



June 1, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Dear Administrator Verma,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) interim final rule with comment period (IFC) regarding the policy and regulatory revisions to Medicare and Medicaid in response to the COVID-19 public health emergency. Our comments are outlined below.

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 (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness.

- I. Considerations Related to the Interim Final Rule**
 - A. *Include community behavioral health organizations with rural health clinics (RHCs) and federally qualified health centers (FQHCs) for expanded telehealth services.***

RHCs and FQHCs provide critical services and access to care in underserved areas. Similarly, behavioral health organizations (BHOs) are also a vital component for healthcare for the underserved population of people

experiencing mental health and SUDs.¹ BHOs can fall under three categories: accredited by an independent, national accrediting organization, receive state or tribal funding, or qualify as community mental health centers (CMHC) as defined in Section 1913(c) of the *Public Health Service Act*.² BHOs are especially important in the midst of the current public health emergency since the uncertainty and fear surrounding COVID-19 is impacting mental health.³ In fact, nearly half of Americans report that the pandemic is harming their mental health.⁴ Under Section L of the proposed rule, CMS is allowing RHCs and FQHCs to bill for new services provided via telehealth, provide telehealth services to a new patient (i.e. eliminating the initial face-to-face requirement), and procure consent at the time of the service (as opposed to prior to providing the service). We agree that these are positive changes that will lead to better access to medical care for patients.

Accordingly, we urge CMS to consider that people with MH and SUDs often are unable to leave their homes to meet the initial face-to-face requirement before receiving care via telehealth. Given the impact COVID-19 has already had on patients with MH and SUDs,⁵ we believe it is prudent that these patients have unfettered access to telehealth for behavioral services. While CMS has lifted telehealth restrictions for CMHCs in the second interim final rule released April 30th (which addresses additional policy and regulatory revisions in response to the COVID-19 public health emergency) we request CMS extend this action to the wider net of BHOs as well.

¹ The National Center for Health Workforce Analysis. *National Projections of Supply and Demand of Selected Behavioral Health Practitioners: 2013-2025*, 2016.

<https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf>. Last visited May 8, 2020.

² Letter to Congress re: emergency funding for mental health and substance use disorders, May 1, 2020.

<https://www.warren.senate.gov/imo/media/doc/2020.04.29%20Letter%20to%20Congressional%20leadership%20re%20mental%20health%20emergency%20funding.pdf>, last visited May 11, 2020.

³ Wan, William, *The coronavirus pandemic is pushing America into a mental-health crisis*. May 4, 2020. <https://www.washingtonpost.com/health/2020/05/04/mental-health-coronavirus/>. Last visited May 8, 2020.

⁴ Chidambaram, Priya. *The Implications of COVID-19 for Mental Health and Substance Use*. Kaiser Family Foundation, April 21, 2020. <https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>. Last visited May 8, 2020.

⁵ *Id.*

B. Invest in research to determine quality of audio-only therapy for opioid treatment programs (OTPs).

ABHW agrees that measures to make treatment available in various ways during the public health emergency are of the utmost importance. As such, we support Section N of the proposed rule, which allows the therapy and counseling portions of the weekly bundle of services furnished by OTPs to be conducted by audio-only if beneficiaries do not have access to two-way audio/visual technology. However, we believe there is a chance this restriction may stay lifted beyond the pandemic as private entities may not want to reopen even after the government declares the public health emergency to be over and cases of opioid addiction (as a result of social isolation, job loss, etc.) will continue to emerge long after public health emergency has ended. While we support patients having access to care, we also want it to be quality, evidence-based care; therefore, we urge CMS to collect and analyze data on whether audio-only therapy and counseling are effective as a long-term strategy.

C. Audio-only encounters should be counted as complete encounters when conducted by behavioral health providers.

In light of the current pandemic, we believe that those who solely have access to audio-only communications should be allowed to receive behavioral health services in this manner during the public health emergency to avoid a lapse in care. We appreciate that CMS has included behavioral health service providers to provide audio-only services to Medicare patients in the second interim final rule. However, as stated above, we believe that the restriction against audio-only encounters by behavioral health providers may remain lifted after the public health emergency is declared to be over and we urge CMS to conduct research as to which behavioral health services have sustained efficacy when provided by audio-only.

In addition, we ask CMS to build on the changes made to telehealth by allowing (starting in calendar year 2020) audio-only tele-visits to be used to obtain diagnoses for the purposes of risk adjustment during the public health emergency. We believe this will help maintain an essential component of payment – basing payment on beneficiary health status and diagnosis data. Without this change challenges will be created for providers, beneficiaries, and CMS to sort out which encounters are audio-only, and how such encounters can be reimbursed.

II. Other Considerations Directly Related to the COVID-19 Public Health Emergency

A. CMS should not waive actuarial soundness for Medicaid health plans.

ABHW members, along with many others in the payer community, have pledged to ensure patients are receiving the behavioral health services they need during the public health emergency. To effectively pay providers and cover claims, health plans rely on federal regulations requiring states to set rates in an actuarially sound manner. We are aware that several states have sought to waive actuarial soundness via 1115 waivers, Healthy Adult Opportunity Waivers, and 1135 emergency waivers. Anticipating that more people will need behavioral health services during and beyond the pandemic, ABHW is concerned that a lack of federal oversight and efforts to allow states to waive the requirements for actuarial soundness will undermine plans' ability to maintain stable provider networks in these challenging times. We applaud CMS for not granting any of the aforementioned waivers and urge you to conduct strong federal oversight of state Medicaid managed care rate-setting to ensure that health plans can continue to deliver benefits.

B. Increase the Federal Medical Assistance Percentage (FMAP) to states.

The Families First Coronavirus Response Act increased FMAP by 6.2 percent to states. However, to ensure that states have sufficient resources to adequately cover and care for the Medicaid population during this crisis, additional increases are needed. ABHW strongly supports an FMAP increase, as do the National Governors Association, Partnership for Medicaid and the National Association of Medicaid Directors. As such, we recommend an additional FMAP enhancement of at least 12% that extends beyond the public health emergency to assist states and ensure that patients receive the care they need.

C. Allow Medicaid managed care organizations (MCOs) to provide social determinants of health and incorporate costs into capitation rates.

As healthcare is becoming more and more integrated, it is clear that there is a need to treat the whole patient, not just individual symptoms. A mental health system that works for the patient and promotes sustained recovery must include social determinants of health (SDOH), such as housing, jobs, childcare,

and others. We believe that SDOH costs should be built into rates and included in the numerator of the medical loss ratio calculation, as opposed to categorized as an administrative cost. This would help reflect the true value of SDOH services and ensure patients are receiving the care they need.

D. Safeguard MH and SUD benefits.

We urge CMS to recognize that in light of the pandemic states are currently making, or will consider making, cuts to Medicaid programs. We are concerned that any cuts to MH or SUD services may negatively affect patient health. During the public health emergency, there have been numerous reports predicting an increase in MH and SUDs^{6,7} and we anticipate individuals will continue to face these challenges related to the pandemic. As such, it is of the utmost importance that CMS do what is necessary to protect these vital services in Medicaid programs.

A. Extend behavioral health benefits provided by telehealth beyond the public health emergency.

ABHW strongly supports telehealth benefits provided by an audio-visual format and applauds CMS for lifting many of the telehealth restrictions via the 1135 waiver granted on March 17, 2020. Our members have seen a significant increase in telehealth services during the pandemic, and as previously stated, reports suggest that the pandemic itself is a cause for MH and SUDs.⁸ Therefore, we anticipate that behavioral health services delivered via telehealth will be needed long after the pandemic is deemed to be over, as it may take time for individuals to feel safe leaving their homes for these services. As such, we urge CMS to extend telehealth utilization for behavioral health services for at least one year after the public health emergency has ended. In parallel, we ask that CMS invest in understanding which services are clinically beneficial to patients at the same (or higher) quality as in-person visits.

⁶ Centers for Disease Control and Prevention, Coping with Stress. Last visited May 26, 2020. <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html>

⁷ Hamblin, James. Is Everyone Depressed? *The Atlantic*, May 22, 2020. Last visited May 26, 2020. <https://www.theatlantic.com/health/archive/2020/05/depression-coronavirus/611986/>

⁸ *Id.*

III. Conclusion

Thank you for the opportunity to comment on this important proposed rule. Please feel free to contact Deepti Loharikar, Director of Regulatory Affairs, at loharikar@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