AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-1770-P

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Child and Adolescent Psychiatry (AACAP), I am writing today to provide comments on the Centers for Medicare and Medicaid Services (CMS) Medicare Physician Fee Schedule (PFS) Proposed Rule for 2023. AACAP is the professional home to 10,000 child and adolescent psychiatrists, some of whom also treat adults and transitional age youth (age 18 years and above). Our mission includes promoting the healthy development of children, adolescents, and families. We therefore have a strong interest in the policies and payment issues that affect how psychiatric services are delivered, documented, and reimbursed, as elements of the regulatory framework in the Medicare program are frequently adopted by private payers, as well as the Children's Health Insurance Plan (CHIP) and Medicaid. We offer the following comments in the context of continuing workforce shortages in mental and behavioral health providers, coupled with significant unmet needs for mental and behavioral health services for both children and adults.

Reduction in Conversion Factor

Physicians are experiencing financial strain due to inadequate payments in federal health care programs, and in many cases must carefully balance their case-mixes to include other payers to ensure that they can keep their doors open. CMS proposes a 4.6% decrease in payments in the Medicare program for 2023 due to a reduction in the conversion factor, budget neutrality requirements, and the expiration of a temporary bump to prevent a 3% decrease in payments last year, notwithstanding effective advocacy efforts by the physician community. A cut of this magnitude is unacceptable. Over the years, payments to physicians have not kept up with inflation, yet medical expenses continue to rise. The reality of this financial environment stymies physician health care delivery innovation, such as the adoption of collaborative care models to integrate behavioral health and primary care as a means to provide whole-person care. Adherence to regulatory requirements related to Alternative Payments Models, the No Surprises Act, and others, also place additional administrative and financial burdens on physicians. We recognize that it is up to Congress to avert the proposed reductions in Medicare payments for 2023, but CMS should be aware of the financial strain that physicians will experience should it stand.

Evaluation and Management (E/M) Services for 2023:

CMS is proposing to update the E/M visit coding guidelines for hospital inpatient, hospital observation, emergency department, nursing facility, home or resident services, and cognitive impairment assessment, effective January 2023. AACAP supports the CMS plan to largely align the guidelines with the office outpatient E/M codes implemented in 2021, though we have concerns about the proposals for prolonged services. CMS is choosing to propose new G-codes for these services, rather than adopt the existing CPT codes for prolonged services (99417, 993X0). This plan has many unintended consequences: (1) There will be no RVUs assigned to the codes so that patients covered by non-Medicare payers who use Medicare as a guide will not have access. (2) Employed physicians are commonly paid based on RVUs so that, even when prolonged services are reimbursed by non-Medicare payers, these physicians will not be paid for these services. (3) It is confusing for providers and administrators to have different codes for similar services based on payer. The differential in criteria between the prolonged service CPT codes and G codes adds to the confusion.

A primary goal of the American Medical Association's E/M Workgroup was to coordinate more fully with CMS in an effort to align payment policies between Medicare, Medicaid, and other payers. In fact, CMS was a regular contributor to the E/M Workgroup's discussions. We strongly suggest that CMS reconsider its proposed approach related to prolonged services and rely on the current CPT codes and guidelines which would more fully align CPT and Medicare E/M policies. It is imperative that physicians have one set of codes and guidelines to report these

services across all payers, and we would like to highlight that the RUC is making the same recommendation.

Telehealth Proposals

The proposed rule discusses actions CMS will take upon expiration of the Public Health Emergency (PHE). Last year, during the rulemaking process for the Medicare Physician Fee Schedule, several codes that AACAP members use to furnish mental health services were permanently placed on the CMS list of telehealth codes, including those approved for audio-only services. AACAP remains grateful for these changes as the use of telehealth technology and audio-only services support access to and continuity of care for many patients unable to access health care in person. AACAP also supports the CMS proposal to make several codes that are temporarily available as telehealth services for the duration of the PHE available through calendar year 2023 on a Category 3 basis to allow time to collect additional data that could result in their permanent inclusion on the list of Medicare telehealth services.

CMS is also planning to implement the statutorily required telehealth provisions in the Consolidated Appropriations Act of 2022, which call for extending certain telehealth flexibilities put in place during the PHE for 151 days after it ends. This would continue the flexibility around geographic restrictions and originating sites as providers and patients transition back to a pre-PHE world. This would also include a delay to the in-person visit requirement before initiation of telehealth visits for mental health conditions, after which time it would once again be required no more than 6 months before the first such visit.

The nation is still grappling with a mental health crisis for both adults and children, with rates of depression and other mental illnesses, in both adults and youth, at all-time highs[1]. Against this backdrop, AACAP continues to be concerned about the in-person visit requirement, as we believe that it will create unnecessary barriers to access for patients who otherwise would not receive mental health care. There are many patients who are not able to take several hours away from work for an appointment and potentially travel long distances to receive needed mental health services either because they do not have the resources, or they have physical or emotional challenges that prevent them from attending an in-person meeting. While some federally funded health care programs include patient transportation to appointments, AACAP members have reported that they are not always reliable, resulting in missed appointments. Such obstacles to attending in-person visits can threaten continuity of care and positive outcomes for some of the most vulnerable patients. Moreover, certain mental health conditions are better treated via telehealth, such as severe anxiety disorders. Ultimately, the

[1] Prevalence Data 2022 | Mental Health America (mhanational.org)

decision to require an in-person visit is best left to the professional judgment of the clinician to decide what is best for the patient, given their circumstances and diagnosis.

Psychiatrists, including child and adolescent psychiatrists, and other mental health care clinicians are all in short supply and the telehealth flexibilities put in place during the PHE have served as a lifeline for many people who otherwise would not have been seen for their mental health condition. AACAP therefore urges CMS to exclude psychiatrists from the in-person visit requirement, pending potential Congressional action to permanently eliminate the requirement.

While rules related to electronic prescribing of controlled substances are under the jurisdiction of the Drug Enforcement Agency (DEA), AACAP is concerned that without further action, patient access to evidence-based psychiatric medications, post PHE, is at risk. In response to the PHE declaration, the DEA granted an exception to the Ryan Haight Act that allowed DEA-registered prescribers to prescribe controlled substances without first conducting an in-person evaluation so long as the following conditions were met: (1) the prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice; (2) the telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and (3) the practitioner is acting in accordance with applicable Federal and State law.

Despite the SUPPORT for Patients and Communities Act becoming law in 2020, which statutorily required the DEA to issue a special registration process allowing providers to legally prescribe a controlled substance via telehealth, the DEA has failed to establish the required special registration and is therefore not complying with federal law. While the DEA PHE flexibility has been essential for psychiatrists and other physicians to widely adopt telehealth visits, the missed deadline for the DEA to establish a special registration for DEA-registered providers should not stand in the way of the provision of telehealth following the end of the federal PHE. We urge CMS to work with the DEA on a possible solution, especially since this proposed rule outlines requirements to transition physicians and practices toward e-prescribing of controlled substances in Medicare Part D plans.

CMS is also seeking public comment on whether to allow periodic assessments to continue to be furnished using audio-only communication technology following the end of the PHE for patients who are receiving opioid use disorder treatment via buprenorphine, and if this flexibility should also continue to apply to patients who are receiving methadone or naltrexone. AACAP believes that audio-only services are necessary for this patient population and should remain, given uneven access to reliable internet service in several regions throughout the country, and devices to access the internet. We know that this issue is being addressed at the

federal level and progress has been made, but AACAP members continue to report that unreliable internet service can be an obstacle to life-saving treatment. Further, coverage for audio-only services should not differentiate between types of opioid use disorder medication.

Proposed GBHI1 Code

AACAP recognizes the urgent need for mental health clinicians to work at the top of their licenses and practice in collaborative arrangements to help address the increased need for mental health services, given extreme shortages of mental health clinicians, including child and adolescent psychiatrists. As part of its Behavioral Health Strategy to address the situation, CMS is proposing a new G code to describe General Behavioral Health Integration performed by clinical psychologists and clinical social workers for models of collaborative care other than the psychiatric Collaborative Care Model (CoCM) that would be valued at the same level as the existing General Behavioral Health Integration code, 99484, when the mental health services furnished by a clinical psychologist or clinical social worker are serving as the focal point of care integration.

While AACAP supports the evidence based CoCM from the Advancing Integrated Mental Health Solutions in Integrated Care Center[2], we have concerns about how the medical management of patients would play out should the proposed code be finalized, especially with respect to prescribing medications and proper differential diagnosis and the clinical expertise this requires. We recognize that the careful wording of this proposed code does not include providing medical or prescription advice. However, in the absence of psychiatric involvement, primary care physicians will potentially be put in the position of being asked to prescribe medications by clinical psychologists or clinical social workers. To ensure the highest quality of care is delivered to patients, primary care physicians, clinical psychologists, and clinical social workers must be able to access immediate advice on prescribing medications for mental health conditions from psychiatrists, since clinical psychologists and clinical social workers do not have the education and training to make appropriate prescribing recommendations. Psychiatrists and child and adolescent psychiatrists have in-depth knowledge of appropriate prescribing and polypharmacy, gained through extensive education as medical doctors followed by specialty training. The ability of all clinicians to receive immediate advice on prescribing from a psychiatrist or child psychiatrist, as in the existing evidence based psychiatric CoCM model, should also be a mandatory element in all other collaborative care models to ensure patient safety and high-quality patient care. In fact, reimbursement for interprofessional consultation codes was specifically mentioned in the Administration's Mental Health Strategy, part of its

[2] AIMS Center | Advancing Integrated Mental Health Solutions in Integrated Care (uw.edu)

Unity Agenda[3], as one of many potential solutions to help improve access to mental health care (CPT codes 99446-99449, 99451-52). AACAP urges CMS to consistently reimburse for these codes throughout federal health care programs. We urge the agency to emphasize the importance of these consultative relationships between psychiatrists, primary care physicians, pclinical psychologists, and clinical social workers, to ensure high-quality patient care, should GBHI1 be finalized.

"Incident To" Proposals

In further efforts to increase access to mental health services, CMS is proposing to change the supervision requirements for a range of non-medical behavioral health clinicians such as licensed professional counselors and marriage and family therapists. Currently these clinicians work under direct supervision, which requires a physician to be immediately available. The CMS proposal would change the direct supervision requirement to general supervision, which does not require a physician to be immediately available. In addition, CMS is proposing to allow clinical psychologists to furnish and to bill for services that are provided "incident to" when they are furnishing services in connection with the proposed GBHI1 code.

AACAP has several concerns about these proposals. Under current direct supervision rules, there is a limit to the number of clinicians that a physician or other licensed clinician can supervise, ensuring greater access to assistance when needed. Onsite supervision provides a safety net for clinicians when faced with unusual clinical circumstances since they can receive immediate insight from clinicians with greater expertise, ensuring more uniform quality and coordination of care. Under general supervision, the supervising clinician generally provides oversight to a much larger number of non-medical behavioral health clinicians, which creates an obstacle to in-the-moment communication, when needed, depending on the team meeting schedule and the opportunities for consultation.

Clinical psychologists are valuable members of a health care team. However, in collaborative care models where they are billing for "incident to" services, should this proposal be finalized, AACAP is concerned that medical management, appropriate prescribing, and overall quality of care will be compromised. We believe that guardrails must be built into care processes so that appropriate psychiatry consultation is available and high-quality patient care is preserved. Another concern with loosening the rules around "incident to" billing is the potential for fraud and abuse, particularly with the movement of private equity that is taking place. This could incentivize inadequate and uncoordinated care with undertrained staff who capitalize on being

[3] FACT SHEET: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union - The White House

able to bill at higher rates and has the potential to expose patients to inferior mental health care. CMS should be cautious about the downstream effects of such policy changes.

AACAP believes that a psychiatrist, or a primary care physician who has access to consultation with a psychiatrist, should be immediately available in order to ensure the uniform delivery of high-quality care to patients with mental or behavioral health conditions being seen in collaborative care arrangements.

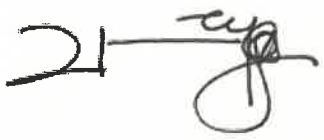
Caregiver Behavior Management Training Codes (96X70 and 96X71)

AACAP, along with the American Psychological Association, and the Academy of Nutrition and Dietetics, surveyed its members during the RUC process for the new Caregiver Behavior Management Training codes, reflecting the interest that several AACAP clinical practice committees expressed in having these codes available in the CPT code set. While these codes will be new in the CPT code set in 2023, CMS states that it will not reimburse for them in 2023 because Medicare payments are limited to items and services that are reasonable for the diagnosis or treatment of injury, or that improve functioning of a body member, and will not pay for services that are furnished to someone other than the Medicare beneficiary. AACAP disagrees with this rationale. These codes are necessary to report evidence-based behavioral management/modification training provided to multiple-family groups of caregivers or parents (without the patient present) of a patient with a mental or physical health diagnosis, with the goal of improving the patient's mental and/or physical function while working toward improved clinical outcomes related to the primary diagnosis and treatment plan.

The codes would allow for reporting the physician or qualified health professional's work and time associated with the caregiver training which are performed in tandem with the diagnostic and intervention services rendered directly to the identified patient to support the patient's optimal level of function. There is a growing evidence base to support the effectiveness of direct intervention with the parents and caregivers of children, adolescents, and adults to improve symptoms, functioning, and adherence to treatment related to the patient's primary clinical diagnosis. Caregiver training provides the parent or caregiver with the skills and strategies to help support compliance with the treatment plan, and therefore contributes to the positive outcome of the patient. Given the shortage of mental health professionals, the ability to therapeutically engage with multiple families could improve outcomes for the identified patients. We therefore recommend that CMS cover these services in 2023 and provide reimbursement for them at the RUC-recommended values.

In closing, we appreciate the opportunity to share our comments and concerns with you. Should you have questions for us or for our member experts, please do not hesitate to reach out to Karen Ferguson, Deputy Director of Clinical Practice, at kferguson@aacap.org.

Sincerely,



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