



September 27, 2019

The Honorable Seema Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CY 2020 Medicare Physician Fee Schedule Proposed Rule (CMS-1715-P)

Dear Administrator Verma,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Center for Medicare and Medicaid Services' (CMS's) proposed rule for revisions to payment policies under the Medicare Physician Fee Schedule (PFS) and other changes to Part B payment policies, including the Medicare enrollment of Opioid Treatment Programs (OTPs) and bundled payments for substance use disorders (Proposed Rule).

ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to over 200 million people in both the public and private sectors to treat mental health, substance use disorders (SUDs), and other behaviors that impact health and wellness.

ABHW has detailed comments on two main provisions in the Proposed Rule, Medicare coverage for opioid use disorder treatment services furnished by OTPs and bundled payments under the PFS for SUD.

Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by OTPs

Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) established a new Medicare Part B benefit for opioid use disorder (OUD) treatment services furnished by OTPs. CMS sets forth provisions in the Proposed Rule to implement this benefit by January 1, 2020. ABHW has comments on the following proposals:

- **Implementation Date.** CMS plans to implement this benefit by January 1, 2020, as required by the SUPPORT Act. Although the implementation date is set forth in statute, it may be difficult for OTPs to ensure they are complying with all requirements of this new benefit in such a short time frame. We recommend that CMS be cognizant of the time limitations and consider phasing-in compliance requirements over a 12-month period beginning January 1, 2020.
- **Cost-Sharing.** CMS proposes to set the Medicare beneficiary copayment at zero for a time-limited duration, and will reevaluate when it may be appropriate to institute future cost-sharing. ABHW is in support of this proposal because it would reduce barriers to patient access to OUD treatment services.
- **Telehealth.** CMS proposes to add three Healthcare Common Procedure Coding System (HCPCS) codes describing a bundled episode of care for treatment for OUD to the list of Medicare telehealth services. ABHW supports expanding the list of Medicare telehealth services.

ABHW is supportive of expanding access to telehealth services in general because it will help to fill in gaps in availability of treatment for SUDs. Telehealth services have been proven to drive important advancements for patients, expand access to care, improve health outcomes, reduce inappropriate use of psychotropic medications, overcome the stigma barrier, and reduce costs. Given that approximately 1 in 5 adults have a mental illness and 1 in 12 have a SUD, and the fact that there is a growing shortage of behavioral health providers to respond to this significant need for services, the expansion of telehealth is vital to help address this growing need for ready and timely access to necessary treatment.

In particular, telebehavioral health care has gained recognition over the past decade as a solution to enhance access to quality behavioral health care in the United States. Telehealth can create an equitable treatment option to those with

limited or no access to behavioral health services. Telebehavioral health can improve access, clinical efficacy, coordinated care, and cost-effectiveness. While great legislative and regulatory advancements have been made to eliminate barriers to reimbursement for telehealth, barriers to its use and expansion remain. Some changes that could reduce these barriers include:

- Lessen the barriers created by the Ryan Haight Act that prevent providers from prescribing medicine via telehealth services without a prior face to face visit. There is little evidence to support this policy and it creates a barrier to medically necessary care. Not all people are able to have an initial visit with a provider in person due to behavioral health provider shortages or physical difficulty traveling to an appointment.
- Expand the list of eligible Medicare providers to include all behavioral health practitioners who are licensed to practice independently. Doing so will not only help increase access to telehealth by growing the pool of available providers, it will also help reduce costs because these providers provide quality, evidence-based care that is oftentimes a less expensive alternative to a doctor's care.

- **Bundled Payments.** ABHW supports a bundled payment for OUD treatment services that includes a drug component and a non-drug component. We support a continuum of evidence-based, person-centered care to treat individuals with an OUD, including medication assisted treatment (MAT) along with counseling. Use of this combination as part of a treatment plan dramatically improves an individual's chance of recovery and decreases the relapse rate.

It is important for CMS to account for the fact that there are several types of medication that treat OUD with different types of delivery models. The bundled payments should reflect the variety of MAT, what's required for each, and adequately address these differences. The intensity add-on code could also be expanded to reflect the requirements for use of different types of medications (e.g., a detoxification).

We also recommend that CMS provide clarity and guidance about bundled payments in the following areas:

- An OTP can bill for a full episode of care or partial episode of care depending on whether it has furnished the majority (51 percent or more) of the services identified in the patient’s current treatment plan. It would be helpful to have guidance on how an OTP can ensure it has furnished the majority of the services, and the documentation requirements to bill these bundled codes.
- Not all OTPs will be able to or want to bill for services through bundled codes. Will they still be able to bill through traditional fee-for-services codes?
- How will CMS undertake compliance monitoring?

Bundled Payments Under the PFS for SUD

ABHW is supportive of the concept of a bundled episode of care for management and counseling treatment for SUDs. As stated above, we support a continuum of evidence-based, person-centered care. The bundled payments proposed by CMS are for the overall treatment of OUD, including management, care coordination, therapy, and counseling.

We ask CMS to also consider bundled payments for treatment of other SUDs. As reported by the 2018 National Survey on Drug Use and Health, approximately 20.3 million people aged 12 or older had a SUD related to their use of alcohol or illicit drugs, including 14.8 million people who had an alcohol use disorder and 8.1 million people who had an illicit drug use disorder.¹ The most common illicit drug use disorder was marijuana use disorder (4.4 million people), and an estimated 2.0 million people had an OUD. There are SUDs outside of OUD that would also benefit from bundled payments.

CMS also requests comments on the use of MAT in the emergency room (ER) setting, including initiation of MAT and the potential for either referral or follow up care, to help inform whether CMS should propose separate payment for these services in a future rulemaking. ABHW supports initiation of MAT in the ER, but we have concerns about how the ER follow up care would fit in to a payment structure. ERs are not always equipped to provide follow up care or to track follow up care after an ER visit. This is especially true given the 42 CFR Part 2 (Part 2) constraints.

¹ <https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report>

Part 2 governs confidentiality of SUD patient records, and sets requirements limiting the use and disclosure of patients' substance use records from certain substance use treatment programs. Patients must submit written consent prior to the disclosure of their SUD information. Part 2 severely constrains the health care community's efforts to coordinate care for patients with a SUD by preventing the ability of plans and providers to share important information with health care practitioners providing treatment to individuals suffering from SUDs. Part 2 may prevent a provider from obtaining information about SUD treatment, whether in the ER or with follow up care, making it difficult to bill these services in a bundled code.

Thank you for the opportunity to comment on the Proposed Rule. Please feel free to contact Kate Romanow, Director of Regulatory Affairs, at romanow@abhw.org or (202) 449-7659 with any questions.

Sincerely,

A handwritten signature in cursive script that reads "Pamela Greenberg".

Pamela Greenberg, MPP
President and CEO