AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1807-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1807-P; Medicare and Medicaid Programs, CY 2025 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 2025. AACAP is the professional home to 11,000 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 members primarily treat children and adolescents, but some of them also treat adults and some minors who have disabilities who could be Medicare beneficiaries. In any case, CMS has a responsibility to the entire field of medicine to set acceptable standards for payment and quality. The proposed conversion factor for 2025 of $32.3562 represents a 2.8% reduction from 2024, a result of budget neutrality requirements and the expiration of a 2.93% temporary update to the conversion factor included in the Consolidated Appropriations Act of 2024. Reimbursements for medical services in Medicare have not kept up with inflation due to continued cuts year after year. Continued cuts in payment threaten the existence of the healthcare workforce, and over time, can make access to medical services more difficult. We recognize that Congress will need to take action to avert this cut, but the situation becomes more dire every year, and AACAP requests that the agency do everything within its discretion to mitigate the cuts for 2025, and ease potential administrative burdens resulting from last-minute Congressional action.

CMS Proposals Extending Telehealth Flexibilities

AACAP appreciates that CMS has proposed providing extensions, or making permanent, telehealth flexibilities within its discretionary authority, including:

- Delaying compliance with the requirement to have an in-person visit within 6 months of receiving a mental health visit provided via communication technology to patients being seen in their homes if being treated by a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). FQHCs and RHCs would have until January 1, 2026, to comply with the in-person visit requirement under this proposal. AACAP recommends making this extension permanent. Doing so would continue to ensure access to mental health care for patients who already have limited access to services.
- Continuing the current policy of allowing teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only when the service is furnished virtually through a 3-way telehealth visit, with the patient, resident, and teaching physician in separate locations. This proposal would permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought, when clinically appropriate, in any residency training location through December 31, 2025. The teaching physician's virtual presence would continue to require real-time observation (not mere availability) and excludes audio-only technology. 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."[i] 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, and also permitting virtual supervision of an in-person visit between a resident and a patient, given that we've heard from members that identifying an appropriate number of teaching physicians for in-person supervision can be challenging and threaten the viability of some training programs.

- Continuing to define direct supervision to permit the present and "immediate availability" of the supervising practitioner through real-time audio and visual interactive communications through December 31, 2025, improving access to care and extending the existing workforce. AACAP would recommend making this proposal permanent when virtual supervision is clinically appropriate.
- Permitting the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home, citing concerns about practitioner safety. This is another proposal that AACAP would like to see made permanent, as unfortunately, we cannot imagine a time when physicians and other clinicians would be safe providing their home address as a practice location.
- Making permanent a revised definition of interactive telecommunications system to include real-time audio-only communication for any telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined as multimedia communications equipment that includes audio-visual equipment permitting two-way, real-time interactive communication but the patient is not capable, of or does not consent to, the use of video technology. This policy change will also improve access to care for patients.

AACAP recognizes that the requirement for patients to be seen in-person within 6 months of starting telehealth care for mental health services, outside of RHCs and FQHCs, will require Congressional action to remove, and we are hopeful, that in the future, clinicians will have the ability to make their own determinations about how frequently to see patients in-person. 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 visits for mental health conditions or substance use disorders should be left to the discretion of the treating physician or clinician, permitting patients in urgent need of care, including populations who are underserved, to receive it via telehealth or audio-only communication when necessary.

Safety Planning Interventions

CMS is proposing to establish separate coding and payment under the PFS describing safety planning interventions with six evidence-based structured elements, via the creation of an add-on G code, GSPI1, for safety planning interventions that would be billed along with an Evaluation and Management (E/M) visit or psychotherapy when safety planning interventions are personally performed by the billing practitioner, in a variety of settings. AACAP believes that the time and work involved providing such interventions to patients with suicidality or at risk of suicide justifies additional payment. The most recent Youth Risk Behavior Survey[ii] from the Centers for Disease Control and Prevention reflects increases in the percentage of students who experienced

persistent feelings of sadness or hopelessness, seriously considered attempted suicide, made a suicide plan and attempted suicide, lending urgency to addressing safety planning in care delivery settings, whether for mental or physical health care. Adult rates of suicide show similar trends.[iii] We are therefore very supportive of separate coding and payment for safety planning services.

Digital Mental Health Treatment

CMS is proposing to create three (3) new G codes for digital mental health treatment (DMHT) devices furnished incident to or integral to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care.

GMBT1; *Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan* for furnishing a DMHT device. GMBT1 would be used only if the DMHT device has been Food and Drug Administration (FDA) cleared and the billing practitioner is incurring the payable cost of furnishing the DMHT device to the beneficiary.

GMBT2; *First 20 minutes of monthly treatment management services directly related to use of the DMHT device*. CMS is proposing to value this code based on a direct crosswalk to CPT code 98980; *Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes*, which has a work RVU of 0.62.

GMBT3; *Each additional 20 minutes of monthly treatment management services directly related to DMHT device.* CMS proposes to value this code based on a crosswalk to code 98981; *Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes*, which has a work RVU of 0.61.

Digital behavioral health treatment devices deliver evidence-based, clinically validated behavioral health interventions through legally marketed software cleared by the FDA to treat or manage a broad spectrum of diseases and disorders. We thank CMS for its willingness to engage with stakeholders on this issue and acknowledging that there remain gaps in care for beneficiaries with mental health issues.

We support CMS's proposal to establish coding and payment for Digital Mental Health Treatment (DMHT) devices furnished incident to a professional behavioral health service. We appreciate that the proposal includes reimbursement not just for the supply of the digital product, but also for professional management of interventions furnished through the product.

AACAP supports:

- establishing separate codes for the (a) onboarding, education, and supply of the device (GMBT1), and (b) treatment management services that support their use (GMBT2 and GMBT3);
- the design of the supply code (GMBT1) that includes onboarding, education and access to the supply and is paid once per course of treatment; and
- the design of the treatment management codes (GMBT2 and GMBT3) that reflect the professional services involved in managing treatment with the device as part of the mental health therapy plan.

However, not all devices generate and transmit data from patient observations or patient specific inputs. The devices are therapy programs that patients access as part of their treatment. The treating provider interacts with the patient over the course of a calendar month during which treatment is ongoing to inquire about the therapeutic use of the device as part of the behavioral therapy plan, but that interaction does not always involve transmission or review of data generated by the device. We recommend a slight modification to the descriptors for GMBT2 and GMBT3. Specifically, we recommend that CMS modify the descriptor by replacing the words "reviewing data generated from the DMHT device from patient observations and patient specific inputs in a calendar month" with "reviewing information related to the use of the DMHT device, including patient observations and patient specific inputs in a calendar month."

Geographic Location and Site of Service Proposals

Under the current statute, the geographic location and site of service restrictions on Medicare telehealth services will once again take effect for services furnished beginning January 1, 2025. Although there are some important exceptions, including for behavioral health services and End Stage Renal Disease-related clinical assessments, most Medicare telehealth services will once again be available only to beneficiaries in rural areas and only when the patient is located in certain types of medical settings.

Although behavioral health services are excepted from these restrictions, AACAP is concerned that access to primary care and other necessary medical services will be threatened by this sudden change. For example, the Collaborative Care Model (CoCM), wherein a patient's behavioral health needs are addressed in primary care settings, is being more widely adopted as a means to increase access to behavioral health services, including in pediatric practices. Providing whole-person care to beneficiaries, whether through the CoCM, or other models, will be much more difficult without addressing geographic location and site of service on a permanent basis. AACAP urges the agency to delay implementation of these restrictions to the extent it can in order to preserve access to care.

Telehealth E/M Codes

With respect to the new telemedicine E/M CPT codes, CMS states that the code descriptors and requirements for billing with the newly established codes generally mirror the existing office/outpatient E/M codes CMS already reimburses for with the exception of the technological modality used to furnish the service. Therefore, CMS does not see a need at this time to recognize audio/video and audio-only telemedicine E/M codes for payment. These new codes will be in the CPT code set starting in 2025, however, and other payers may acknowledge and pay for them. Such a situation could present an administrative burden for physicians, medical offices, and even for patients, with different payers adopting different coding for telemedicine E/M codes. AACAP would appreciate a restatement of requirements when billing for telemedicine E/M services in Medicare with respect to modifiers and Place of Service codes.

Support for Opioid Treatment Services

In order to minimize disruptions in care, Opioid Treatment Programs (OTPs) may furnish periodic assessments using audio-only communications technology when video is not available, on a permanent basis, beginning January 1, 2025. Under this proposal, CMS would allow periodic assessments to be furnished via audio-only when video is not available to the extent that the use of audio-only communications technology is permitted under the applicable Substance Abuse Mental Health Services Administration (SAMHSA) and Drug Enforcement Administration (DEA) requirements at the time the service is furnished, and all other applicable requirements are met. For methadone, CMS is proposing to make permanent audio-visual technology prescribing (but not audio-only). AACAP supports these proposals and the extra support they will provide for this vulnerable patient population.

We recognize and appreciate that CMS is doing all it can do within its discretion to preserve important policies that continue to increase access to mental health and substance use disorder care. Should you have questions, please do not hesitate to contact Karen Ferguson, Deputy Director of Clinical Practice, at kferguson@aacap.org.

Sincerely,

Tami D. Benton, MD
President

[i] Common Program Requirements - Residency (acgme.org)
[ii] YRBS Data Summary & Trends Report | Youth Risk Behavior Surveillance System (YRBSS) | CDC
[iii] Suicide Data and Statistics | Suicide Prevention | CDC