National Association for Behavioral Healthcare

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6 September 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically to: http://www.regulations.gov

RE: Proposed Rule on the FY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Brooks-LaSure:

On behalf of the National Association for Behavioral Healthcare (NABH), thank you for the opportunity to comment on the proposed rule for the FY 2023 payment policies under the Physician Fee Schedule. We greatly appreciate the progress CMS has made in behavioral health with this year's proposed policies, and we are hopeful that CMS will continue to prioritize policies that promote behavioral health equity, access, coverage, and flexibility. We are providing this comment letter following discussions with our members.

NABH represents behavioral healthcare systems that provide mental health and addiction treatment across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility-based outpatient programs including about one-third of the national's opioid treatment programs (OTPs). Our membership includes behavioral healthcare providers across the United States in 49 states and Washington, D.C.

The Covid-19 pandemic illuminated the widespread inequities in behavioral health coverage and services. In particular, substance use disorders surged during the pandemic with more than 107,000 drug overdose deaths reported in the United States between December 2020 and December 2021.[1] This is a drastic increase from the estimated 62,000 preventable drug overdoses in 2019.[2] Further, the prevalence of anxiety and depression increased by an astounding 25% during the pandemic.[3] Improving access to behavioral

[1] FB Ahmad et al., *Provisional Drug Overdose Death Counts*, NATIONAL CENTER FOR HEALTH STATISTICS, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (last accessed Aug. 18, 2022).

[2] National Security Council, Safety Topics – Drug Overdoses, Injury Facts, https://injuryfacts.nsc.org/home-and-community/safety-topics/drugoverdoses/data-details/ (last accessed Aug. 18, 2022) (citing data from the Centers for Disease Control and Prevention, National Center for Health Statistics).

[3] World Health Organization, *Mental Health and COVID-19: Early Evidence of the Pandemic's Impact*, Scientific Brief (March 2, 2022), https://www.who.int/publications/i/item/WHO-2019-nCoV-Sci_Brief-Mental_health-2022.1 (last accessed Aug. 29, 2022); *see also* COVID-19 Mental Disorders Collaborators, *Global Prevalence and Burden of Depressive and Anxiety Disorders in 204 Countries and Territories in 2020 Due to the COVID-19 Pandemic* Lancet 2023; 398: 1700-12, https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2902143-7 (last accessed Aug. 29, 2022) (estimating a "a substantial increase in the prevalence and burden of major depressive disorder and anxiety disorders as a result of the COVID-19 pandemic").

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healthcare is critical to improving outcomes, and CMS' Physician Fee Schedule is the blueprint and foundation for that access.

With consideration for the background and experience of our membership, we respectfully submit the following comments on the proposed rule for the FY 2023 payment policies under the Physician Fee Schedule.

Proposed FY 2023 Changes

I. Proposed Revisions for "Incident to" Regulations

The new rule proposes to amend the direct supervision requirement under CMS' "incident to" regulation to allow services provided by licensed professional counselors (LPCs), licensed marriage and family therapists (LMFTs), and other behavioral health practitioners to be furnished under the general supervision of a physician or a non-physician practitioner (NPP).

Response: NABH strongly supports CMS' proposal to allow LPCs, LMFTs, and other behavioral health practitioners to furnish services under the general supervision of physicians or NPPs. This change will significantly expand access to behavioral healthcare by allowing LPCs, LMFTs, and other practitioners to provide behavioral healthcare services that are within their scope of practice without requiring a physician or NPP on site. With this adjustment, a greater proportion of practitioners will now be able to provide a broader range of services – making use of the full scope of their license – while still ensuring they provide safe and effective care. We anticipate this proposal will increase the availability of behavioral healthcare services in rural areas or areas with physician or NPP shortages. Implementing this proposal is vital to address provider shortages that have been especially persistent in rural communities.

While unwavering in our support for this proposal, NABH urges CMS to recognize that a move to general supervision will increase the need for behavioral healthcare coordination and CMS should consider expanding the tasks that are delegable to these practitioners.

II. CY 2023 Conversion Factor

The proposed rule estimates the CY 2023 Physician Fee Schedule conversion factor to be 33.0775, which is more than 4% less than the CY 2022 conversion factor. CMS states that this decrease is due to: 1) the expiration of a conversion factor increase contained within the *Protecting Medicare and American Farmers from Sequester Cuts Act*, 2) a statutorily required budget neutrality adjustment, and 3) a zero percentage update adjustment factor required by law.

Response: While we understand CMS' statutory constraints, NABH strongly opposes the CY 2023 conversion factor. The proposed conversion factor is not realistic nor appropriate, given current inflation rates, and it threatens behavioral healthcare access for Medicare patients. The conversion factor would also acutely undercut CMS' major strides to expand the scope of "incident to" services. Decreasing payments diminishes what should be a celebrated proposal for "incident to" expansion. NABH urges CMS either to: 1) use its emergency authority, or 2) work with Congress to stabilize and increase the CY 2023 conversion factor to recognize rising inflation rates, continued pandemic-related expenses, and the importance of supporting adequate behavioral healthcare coverage.

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III. Telehealth

The new rule proposes to implement certain statutory provisions to extend telehealth pandemic flexibilities for 151 days after the public health emergency (PHE) ends.

Response: NABH appreciates CMS' inclusion of a transition period for telehealth services after the end of the PHE. However, allowing these telehealth flexibilities to lapse at all would be a tremendous disservice to Medicare patients. Data demonstrate that telehealth is a proven, effective way to ensure access to behavioral healthcare services, and the flexibilities implemented early in the Covid-19 pandemic have positively altered the behavioral healthcare landscape.[4] Telehealth allows patients to circumvent barriers related to scheduling, technology, and transportation so they can access the behavioral healthcare services they need. Further, telehealth, in particular audio-only telehealth, has helped revolutionize behavioral health services in rural areas. Rural patients who once could not find a clinician within driving distance or who did not have access to broadband internet now receive critical behavioral healthcare support by phone. In addition, many rural areas continue to have a stigma surrounding behavioral healthcare, and the ability for patients to receive care in the setting of their choosing enables them to obtain indispensable behavioral healthcare treatment with an appropriate level of privacy.

Our members report that telehealth has resulted in vast behavioral healthcare improvements related to patient attendance, compliance, and engagement. Patients can access care in a timelier manner and report a high rate of satisfaction with telehealth.

Telehealth has transformed behavioral healthcare by making access to care both flexible and easy. Permitting these flexibilities to lapse after the PHE would undermine that progress. NABH urges CMS to make the pandemic-implemented telehealth services permanent, to forgo any additional barriers to telehealth services, and to rally Congress to achieve that goal.

IV. Opioid Treatment Services

The new rule advances several areas in opioid treatment, including: 1) updating the methadone payment methodology to the Producer Price Index (PPI) and increasing rates to OTPs, 2) revising the Medicare Economic Index (MEI) used for annual updates to the non-drug portion of the OTP bundle, 3) permitting individual therapy sessions for 45-minute sessions, 4) confirming that OTPs may bill Medicare for services performed by mobile units without obtaining a separate registration, 5) allowing initiation of buprenorphine through telehealth, and 6) requesting comment on post-pandemic periodic assessments. We also address reimbursement for methadone induction (paragraph 5 below), 7) add-on payments for rural and low-density areas, 8) removing OTPs from the high-risk designation, 9) eliminating restrictions on reimbursement for OTPs with provisional certification and/or accreditation status, and 10) creating an add-on code for contingency management (CM).

[4] Subho Chakrabarti, *Usefulness of Telepsychiatry: A Critical Evaluation of Videoconferencing-Based Approaches*, 5 WORLD J. PSYCHIATRY 286, 286–304 (Sept. 22, 2015).

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Response:

1. NABH appreciates the agency's thoughtful approach in moving away from the Average Sales Price (ASP) methodology toward the PPI approach to determine methadone rates for CY 2023. The new proposed rates will help to ensure the continued availability of OTPs to treat the growing numbers of individuals with opioid use disorder (OUD). We support CMS in maintaining the PPI rate methodology to better reflect service costs and facilitate pricing stability. We also recommend that CMS consider using the hospital market basket index methodology simultaneously (see comments immediately below).

2. CMS proposes to update the non-drug component of the OTP bundle according to the MEI, which reflects the cost of physician practices. We encourage CMS to reconsider use of this methodology and instead use the IPPS hospital market basket. OTPs are not physician practices and they do not function as physician practices. Standard OTP infrastructure is more consistent with the operation of hospital outpatient facilities in their regulatory, accreditation, staffing, and delivery structures. OTPs employ a wide range of multidisciplinary staff to manage laboratory, medication administration, inventory management, and case management, in addition to medical directors, counselors, nurses, pharmacists, social workers, and others who provide clinical care. OTPs also have a high level of security and diversion control requirements, as they are subject to Drug Enforcement Administration (DEA) regulations, state regulatory requirements, federal CMS and Substance Abuse and Mental Health Services Administration (SAMHSA) regulatory requirements, and accreditation standards, typically by The Joint Commission and the Certification of the Commission on Accreditation of Rehabilitation Facilities. As such, using the MEI is not an appropriate reimbursement methodology because it does not accurately reflect the costs for these functions and services.

3. NABH appreciates and agrees with CMS' proposal to permit individual therapy sessions at 45 minutes, because this better reflects the treatment provided in OTPs and supports individualized care. Counseling services are central to recovery from a substance use disorder. Medications alone do not provide the psychosocial services needed to address underlying psychological issues and restore individuals to social and civic functioning. Unfortunately, the reimbursement rates for counseling services continue to be far below what the marketplace demands. Substance use disorder treatment programs have historically had difficulty in attracting a sufficiently skilled workforce due to the low rates that public and private payors provide. This has been compounded by recent economic pressure on the workforce and competition with other industries. This results in programs curtailing services at a time when the opioid epidemic continues to get worse. OTPs will not be able address the growing opioid epidemic without adequate attention to this issue. Staff are under-reimbursed for their type and length of training and education compared with other medical professionals. While the opioid bundle uses a value-based funding approach, the historically depressed fee-for-service rates upon which the rates are based violate mental health and substance use parity principles. We therefore recommend that CMS apply the market basket methodology to these rates.

4. NABH supports aligning reimbursement of mobile methadone with the new DEA regulations that permit the use of mobile components.

5. NABH supports the OTP intake add-on code for buprenorphine initiation via telehealth. However, we urge CMS to collaborate with SAMHSA and DEA to provide additional flexibility for OTP prescribers to

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perform methadone induction through telehealth in cases where the patient and a qualified health professional are at the OTP and the prescriber is at another facility. This would optimize the use of physician time generally and expand the potential of mobile components to serve a larger number of individuals. Without prescriber telehealth, the reach of mobile components will not be fully realized. As qualified staff and the patient are located at the OTP, this telehealth model does not pose any safety risks to the patient. Such a change is consistent with federal strategies to expand access to methadone treatment.

6. NABH supports allowing periodic assessments using audio-only technology for patients busing buprenorphine after the PHE ends. We recommend that periodic assessments also be permitted for patients receiving methadone and naltrexone. Individual patients are constantly assessed for the safe and appropriate use of telehealth and permitting all treatment options advances high quality individualized patient care, regardless of the medication an individual receives.

7. In addition, NABH requests that CMS consider a 17% add-on for services provided in rural areas to incentivize treatment in these low-density areas that have historically demonstrated high opioid overdose rates. This is consistent with the 17% add-on provided to inpatient psychiatric facilities in rural areas. We recommend that this consideration also be applied to non-rural areas that demonstrate a lack of an OTP provider within 30 miles or 40 minutes. This would sensibly conform OTP access to the network adequacy standards for Marketplace plans.

8. NABH respectfully requests that OTPs be removed from the category of high-risk providers and that CMS defer to the SAMHSA and DEA regulations that adequately provide oversight. The requirements are duplicative, onerous, costly, and unnecessary. The industry has demonstrated good partnership with CMS since the opioid bundle was created and we believe we can continue to do so without the additional oversight.

9. A similarly unnecessary deviation from the SAMHSA regulations includes the CMS restriction on reimbursement for OTPs that have SAMHSA provisional certification and accreditation designations. As we have stated, these provisional designations are a legitimate type of certification and accreditation, and we ask that CMS recognize them as such by authorizing payment for their services.

10. NABH requests that CMS develop an add-on service code for the use of CM in OTPs. More than 16,000 Americans died from an overdose involving psychostimulants in 2019, an increase of 28% from 2018.[5] Nearly 23% of all drug overdose deaths in 2019 involved psychostimulants.[6] This reflects the high level of co-use of opioids and stimulants. Individuals who use methamphetamine are at risk for an addiction with additional long-term negative health outcomes such as heart and brain damage, anxiety, confusion, insomnia, mood disturbances, and violent behavior.[7] In 2020, 2.5 million Americans aged

[5] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, *Other Drugs: Psychostimulant Overdose Deaths Increased by 28% from 2018 to 2019*, https://www.cdc.gov/drugoverdose/deaths/other-drugs.html (last accessed on Aug. 29, 2022).

[6] *Id.*

[7] Substance Abuse and Mental Health Services Administration, *Know the Risks of Meth,* https://www.samhsa.gov/meth (last accessed on Aug. 29, 2022).

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12 or older reported having used methamphetamine in the past year[8] and between 2015-2018, of those who used methamphetamine and had a methamphetamine use disorder, fewer than one in three received substance use treatment in the past year. The federal government has supported broadening the use of CM through their creation of a Department of Health and Human Services/Behavioral Health Coordinating Committee workgroup on CM and an Office of National Drug Control Policy (ONDCP) Interagency Work Group (IWG) on the subject, as well as other activities. The California Medicaid pilot has introduced new codes and staff level definitions to facilitate the implementation of CM and HHS is working on developing training protocols with guardrails to prevent fraud and abuse. We urge CMS to recognize this highly effective treatment by providing reimbursement fir CM within the OTP bundle.

V. Medicare Shared Savings Program Accountable Care Organizations (ACOs)

The new rule proposes to incorporate advance shared savings payments to certain new Medicare Shared Savings Program ACOs that could be used to hire behavioral healthcare practitioners and address the social needs of people with Medicare, such as food and housing.

Response: NABH is encouraged by CMS' proposed policies to make advanced shared savings payments to smaller ACOs and believes this is a positive step forward for behavioral health in rural communities.

Comment Solicitation on Intensive Outpatient Mental Health Treatment, Including Substance Use Disorder (SUD) Treatment, Furnished by Intensive Outpatient Programs (IOPs)

VI. Coding and Payment Mechanisms and Gaps

CMS seeks comments on whether the current coding and payment mechanisms under the PFS adequately account for intensive outpatient services that are part of a continuum of care in the treatment. CMS also seeks comments on whether there is a gap in coding under the PFS or other Medicare payment systems that may be limiting access to needed levels of care for treatment of mental health or substance use disorder treatment, including and especially SUDs, for Medicare beneficiaries.

Response: We are encouraged by CMS' review of IOPs and support CMS' efforts to assess expanding Medicare's coverage to include the full continuum of clinically appropriate care. IOPs serve as step-up or step-down care between inpatient, residential, or partial hospital treatment and individual or group outpatient treatment. Research shows IOPs are an effective form of treatment for patients and IOP treatment enables patients to receive a high level of care while living at home.[9] It is both efficient and effective to provide coverage for the full continuum of care so that patients can receive the care they need in the most appropriate setting. Further, expansion of IOPs and other intermediate behavioral health options reduce patient reliance on emergency departments in instances of psychiatric crises.

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[8] Substance Abuse and Mental Health Services Administration, *Results from the 2020 National Survey on Drug Use and Health: Detailed Tables: Prevalence Estimates, Standard Errors, and Sample Sizes*, https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf (last accessed on Aug. 29, 2021).

[9] D. McCarty et al., *Substance Abuse Intensive Outpatient Programs: Assessing the Evidence*, 65 PSYCHIATRIC SERV. 718, 718–26 (June 1, 2014).

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Despite the vital services provided by IOPs, Medicare coding and payment mechanisms are inadequate. At a foundational level, we urge CMS to recognize IOPs as a defined, covered benefit under Medicare, distinguishable from other general outpatient hospital psychiatric services. This coverage should, at a minimum, provide a clear definition for IOPs, recognize various settings of care for IOPs (e.g., hospital-based, community-based, or in physician offices), and acknowledge the complex needs of IOP patients as individuals with often multiple diagnoses.

When establishing IOP-specific coverage, Medicare should also recognize the interplay between IOPs and higher or lower levels of care by building in a variety of practical IOP coverage flexibilities. For example, when a patient is discharged from inpatient care and begins IOP treatment, the patient may need 20-30 hours a week in IOP to transition down from inpatient care. Four weeks later, that same patient may only need 9 hours of care weekly, depending on the patient's progress and treatment plan. The next week, the same patient may experience a small crisis and may need 20 hours of care. This example only serves to demonstrate that IOP treatment (and SUD treatment in general) is not perfectly linear. Sustainable behavioral healthcare can only be achieved when treatment is tailored to a patient's changing needs, rather than a rigid Medicare standard. Individualized treatment planning is the hallmark of high-quality care and CMS standards should not disincentivize such treatment. Comprehensive and flexible IOP Medicare coverage is desperately needed to bridge the gap in treatment options.

VII. Detailed Information about IOP Services

CMS is also seeking information regarding IOP services, including typical settings of care for these programs, the range of services offered, the range of practitioner types that furnish these services, and any other relevant information.

Response: IOP services may occur in a hospital setting, community setting, or a physician's office. In addition to individual or group therapy, IOPs may offer recovery management (healthy coping skills such as exercise, etc.), crisis management, nutritional therapy, vocational support, family health (including multi-family therapy), life/social services (housing, transportation), and/or health coaching for chronic conditions. Services may be offered during normal business hours or after hours, enabling patients to seek out work opportunities or juggle family responsibilities while also receiving treatment. IOPs typically provide services for a couple hours a day, several days a week, for about a one- to three-month period, depending on the patient's needs. Certain patients coming from inpatient or residential treatment may need more hours of treatment per week than a patient who has successfully been in IOP treatment for a month. IOPs may also be tailored by common patient characteristics. For example, IOPs may focus on patients with opioid addiction with other dual-diagnoses, patients facing housing insecurity, or adolescent patients only. Given the variety of patients engaged in IOP treatment and the use of IOP treatment as an intermediary step (either as a step-up or step-down), flexibility in coverage will be key to ensuring CMS' coverage of IOPs is comprehensive, effective, and practical.

Comment Solicitation on Payment for Behavioral Health Services Under the PFS

VII. Beneficiary Access to Behavioral Health Services and Adjustments to Rate-Setting Methodology for Behavioral Health

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CMS is soliciting commenst on "how CMS can best ensure beneficiary access to behavioral health services, including any potential adjustments to the PFS rate-setting methodology, for example, any adjustments to systematically address the impact on behavioral health services paid under the PFS."

Response: NABH supports and commends CMS for initiating discussions about beneficiary access to behavioral healthcare services and the systematic issues affecting the PFS rate-setting methodology in behavioral healthcare. Regarding rate setting, the RVU calculation method has been shown to generally disadvantage cognitive care, including behavioral healthcare providers.[10] For the work RVU – which represents the time, technical skill, judgement, etc. used to perform the service – the current rate-setting method rewards procedural services while undervaluing the time spent on face-to-face cognitive care with patients. While behavioral healthcare services may not require as much investment in higher-cost equipment as procedural care, many behavioral healthcare services are incredibly time intensive, which is not appropriately accounted for in the Medicare rate setting.

In undervaluing cognitive care, the RVU rate-setting method provides financial disincentives for providers to spend their time on this care. Such limitations highlight the inconsistencies with Medicare's treatment of behavioral health services versus other specialties and further impairs beneficiary access to behavioral healthcare services. For example, a 2013 study reported that Medicare's work RVU rates reimbursed common procedural services at rates 3 to 5 times higher than cognitive care for the same amount of time worked.[11] This significant reimbursement discrepancy is likely a central factor in the overall decline in the number of behavioral healthcare practitioners accepting Medicare. One study found that only 55% of psychiatrists accepted Medicare reimbursement, compared with 86% of physicians in other specialties.[12]

Addressing the behavioral healthcare provider shortage gaps will continue to be difficult if Medicare does not adequately reimburse behavioral healthcare practitioners for the time it takes to provide the care patients need. This issue is not limited only to Medicare reimbursement. Because many other public and private payors use Medicare rates as a basis for their own rate setting, undervaluing the time necessary to provide behavioral health in Medicare permeates across other payors.

In addition, ensuring equitable payment for behavioral healthcare services will promote parity in Medicare between behavioral health and other medical conditions. Research demonstrates about a third of the population in the United States has a diagnosable mental illness, but only about 8% of the population seek treatment for that illness.[13] Mental health is vital to a person's overall health and untreated mental illness

[10] *E.g.*, Maura Calsyn & Madeline Twomey, *Rethinking the RUC – Reforming How Medicare Pays for Doctors' Services*, CENTER FOR AMERICAN PROGRESS (July 13, 2018), https://www.americanprogress.org/article/rethinking-the-ruc/.

[11] Christine A. Sinsky, M.D. & David C. Dugdale, M.D., *Medicare Payment for Cognitive vs Procedural Care – Minding the Gap*, 173 JAMA Internal Med. 1733, 1735 (Aug. 12, 2013).

[12] Tara F. Bishop et al., *Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Healthcare*, 71 JAMA PSYCHIATRY 176, 176–78 (Feb. 2014).

[13] Jessica A. Scarbrough, *The Growing Importance of Mental Health Parity*, 44 American Journal of Law & Medicine 453–474 (2018).

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can lead to a variety of physical ailments. Unequal Medicare rate setting for behavioral health exacerbates these issues and reinforces stigmas by sending a message that behavioral health services are not valuable.

If CMS continues to use the existing Physician Fee Schedule rate-setting methodology for behavioral healthcare rates, NABH urges CMS to consider creating guardrails for behavioral healthcare services, re-evaluating the work RVUs for behavioral health codes to ensure they are accurate, or establishing add-on percentages that balance the inequities baked into the existing Physician Fee Schedule methodology.

Thank you for considering our comments and recommendations. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100.

Sincerely,

Shawn Coughlin
President and CEO

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