13 September 2022

Chiquita Brooks-LaSure

Administrator, Centers for Medicare & Medicaid Services

Department of Health and Human Services

**Submitted Electronically**

Re:Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating [CMS-1772-P]

Dear Administrator Brooks-LaSure:

The National Association for Behavioral Healthcare (NABH) respectfully submits to the Centers for Medicare & Medicaid Services (CMS) the following comments on the CY 2023 Proposed Rule for Medicare Hospital Outpatient Prospective Payment System (OPPS). 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 medication assisted treatment centers. Our membership includes behavioral healthcare practitioners in 49 states and Washington, D.C.

**Proposed CY 2023 Update**

NABH is concerned about CMS’ proposed payment update of 2.7% given the extraordinary inflationary environment and continued labor and supply cost pressures hospitals and health systems face. The healthcare delivery system has been on the front lines of the Covid-19 pandemic for more than two years. While we have made great progress in the fight against the virus, our members continue to face a range of significant challenges that affect care delivery. The final CY 2023 OPPS update must reflect these considerations.

The proposed market basket update of 3.1% for CY 2023, especially when paired with the proposed productivity offset of a negative 0.4 percentage point, would result in a severely inadequate payment update. The low market basket update does not capture the current inflationary environment facing outpatient providers and the rest of the healthcare delivery system. This is because the market basket is a time-lagged estimate that uses historical data to forecast into the future, with the productivity projections also based on historical data. When these data are no longer a good predictor of future changes – as is the case with our current scenario – the market basket and productivity projection methodologies become unreliable and can produce inaccurate payment updates.

Using more recent data,[[1]](#footnote-1)[1] we see that the market basket for CY 2022 is trending toward 4.8%, well above the 2.7% OPPS market basket implemented in the CY 2022 final rule. Additionally, while CMS proposes a productivity cut of 0.4 percentage points, the latest data indicate *decreases* in productivity, not gains.[[2]](#footnote-2)[2]

**Therefore, we ask that in the final rule CMS examine ways to account for these increased costs to ensure that beneficiaries continue to have access to quality outpatient care. We also urge the agency to reduce the productivity cut for CY 2023 because such a cut does not align with NABH members’ Public Health Emergency (PHE) experiences related to actual losses in productivity during the COVID-19 pandemic.**

# Data Used for CY 2023 Update: To update the OPPS, community mental health center (CMHC), and hospital-based partial hospitalization program (PHP) weights and rates, the NABH supports CMS’ proposal to use CY 2021 claims and the cost report data (from the June 2020 extract from HCRIS) for CY 2023 rate setting. We appreciate the agency’s recognition of the unusual nature of the CY 2020 cost data. That said, NABH’s support of this methodology only pertains to the proposed CY 2023 update. The data used in future years’ rulemaking should be revisited annually.

**340B – Acquired Drugs**

As CMS takes steps to account for prior 340B hospital cuts that the Supreme Court deemed unlawful in 2022, we urge the agency to ensure that other indirectly related payment updates are held harmless as the agency works to comply with the court’s ruling. We are concerned because 2023 payments for drugs will affect all medications, regardless of whether a drug was acquired through the 340B program. Further, we recognize the likelihood that this adjustment will have a ripple effect on CY 2023 payments for non-340B items and services due to the budget-neutral nature of the OPPS. We generally support CMS’ plan in the final rule to adjust payments to budget neutralize the increased spending associated with payments for drugs acquired through the 340B program. **That said, we urge CMS to apply caution with its pending budget-neutrality adjustments to ensure that non-340B hospitals remain unharmed during this transition.**

**Proposed Expansion ~~to~~ of Telehealth Services Coverage**

Currently, patients can receive remote behavioral healthcare services from hospital outpatient department clinical staff under the authority granted by certain emergency waivers issued due to the Covid-19 PHE. CMS proposes adding remote behavioral healthcare services as covered outpatient services paid under the OPPS after the PHE ends. These services would be performed by the clinical staff of a hospital using hospital-based telecommunication technology to interact with home-based beneficiaries. Such hospital-based outpatient services are generally furnished by hospital-employed counselors or other licensed professionals through psychoanalysis, psychotherapy, and other counseling services. While some provider types, such as marriage and family therapists or licensed professional counselors, are not included in a Medicare benefit category that would allow direct Medicare reimbursement, their services, in many cases, can be covered under the OPPS when hospital personnel provide those services.

**NABH supports expanding Medicare coverage to include remote behavioral healthcare services.**

As the proposed rule notes, telehealth can increase access to mental health and addiction treatment in communities – urban, suburban, and rural – that face a shortage of local providers, and for individuals who have difficulty attending in-person appointments. We applaud CMS for using its emergency authority during the pandemic to expand Medicare coverage for telehealth, which helped providers adjust to social distancing and other infection-control policies. Looking beyond the pandemic, ongoing flexibility and expanded coverage of telehealth will be critical on an ongoing basis, and as we anticipate future pandemics and further development and investment in the behavioral healthcare infrastructure.

Our members report that their experience delivering behavioral healthcare during the pandemic, including PHP services, is consistent with recent research studies that found patients who received telehealth services were more likely to stay in treatment until completed. NABH members have also found that various types of behavioral healthcare services delivered in PHPs can be provided effectively via telehealth, including depression screening, follow-up care after hospitalization, behavioral healthcare counseling for substance use disorders (SUD), and medication management.

With regard to optimizing existing behavioral healthcare resources, our members found that using remote services during the pandemic significantly reduced missed patient appointments. In addition, telehealth has enabled patients and family members who do not have PHPs in their communities to access these services remotely, which has significantly improved access to a level of care that is not available otherwise.

**Prior 6-month Requirement and 12-month Follow-up Requirement.** In its CY 2022 physician fee schedule final rule, CMS required that, after the first mental health telehealth service in the patient’s home, there must be an in-person, non-telehealth service within 6 months prior to and 12 months following each mental health telehealth service. The process includes a mechanism for limited exceptions; it states that if the patient and practitioner agree that the benefits of an in-person, non-telehealth service within 12 months of the mental health telehealth service are outweighed by risks and burdens associated with an in-person service, and the basis for that decision is documented in the patient’s medical record, the in-person visit requirement will not apply for that 12-month period. Exceptions to the 12-month oversight step require a clear justification documented in the beneficiary’s medical record, including the clinician’s professional judgement that the patient is clinically stable and/or that an in-person visit has the risk of worsening the person’s condition, creating undue hardship on the person or his or her family, or would otherwise result in disengaging with care that has been effective in managing the person’s illness. Hospitals must also document that the patient has a regular source of general medical care and is able to obtain any needed point of care testing, including vital sign monitoring and laboratory studies.

We recognize and fully support the patient safety and quality of care objectives of these two requirements. However, given the unique pressures of certain emergency scenarios, such as a future national pandemic, plus the time urgency of certain behavioral health needs, we ask CMS to meet with behavioral health stakeholders to discuss how these requirements, as already implemented under other Medicare payment systems, are working in the field and how they may need adaptations to best fit with protocols for remote behavioral health services. Such engagement will help both the agency and the provider community fully understand the clinical and operational needs that providers face when implementing these requirements, ramifications on the quality of care, and possible improvements. In particular, the 12-month follow-up requirement warrants close examination given the difficulty all providers face in tracking patients following discharge. **However, given the unique pressures of certain emergency scenarios, such as a future national pandemic, plus the time urgency of certain behavioral health needs, we ask CMS to meet with behavioral healthcare stakeholders to discuss how these requirements, as already implemented under other Medicare payment systems, are working in the field to help identify any adaptations that could be needed to align with remote behavioral healthcare service practices**.

**NABH urges CMS to clarify that facility fees for providing PHP services via telehealth will continue to be covered.**

Our members are extremely grateful that CMS recognized the need to cover facility fees for PHP services provided via telehealth. In an interim final rule issued in April 2022, CMS recognized that when a physician or practitioner who ordinarily practices in a hospital outpatient department furnishes a telehealth service to a patient located at home, the hospital still must provide administrative and clinical support for that service. These additional administrative and ancillary services include scheduling, record-keeping, assisting beneficiaries with technological challenges, and other support services. As Medicare coverage expands for PHP services provided via telehealth, it will be critical to continue covering administrative and other clinical support services that these facilities provide. This coverage is also critical to ensure continued improved access to PHP services for Medicare beneficiaries.

**NABH recommends that CMS continue Medicare coverage of PHP services via audio-only telehealth.**

Our members are concerned that access to video technology remains unattainable for many of their more vulnerable patients, including homeless patients. A particular challenge in rural areas, lack of access to video technology is also relatively common in other geographic regions, due to patients’ financial and/or structural limitation of their residences. Inadequate video access, when paired with the severe national shortages of behavioral healthcare practitioners, makes audio-only telehealth services a critical vehicle for access to care. Removing the audio-only option would significantly impair access for some of our most vulnerable PHP patients. On a positive note, we are pleased that during the pandemic, many practitioners and patients have become more familiar with and proficient using of audio-only telehealth.

**Request for Information (RFI) Regarding Remote PHP Services Furnished by HOPDs and CMHCs during the COVID-19 PHE**

To inform future policy development, CMS seeks guidance from the field regarding the use of remote PHP mental health services during the PHE and the potential future need for such services delivered in intensive outpatient programs (IOP). We are encouraged by CMS’ review of IOPs and support the agency’s consideration of expanding Medicare’s coverage to include IOPs, which would enhance the effectiveness of the entire behavioral healthcare continuum.

IOPs play a valuable role as either “step-up” or “step-down” care within inpatient, residential, or partial hospital treatment and individual or group outpatient treatment. IOP treatment enables patients to receive a high level of care while living at home. Expanding the current continuum of care to include IOPs would increase the ability of physicians to ensure that patients can receive the care they need in the most appropriate setting. Further, in the case of complex psychiatric cases, expansion of IOPs and other intermediate behavioral healthcare options reduces patient reliance on emergency departments.

IOP services may occur in a hospital setting, community setting, or a physician’s office. Whether in individual or group therapy, IOPs may offer recovery management (healthy coping skills like 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.

When establishing IOP-specific coverage, Medicare should recognize the interplay between IOPs and higher or lower levels of care by developing 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 nine 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 be achieved only when treatment is tailored to a patient’s changing needs, rather than to a common 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.

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

1. [1] IHS Global, Inc.’s (IGI’s) forecast of the IPPS market basket increase, which uses historical data through fourth quarter 2021 and first quarter 2022 forecast. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData> [↑](#footnote-ref-1)
2. [2] U.S. Bureau of Labor Statistics. (May 5, 2022). Productivity and Costs, First Quarter 2022, Preliminary - 2022 Q01 Results. <https://www.bls.gov/news.release/pdf/prod2.pdf>. [↑](#footnote-ref-2)