

# AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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September 11, 2023

The Honorable Chiquita Brooks-LaSure

Administrator

Centers for Medicare and Medicaid Services

U.S. Department of Health and Human Services

Hubert H. Humphrey Building, Room 445-G

200 Independence Avenue, SW

Washington, DC 20201

Re: CMS-1784-P - Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies – *Submitted Electronically*

Dear Administrator Brooks-LaSure:

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to comment on the annual Medicare Physician Fee Schedule (PFS) proposed rules for calendar year 2024. AACAP is the professional home to 10,000 child and adolescent psychiatrists, fellows, residents, and medical students, 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 often 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 for mental and behavioral health providers, coupled with

significant unmet needs for mental and behavioral health services for both children and adults. We appreciate CMS' focus on advancing access to behavioral health care, and the importance of whole-person care, social determinants of health, and health equity. AACAP also applauds new proposals that would provide coverage for intermediate levels of mental health care in intensive outpatient programs for patients in the Medicare program.

### **Non-Facility Payment Rate/Place of Service (POS)**

CMS is proposing to align with the telehealth-related flexibilities that were extended via the CAA of 2023, by continuing to pay for telehealth services provided to patients in their homes at the non-facility payment rate for 2024 when the services are reported with Place of Service (POS) code 10. AACAP appreciates CMS' recognition that physicians who provide both in-person office services and telehealth services need to receive sufficient compensation to cover the expense of maintaining a medical office space. Under the new POS proposals, however, CMS is limiting the options for where a patient can be seen for a telehealth visit. If a patient is receiving telehealth in a location other than their home or a facility, as defined by CMS, the physician will receive the facility rate for their services. We submit that physicians should not be penalized based on where the patient is located if they happen to be in a car, or in a quiet area outdoors, while they are being seen, and feel that ultimately the proposal, if implemented, may limit access to mental health services.

### **Caregiver Training Services**

AACAP applauds the Centers for Medicare and Medicaid Services (CMS) for reconsidering and accepting the recommended RUC values for Caregiver Training Services and establishing an active payment status for a series of three new CPT codes established to capture functional caregiver training services provided to groups of caregivers, without the patient present. These new codes will enhance communication between physicians and caregivers, while improving patient outcomes. CMS coverage of these services acknowledges the importance of caregiver training to alleviate the significant burden that falls greatest on caregivers in diverse populations, supporting both CMS and Department of Health and Human Services' initiatives addressing diversity, equity, and inclusion for family caregivers. Caregiver training provides the caregiver with the skills and strategies to help support compliance with a treatment plan for the patient in their care. Given the shortage of mental health professionals, the ability to therapeutically engage with family members/caregivers to help the patient comply with their treatment plan also makes effective use of the existing mental health care workforce.

## **Consolidated Appropriation Act (CAA) of 2023**

CMS proposes to implement the telehealth flexibilities that were included in the Consolidated Appropriations Act (CAA), 2023, by waiving the geographic and originating site requirements for Medicare telehealth services through the end of CY 2024. By doing so, patients nationwide in both urban and rural areas will retain the ability to access telehealth services, particularly from their own homes. Based on the CAA of 2023, CMS is also extending payment for the CPT codes for audio-only telephone visits, 99441-99443 and 98966-98968, through 2024. CMS further proposes to continue payment for all other services that were on the 2022 Medicare Telehealth Services List in any category through 2024 when they are provided via telehealth and to delay in-person visit requirements for telehealth services for patients with mental health conditions, which we believe should be permanently removed. AACAP members are dedicated professionals who want to practice medicine safely while doing what's best for their patients, and we believe that the timing of in-person visit requirements for mental health conditions or substance use disorders should be left to the discretion of the treating physician, allowing patients in urgent need of care, including populations who are underserved, to receive it via telehealth or audio-only services when necessary.

The PHE clearly demonstrated the value of telehealth services for patients with mental health diagnoses<sup>i</sup> or substance use disorders<sup>ii</sup>. It is critically important that patients all over the United States be able to continue receiving telehealth services, including audio-only services to improve access to needed care.

### **Supervision of Residents in Teaching Settings**

The ability of teaching physicians to supervise residents through appropriate audio-visual equipment in real time has been an essential flexibility throughout the COVID-19 Public Health Emergency (PHE), and AACAP appreciates that CMS is extending this flexibility through 2024, in addition to looking for ways to extend the flexibility beyond 2024. This would permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought through audio/video real-time communication technology. AACAP would urge the agency to make permanent the virtual supervision of all residents, in all areas, beyond 2024, since significant workforce shortages are also impacting access to care all over the country, and not just in rural areas. In addition, in 2022, the Accreditation Council for Graduate Medical Education (ACGME) amended its rules to allow for audio/visual supervision of residents, and its guidelines now state that direct supervision can occur when "The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology."<sup>iii</sup> With appropriate safeguards and monitoring in place considering each resident's

needs for supervision, taking into account their competency and training, as ACGME has outlined, AACAP supports continuing remote supervision on a permanent basis.

### **Adjustments to Payment for Timed Behavioral Health Services**

CMS is proposing to apply an adjustment to the work RVUs for the psychotherapy codes payable under the PFS, excluding those that are billed with evaluation and management (E/M) services. The proposal would base this adjustment on the difference in total work RVUs for office E/M visit codes (CPT 99202-05 and 99211-99215) billed with a proposed inherent complexity add-on code, HCPCS G2211 (visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition), compared to the total work RVUs for visits that are not billed with the inherent complexity add-on code, creating a 19.1 percent upward adjustment to be fully implemented over a four-year period of time. The American Medical Association's (AMA) Relative Value Scale Update Committee (RUC) has expressed concern about this proposal because it is arbitrary and does not account for relativity, will create distortions and rank order anomalies in the code set if implemented, and is counter to the CPT code framework, which is based on time. In addition, in analysis conducted by the AMA, when this policy is fully transitioned in 2028, the work RVU will be higher than 90838 *psychotherapy, 60 minutes with patient when performed with an evaluation and management service* when reported with a 99213 office visit.

In additional comments on the proposed rule, the RUC also expressed extensive concerns about the implementation of HCPCS G2211, the former policy proposal notwithstanding, citing an overall lack of clarity on its purpose, its use, its interaction with current E/M services, and reporting of this code, believing it to be duplicative of work already captured in the CPT codes, in addition to the negative effect on relativity to other services in the CPT code set. Lastly, implementation of HCPCS G2211, even with utilization assumptions that have been adjusted downward, will drive 90 percent of the -2.17 percent budget neutrality adjustment in the PFS proposed rule for 2024, contributing to the substantial proposed cuts to the conversion factor for 2024. AACAP agrees with and echoes all of the concerns expressed by both the RUC and the AMA concerning the proposed active status of HCPCS G2211 in 2024.


### **Comment Solicitation on Expanding Access to Behavioral Health Services**

Pursuant to the CMS Behavioral Health Strategy, the agency is seeking feedback on expanding access to behavioral health services, including the evidence-based Psychiatric Collaborative Care Model (CoCM)<sup>iv</sup> which encourages systematic communication among clinicians in a primary care practice, including the primary care physicians, behavioral health care managers

and psychiatric consultants, which permits essential physician-to-physician communication and learning. AACAP has commented previously on the need to subsidize initial startup costs for collaborative care arrangements, which include establishing a patient registry, hiring behavioral care managers, providing accessible technical assistance to support needed training of staff, and maintenance costs, in addition to appropriate reimbursement, to ensure financial sustainability. The elements that would ensure success and greater adoption of this model are not unknown. The roadmap exists to pave the way to successful adoption of appropriate funding mechanisms, startup costs, and technical assistance, all of which should be more widely available.

In closing, we once again appreciate the opportunity to share our positive feedback and concerns about this proposed rule. Should you have questions, please do not hesitate to reach out to Karen Ferguson, Deputy Director of Clinical Practice, at [kferguson@aacap.org](mailto:kferguson@aacap.org).

Sincerely,

A handwritten signature in black ink, appearing to read 'W. Ng', with a stylized flourish at the end.

Warren Y.K. Ng, MD, MPH  
President

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<sup>i</sup> [Psychiatrists Use of Telepsychiatry During COVID-19 Public Health Emergency](#)

<sup>ii</sup> [Telehealth improves treatment for opioid use disorder | National Institutes of Health \(NIH\)](#)

<sup>iii</sup> [Common Program Requirements - Residency \(acgme.org\)](#)

<sup>iv</sup> [Who We Are | University of Washington AIMS Center \(uw.edu\)](#)