



September 6, 2022

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

RE: CY 2023 Physician Fee Schedule Proposed Rule [CMS-1770-P]

Dear Administrator Brooks-LaSure,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments on the Centers for Medicare and Medicaid Services' (CMS) proposed CY 2023 Physician Fee Schedule (proposed rule). ABHW serves as the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat mental health (MH) and substance use disorders (SUDs) and other behaviors that impact health and wellness.

Overarchingly, our organization's goals aim to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes. Furthermore, through our policy work, we strive to promote equal access to quality treatment and address the stark inequities created by systemic racism. We are deeply concerned about health disparities in this country in the areas of MH and SUD services and are committed to promoting health equity in the health care system.

We applaud CMS for creating a broad strategy to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation. These qualities are essential in behavioral health, not only because of the recent COVID-19 pandemic, but also to address the long-standing issues

created by systemic health inequity for minority communities. ABHW remains committed to tackling these challenges and submit the following for your consideration.

**Section II (D)(1)(a): Changes to the Medicare Telehealth Services List**

ABHW supports CMS' actions to make services available through CY2023 under the Category 3 designation. This designation has greatly expanded access to behavioral health services. We strongly support the proposal to keep the services in Category 3 until the end of 2023 to provide a glide path to ensure enough time for researching the benefits/program integrity issues of these telehealth services and allowing ample time for individuals to become comfortable post-pandemic.

**SECTION II(D)(1)(e): Implementation of Telehealth Provisions of the Consolidated Appropriations Acts, 2021 and 2022**

Individuals with mental health issues are often unable to get treatment in person due to a physical limitation that keeps them in their homes or due to a provider shortage in their area. To ensure those with mental health diagnoses can receive the care they need following the end of the public health emergency (PHE), we strongly support policies that remove the in-person evaluation requirement. We appreciate the strides the Consolidated Appropriations Acts of 2021 and 2022 (CAA) made in eliminating previously imposed geographic restrictions and pausing the six-month in-person evaluation requirement. We recommend CMS urge Congress to remove the six-month requirement entirely so that mental health services can be readily available.

**SECTION II(D)(1)(f): Use of Modifiers for Medicare Telehealth Services Following the End of the PHE for COVID-19**

ABHW supports patient access to audio-only behavioral health services for the duration of the PHE and recommends that the appropriate regulatory agencies research to determine how best to leverage audio-only technology as a modality to provide quality, evidence-based, and clinically appropriate behavioral health services as a long-term strategy. We support the continued use of the audio-only modifier so that utilization can be tracked. We also

support conducting effectiveness research to differentiate between audio-only and audio-visual research.

Evaluation of audio-only services would be beneficial to demonstrate quality and efficacy for behavioral health. ABHW advocates that payment for audio-only services be evaluated in partial hospitalization programs, applied behavioral analyses, psychological testing, and group therapy to ensure equitable and appropriate reimbursement. We further recommend that regulatory agencies evaluate quality standards and protections against potential fraud, waste, and abuse.

**SECTION II(E)(34): Proposed Revisions to the “Incident to” Physicians Services Regulation for Behavioral Health Services**

ABHW supports the inclusion of mental health counselors (MHCs) and marriage and family therapists (MFTs) included in the new “incident to” billing framework. Medicare is the only payer that does not allow MHCs and MFTs to bill as providers. Most MHCs and MFTs practice in settings where they are not employed by or working directly with physicians or supervisors that would be able to take advantage of the new rule. We appreciate the inclusion of the new flexibility for the limited number of providers that can take advantage of the flexibilities. We acknowledge that you cannot unilaterally add MHCs and MFTs as providers. However, we encourage you to work with Congress to pass the Mental Health Access Improvement Act (S.828/H.R.432), which recognizes MHCs and MFTs as covered Medicare providers.

**SECTION II(E)(35): New Coding and Payment for General Behavioral Health Integration (BHI) billed by Clinical Psychologists (CPs) and Clinical Social Workers (CSWs)**

ABHW appreciates the inclusion of the new code for Clinical Psychologists (CPs) and Clinical Social Workers (CSWs) billing under the Collaborative Care Model (CoCM). ABHW supports the CoCM as an important tool to provide integrated care that helps primary care providers more comfortable talking about behavioral health issues with their patients. It also allows behavioral health providers to practice at the top of their license enabling them to see more patients. We appreciate the steps to integrate behavioral health and primary care and look forward to working with you to enhance this evidence-based model of care.

### **SECTION II(E)(36): Request for Information: Medicare Part B Payment for Services Involving Community Health Workers (CHWs)**

As you consider payment models for community health workers (CHWs), we urge you to include and recognize certified peer support specialists (peers) for behavioral health needs. A peer is a person with lived experience who has been trained to support those who live with mental health, behavioral health, psychological trauma, or substance use. Having personally experienced these challenges, peers use informed expertise to guide patient recovery in conjunction with an integrated care setting. Compensation for peers is vital in Medicare programs where blended teams of health professionals seek to deliver high-quality care that improves treatment outcomes by meeting the physical and mental health needs of seniors and people with disabilities. Peers are a crucial component of integrated teams.

### **SECTION II(E)(38): Request for Information: Medicare Potentially Underutilized Services**

Medicare provides many services to beneficiaries that prevent more complicated health issues. However, many barriers to behavioral health care in the Medicare program prevent beneficiaries from receiving the full benefits of their care. Some of these barriers can be addressed by increasing the integration of care and the workforce. We urge Medicare to expand the eligible provider pool to include mental health counselors (MHCs) and marriage and family therapists (MFTs). These two providers increase the number of providers that can care for the increasing number of older adults experiencing depressive symptoms. We also urge Medicare to cover certified peer support specialists as covered Medicare providers. ABHW recognizes that you cannot do so without Congressional action, and we encourage you to work with Congress.

Coordination and integration of medical and behavioral health care improve health outcomes and is cost-effective. Primary care and behavioral health integration through evidence-based models such as the Collaborative Care Model (CoCM) provide a strong building block to address mental health and substance use disorders by ensuring that patients receive prompt behavioral health treatment within the office of their primary care clinician. By increasing the utilization of the CoCM, more seniors would have access to appropriate mental health services.

ABHW also supports the removal of the Drug Enforcement Administration's (DEA) x-waiver for providers prescribing buprenorphine. Nearly one million adults aged 65 and older live with substance use disorder.<sup>1</sup> The proportion of adults 55 and older seeking treatment for an opioid use disorder increased by nearly 54% between 2013-2015. And the proportion of older adults using heroin more than doubled between 2013-2015. Buprenorphine cuts the risk of overdose death in half. The shortage of healthcare providers who can prescribe buprenorphine would be alleviated if the x-waiver were removed. While this is not within CMS' authority, we urge you to work with other agencies and Congress to eliminate the x-waiver requirement. Removing this outdated policy will increase access to evidence-based, effective treatment for opioid use disorder.

### **Section III(B): Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)**

RHCs and FQHCs provide critical services and expanding their reach is vital to the communities they serve. ABHW strongly supports RHCs and FQHCs continuing to be considered distant site practitioners after the public health emergency (PHE) ends.

### **Section III(F)(4): Mobile Components operated by Opioid Treatment Programs (OTPs)**

ABHW members are committed to ensuring that patients with substance use disorders (SUDs) receive the best care possible. We are particularly interested in curbing the opioid epidemic and supporting a continuum of evidence-based, person-centered care to treat individuals with opioid use disorder (OUD), including medication-assisted treatment (MAT). Given the growing opioid epidemic compounded with the current pandemic, we feel it is even more prudent to increase access to SUD treatment. OTPs serve an important role in treatments for SUDs. We support the ability for OTPs to bill Medicare for services furnished via mobile units as an opportunity to expand access to MAT.

### **SECTION III(F)(5): Flexibilities for OTPs to Use Telecommunication for Initiation of Treatment with Buprenorphine**

---

<sup>1</sup> <https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts>

ABHW strongly supports the removal of the in-person initiation requirement for buprenorphine treatment. Enhancing access to medication-assisted treatment (MAT) is more critical than ever with increasing annual deaths from opioid overdoses. The Centers for Disease Control and Prevention (CDC) estimates in 2021, there were more than 107,000 deaths due to opioid overdoses, and in 2020 there were over 93,000. The Kaiser Family Foundation reports in 2020, 31% of these deaths were Black, Hispanic, or Asian. The in-person evaluation prior to prescribing controlled substances via telemedicine only results in reduced access to care.

During the COVID-19 public health emergency, the Drug Enforcement Agency (DEA) waived the in-person requirement, enabling providers to safely prescribe controlled substances using telemedicine. A Journal of Substance Abuse Treatment study found that removing the in-person requirement significantly increased access to care and addressed health inequities in primary care programs providing buprenorphine treatment. We encourage you to work with DEA and other regulatory agencies to finalize rules that would allow for the permanent removal of this requirement.

**Section III(G)(f): Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health Measures and Future Measure Development – Request for Information**

ABHW advocates that social determinants of health (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.

**Section III(L)(4): Requirement Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan**

ABHW supports policy measures that aim to prevent, mitigate, and end opioid misuse. As such, we appreciate CMS' efforts to implement the Congressional mandate that requires Part D prescribers to utilize Electronic Prescribing for Controlled Substances (EPCS) as it is a necessary tool to address the opioid epidemic. Specifically, fraud and abuse associated with paper-based prescriptions have been identified as contributing factors for doctor and

pharmacy shopping for opioids. EPCS can be an effective solution to reducing fraud and thereby alleviating the negative effects of the opioid epidemic. Given the urgency of the opioid epidemic, especially in light of its exacerbation due to COVID-19, we appreciate CMS implementing the required enforcement with providers who may be unable to comply. As CMS examines additional penalties that may be imposed to enforce the EPCS requirement, we urge the Agency to balance the important need for appropriate and meaningful penalties that also wouldn't create barriers for providers from prescribing medications that are critical for the treatment of opioid use disorder (OUD).

#### **SECTION IV (A)(3)(d): Promoting Interoperability Performance Category**

To successfully coordinate and integrate care, all parties in the healthcare supply chain should be involved, including health plans. One way to integrate health plans into patient care is to expand their access to prescription monitoring programs (PDMPs) so that they have a complete picture of the use of controlled substances in a community. As you consider expanding PDMPs to query for additional drug schedules and facilitating increased communication for providers via health information exchanges, we ask that you consider allowing health plans increased access to PDMP data. If allowed health plans could identify patients at risk of overdose or complications because they seek prescriptions using multiple providers and pay for them through their insurance or cash. Additionally, as critical components of an individual's care management, health plans should have access to PDMP data so that they can have a complete picture of the use of controlled substances in the community, including cash pay prescriptions, which they would not necessarily have from pharmacy claims.

#### **Section IV(G)(2)(a)(4): Use and Management of Payments**

ABHW supports increasing the availability of certified peer support specialists (peers) in as many settings as possible, including accountable care organizations (ACOs). Hiring peers can serve to increase diversity and provide culturally appropriate services. Peers using informed expertise is crucial in ensuring that populations are cared for.

Thank you for the opportunity to provide feedback to address important behavioral health policies. If you have any questions or would like to discuss

ABHW's policy priorities, please contact Maeghan Gilmore, at [gilmore@abhw.org](mailto:gilmore@abhw.org) or at 202-449-2278.

Sincerely,

A handwritten signature in black ink that reads "Pamela Greenberg". The signature is written in a cursive, flowing style.

Pamela Greenberg, MPP  
President and CEO