

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

W W W . A A C A P . O R G

Council

President
Paramjit T. Joshi, M.D.

President-Elect
Gregory K. Fritz, M.D.

Secretary
Aradhana "Bela" Sood, M.D.

Treasurer
David G. Fassler, M.D.

Chair, Assembly
of Regional Organizations
of Child and Adolescent Psychiatry
Warren Y.K. Ng, M.D.

Past President
Martin J. Drell, M.D.

Mark S. Borer, M.D.
Stephen J. Cozza, M.D.
Deborah Deas, M.D.
Debra E. Koss, M.D.
Joan Luby, M.D.
Kaye L. McGinty, M.D.
Kayla Pope, M.D.
Neal Ryan, M.D.
Jennifer S. Saul, M.D.
Harsh K. Trivedi, M.D.

Jerry M. Wiener
Resident Member
Vandai X. Le, M.D.

John E. Schowalter
Resident Member
Marika Wrzosek, M.D.

Executive Director
Heidi B. Fordi, CAE

Journal Editor
Andrés Martín, M.D.

AACAP News Editor
Uma Rao, M.D.

Program Committee Chair
Gabrielle A. Carlson, M.D.

Robert L. Stubblefield
Resident Fellow to AMA HOD
Anita Chu, M.D.

August 25, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-P
PO Box 8013
Baltimore, MD 21244-8013

Re: File Code-CMS-1612-P Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2015; Proposed Rule (July 11, 2014)

Dear Administrator Tavenner:

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the Medicare Physician Fee Schedule Calendar Year (CY) 2015. AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age affected by emotional, behavioral, developmental and mental disorders.

Medicare Telehealth Services

For CY2015, CMS proposes to further expand the services eligible for reimbursement delivered via telehealth, including Current Procedural Terminology (CPT[®]) codes 90845 (psychoanalysis), 90846 (family psychotherapy, without the patient present), 90847 (family psychotherapy, with patient present), 99354 (prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour), and 99355 (prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service, each additional 30 minutes). AACAP strongly supports the addition of these codes to the telehealth list. These codes will ensure that the full range of psychiatric treatment will be available for patients and families.

In CY2014, CMS expanded the geographic locations where telehealth services may be covered by Medicare. AACAP strongly supported this expansion as a means of increasing access to services by many beneficiaries. AACAP remains concerned, however, that many

beneficiaries continue to have limited access to psychiatric services outside of rural areas as determined by the Office of Rural Health Policy. There are many specialties, including child and adolescent psychiatry, whose patients face physician shortages in large regions of the country, even in urban areas. To ensure maximum access to services for all beneficiaries in Medicare and other applicable Federal health programs, AACAP suggests that CMS review the possibility of expanding telehealth qualifications to include physician specialty shortage areas in addition to geographic areas.

Valuing, New, Revised, and Potentially Misvalued Codes

CMS's proposed changes to the CPT code valuation process are driven by the call for additional transparency and comment opportunity in the valuation of physician and other healthcare professional services, which AACAP strongly supports. Unfortunately, the 2016 implementation date is premature, as it will have a serious impact on the development of new codes already underway for the 2016 code set.

As stated in a letter from the AMA, dated August 13, 2014, and signed by AACAP, we believe that it would be highly inappropriate for CMS to implement this proposal in the November 1, 2014, Final Rule. The editorial process for the 2016 codes set will be nearly complete by that date, and requiring publication in a proposed rule next summer will delay their implementation by another year. Those that have solicited new and/or revised CPT codes deserve timely consideration of their applications and fair notice of the implementation date. We support the AMA's recommendation to begin implementing the new timeline and procedures for the CPT 2017 cycle and the 2017 Medicare Physician Payment Schedule.

Additionally, AACAP supports the alternative proposal submitted by AMA modifying the CPT and Relative Value Update Committee (RUC) workflow to accommodate publication in the Proposed Rule. The creation and adoption of temporary G codes, per the CMS proposal, would unnecessarily add to the administrative burden of providers, who would be tasked with having to learn and implement new codes to be replaced within a relatively short period. Moreover, this could create a situation of parallel, but distinct coding, between Medicare and private payers, as private payers may implement new CPT codes as soon as they are published. If CMS adopts the AMA proposal, this will eliminate the need for CMS to create G codes that essentially duplicate the CPT codes.

Chronic Care Management

In 2013, CMS implemented payment for transitional care management services (TCM), and, in 2015, CMS will begin payment for chronic care management (CCM) services. AACAP appreciates CMS's recognition of this essential work and decision to pay for these services. AACAP worked closely with the CPT Editorial Panel and the CPT/RUC Complex Chronic Care Workgroup (C3W) in the creation and valuation of these important non face-to-face services. We urge CMS to continue consideration of payment for other non-face-to-face services, including team conferences.

In the CY2015 proposed rule, CMS discusses nomenclature for a G code, originally proposed in July 2013. Although AACAP appreciates many of the changes by CMS to the proposed G code in response to concerns raised by stakeholders, we support the use of the new code 99490X for

2015 as created by the CPT Editorial Panel, which is intended to address the CMS proposal. The CPT code describes the service “per calendar month,” rather than the G code description of “per 30 days,” which will be easier to implement.

AACAP understands that CMS may not have yet had the opportunity to consider the recommendations submitted by the AMA because the Proposed Rule was drafted prior to their submission. The RUC recommended value of 1.00 is based on a median physician time of 30 minutes, with recommended clinical staff time of 60 minutes. AACAP supports the recommendations for CPT 99490X as submitted by the AMA and urges CMS to continue publishing, and paying, the RUC recommended relative values and direct practice expenses for CPT codes 99487 (complex chronic coordination services, first hour of clinical staff time) and 99489 (each additional 30 minutes of clinical staff time).

Access to Identifiable Data for the Center for Medicare and Medicaid Innovative Models

Per statutory requirement, in order to evaluate the effectiveness of the innovative payment and service delivery models, CMS proposes requiring states and other participating entities to provide identifiable information on all patients, including those not covered by Medicare or Medicaid. AACAP supports the sharing of relevant and medically necessary patient information for the purposes of providing effective, quality care, but has serious concerns about the disclosure of private information, particularly highly sensitive information related to mental health, outside of a treatment team. The new models for payment and care delivery, though usually focusing on primary care settings, are designed to encourage collaborative care processes, and will, therefore, likely include patients with highly sensitive medical information, including mental health or substance use diagnoses and treatment plan information. Substantial stigmatization remains for patients diagnosed with mental health and substance use disorders. For this reason, there are often additional safeguards of this patient information, such as the separate psychiatric note in the medical record.

As a covered entity, Medicare and Medicaid must follow the rules of the Health Insurance Portability and Accountability Act (HIPAA), which allows patient information to be shared with the patient’s insurance carrier or health plan, certain state agencies, and other providers in a treatment team. For the proposed evaluation process, CMS may not be the insurance carrier, health plan, or healthcare provider of the patients participating in the model program. HIPAA also provides for the ability to access patient information for use in research within certain criteria, including de-identification and additional authorization language. Again, for the proposed evaluation process, CMS maintains the need to have identifiable information to effectively measure model success. To address patient concerns about their medical record privacy under HIPAA, particularly their mental health privacy, AACAP strongly recommends that CMS ensure that all entities participating in the innovative model evaluations have patient authorizations to use their records for the purpose of evaluating the payment model and clearly identifying who will be collecting the information.

Malpractice Relative Value Units

As part of the third comprehensive review and update of malpractice relative value units (RVUs), CMS chose to crosswalk the premiums of non-physician specialties to the lowest physician risk factor: Allergy Immunology. Unfortunately, using a crosswalk for non-physician

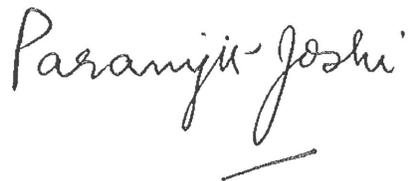
specialties to the lowest physician specialty may overstate the malpractice premiums and risks associated with these non-physician services.

AACAP is concerned about the illogical use of Allergy Immunology as the comparison specialty to non-physician groups, because it was not selected due to its close association with premium costs to non-physician services, but because it represents the lowest premium rates for a specialty in which adequate data was collected. The American Medical Association (AMA) collected data on non-physician specialties through the Physician Practice Information survey process, and they submitted this information to CMS. The AMA data show that premium rates for psychologists and social workers, in 2006, averaged \$1,349, while the premium rate for Allergy Immunology for the CY2015 proposed rule is \$8,198. Although these premium rates reflect 2006 payments and do not represent all non-physician specialties, these data provide a reasonable comparison to suggest that a direct crosswalk to Allergy Immunology is still unrealistic in 2014.

If CMS uses the Allergy Immunology crosswalk, non-physician providers, who pay significantly less than physicians in premiums, per the AMA survey data, will nevertheless receive the same reimbursement level via the malpractice RVU as the physicians. AACAP supports the use of the AMA survey data, and not the CMS crosswalk, to determine accurate premium rates and, therefore, accurate RVUs for the non-physician specialties.

Thank you for the opportunity to comment. We would be happy to speak with you further about our comments. Please contact Ronald Szabat, JD, LLM, Director of Government Affairs and Clinical Practice at rszabat@aacap.org, 202.587.9666, if we can be of further assistance.

Sincerely,

A handwritten signature in black ink that reads "Paramjit Joshi". The signature is written in a cursive style. Below the signature is a short horizontal line.

Paramjit T. Joshi, MD
President