have provided care to an adult or child in the last 12 months of which 34% are 65 years or older.[17] The Centers for Disease Control and Prevention note that caregivers are at increased risk for negative health consequences including depression and have difficulty maintaining a healthy lifestyle and staying up to date on recommended preventive services.[18] Early identification and intervention is crucial to ensuring the health not only of the caregiver but also the individual receiving care. **We urge CMS to reconsider the proposed payment status for 961X1 and to adopt the RUC recommended values for this service.**

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[17] National Alliance for Caregiving and AARP, *Caregiving in the U.S*. 2015. http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Final-Report-June-4_WEB.pdf.

[18] Centers for Disease Control and Prevention. Healthy Aging, last updated March 29, 2016. http://www.cdc.gov/aging/caregiving/.

Reports of Payments or Other Transfers of Value to Covered Recipients

Since the inception of the Physician Payments Sunshine Act establishing the "Open Payments" program, the APA has supported the Administration's efforts to make applicable payments – from manufacturers of covered drugs, devices, biologicals, and medical supplies to physicians and teaching hospitals – transparent to the public. As the national medical specialty society representing more than 36,500 psychiatric physicians and their patients, we promote the highest standards of care for our patients and their families. We recognize that making transfers of value between manufacturers and providers publicly available allows for greater transparency and eliminates concerns regarding conflicts of interest. As CMS considers improvements to the Open Payments program, the **APA encourages the agency to improve the registration process required for psychiatrists, physicians, and other providers to view their transfer of value report.** The current system is cumbersome and requires providers to complete the multi-step program in one sitting. **We encourage CMS to improve the registration process to reduce the complexity as much as possible. Most importantly, we urge the agency to update the process to allow providers to complete their registration in multiple settings by including a "save" feature during the process.** Improving the registration process will lessen the time and the burden – particularly for busy psychiatrists and other physicians who are already drowning in a sea of regulatory requirements – and allow them to more easily access their transfer of value information. These changes would be greatly appreciated by physicians and other providers, and would not appear to require substantial resources from CMS.

Conclusion

Thank you for your consideration of these comments. If you should have any questions or would like to discuss these further, please contact Becky Yowell, Deputy Director of Coding and Reimbursement, at byowell@psych.org or (703) 907-8593.

Sincerely,

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CEO and Medical Director