ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

September 11, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2439-P
PO Box 8016
Baltimore, MD 21244-8016

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; CMS–1784–P

Dear Administrator Brooks-LaSure:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rulemaking (NPRM or proposed rule) for the Medicare and Medicaid Programs: Calendar Year 2024 Payment Policies Under the Physician Fee Schedule (CY24 PFS or PFS) and Other Changes to Part B Payment and Coverage Policies.

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

Our organization aims 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 MH and SUD services in this country and are committed to promoting health equity in the healthcare system. Below are ABHW's comments on the behavioral health provisions in the proposed rule.

I. Telehealth

1. Consolidated Appropriations Act of 2023 (CAA23) Implementation of Telehealth Provisions:

ABHW supports expanding coverage of evidence-based telehealth services and removing unnecessary barriers to telehealth care delivery. We were pleased to see that the PFS proposes to implement the telehealth provisions from the CAA23, including but not limited to:

- The temporary inapplicability of geographic and originating site restrictions;
- The temporary expansion of practitioner types who can be paid for Medicare telehealth services;
- Continued payment for telehealth services furnished by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs);
- Delaying the in-person visit requirements for mental health services furnished via telehealth, including services furnished by FQHCs and RHCs; and
- Audio-only flexibilities for certain telehealth services.

The expansion of telehealth during the federal COVID-19 Public Health Emergency (PHE) has demonstrated the lasting value of telehealth in providing access to mental health care. ABHW supports the extension of PHE telehealth flexibilities that will allow beneficiaries continued access to many mental health services. However, some current Medicare laws and regulations unnecessarily limit access to and coverage of telehealth services and should be permanently changed.

In particular, ABHW continues to advocate with Congress to remove the in-person requirement for mental health services via telehealth. Requiring in-person visits can be a barrier to accessing necessary care, especially for individuals with mental health conditions. This requirement will exacerbate healthcare disparities and impede access for rural populations, older adults, and low-income residents. A blanket requirement for in-person sessions may hinder access for those unable to travel for in-person care or those concerned about the stigma of receiving mental health services.

2. Direct Supervision Through Audio-Visual Extension:

ABHW supports the extension of the telehealth direct supervision through audio-visual modalities according to the CAA23 but requests that CMS permit virtual supervision beyond December 2024. There is no evidence that patient safety is compromised by virtual direct supervision for behavioral health services. Additionally, virtual direct supervision has helped alleviate the burden on the already limited and strained provider workforce. The U.S. does not have enough mental health professionals to meet the demands of the current mental health crisis and must adopt measures that increase the utility of and reduce the burdens on the existing workforce. According to the Health Resources and Services Administration (HRSA), as of March 2023, 163 million Americans live in mental health professional shortage areas (HPSAs), with over 8,000 more professionals needed to ensure an adequate supply. For example, while nearly one-third of the U.S. population is Black or Hispanic, only about a tenth of practicing

psychiatrists come from these communities.[1] Extending virtual supervision beyond December 2024 will help maintain the critical availability of services for Medicare beneficiaries.

3. Place of Service for Medicare Telehealth Services:

Providers include a Place of Service (POS) code used to determine whether a service is paid for at the facility or non-facility rate when submitting claims for telehealth services. This proposed rule suggests that POS Code '02' would be used for telehealth services provided in a location other than the patient's home, and POS Code '10' would be used for telehealth services provided in the patient's home. CMS proposes reimbursing claims billed with POS '02' at the facility PFS rate and POS '10' at the non-facility PFS rate. The facility rate is generally lower than the non-facility rate. However, occasionally, there are facility fees for other costs in addition to payments to the physician.

ABHW agrees that practice patterns for many mental health practitioners have evolved since the PHE expired and that many practitioners are seeing more patients in office settings while continuing to see a significant number of patients via telehealth. **We urge CMS to gather more information on telehealth sites of care before establishing separate reimbursement policies for these POS Codes**. Telehealth services are more cost-effective for providers than in-person visits and require fewer resources. Reimbursement at the non-facility rate for POS Code '10' does not reflect the lower cost of delivering telehealth services. **ABHW recommends that CMS continue to gather and analyze data on sites of care for telehealth before implementing a policy that differentiates reimbursement for POS Codes '02' and '10**'.

4. Outpatient Treatment Programs (OTP):

ABHW strongly supports allowing OTPs to provide telehealth services. This provision will ensure that OTP providers continue prescribing buprenorphine via audio-only or audio-visual appointments. ABHW believes in-person requirements can be fulfilled as virtual visits and is grateful to CMS for this proposal. Telehealth services increase flexibility for patients who might otherwise not be able to get their appointments due to difficulties traveling or provider shortages.

II. Advancing Access to Behavioral Health

1. Marriage and Family Therapists (MFT) & Mental Health Counselors (MHC):

ABHW is grateful for the speedy implementation of the CAA23 and to CMS for adding MFTs and MHCs as providers in the Medicare program. Recognition of MFTs and MHCs as Medicare providers will increase the pool of eligible mental health providers in Medicare by over 200,000.

[1] https://data.hrsa.gov/topics/health-workforce/shortage-areas

Studies have shown that these providers have the highest success and lowest recidivism rates with their patients and are the most cost-effective.[2]

In the proposed rule, MFTs and MHCs must have performed at least two years or 3,000 hours of post-master's degree clinical supervised experience after obtaining the applicable degree. We are concerned that some MFTs and MHCs may not be able to meet this specified experience standard. Many states now allow supervised clinical experience before receiving a qualifying degree to count towards the minimum number of hours or years of supervised experience for licensure. While this might have a small impact, as it usually takes at least two years after graduation to meet the clinical supervised experience requirements, **we urge CMS to consider expanding when clinical supervised experience requirements may be fulfilled.**

Additionally, we support the proposal to allow addiction counselors who have met requirements like MFTs and MHCs to become Medicare providers. Addiction counselors provide support, counseling, and treatment for people with SUD and other co-occurring MH conditions. SUDs present different issues that vary from person to person, and addiction counselors must be trained in addiction and its related causes. This proposed rule requires addiction counselors to have a master's degree or doctoral degree that qualifies for licensure; after obtaining such a degree, performing at least two years or 3,000 hours of supervised experience, and being licensed or certified as an MHC, clinical professional counselor, or professional counselor is acceptable. **ABHW supports this measure as a sensible middle-ground approach, allowing qualified addiction counselors to enroll in the Medicare program and further alleviate the critical shortage of providers for SUD treatment.**

2. Psychotherapy for Crisis Services:

ABHW is grateful to CMS for implementing the CAA23 to allow Medicare to reimburse for psychotherapy for crisis services. With the ongoing implementation of 9-8-8, increasing access to behavioral health services that respond to MH crises in communities is vital. **ABHW supports the proposal to create new codes for mobile crisis services. However, payment for those services should depend upon meeting specific care standards. For example, to advance effective mobile crisis intervention, we urge CMS to establish minimum expectations for mobile crisis team services, such as hours of operation and response times. For crisis services to be mobile, crisis teams should respond to patients at their current location, and a licensed, Medicare-eligible professional should perform a face-to-face evaluation.** Crisis teams should ensure the patient is referred to another facility for additional care needs or assist in arranging transportation. The mobile crisis team should support a connection to ongoing, coordinated care by scheduling follow-up appointments with a warm handoff and notification of all clinically relevant providers, such as behavioral health or primary care providers.

[2] Russell Crane & Scott Payne, 2011 available at Individual versus family psychotherapy in managed care: comparing the costs of treatment by the mental health professions - PubMed (nih.gov)

ABHW also supports reimbursing for crisis services furnished by peers in mobile crisis settings. Certified peer support specialists can be vital in helping people with mental health conditions and SUDs. A peer support specialist is a person with lived experience trained to support those who struggle with behavioral health, psychological trauma, or substance use. Having personally experienced these challenges, peer support specialists use informed expertise to guide patient recovery in conjunction with an integrated care setting.

The proposed two new G codes for billing psychotherapy at non-facility rates do not capture the work done by peers in mobile crises. **We urge CMS to clarify that the new G codes include a pathway for peers in mobile crisis teams to be reimbursed and adequately describe peer activities in the practice of a mobile team.** Psychotherapy is not within the scope of peer activities. Peers provide engagement services, including education, support, and sharing of lived experiences to help individuals participating in crisis psychotherapy.

3. Peer Support Specialist – Principal Illness Navigation (PIN) and Regulatory Definition:

ABHW is grateful for the attention of CMS on peer support specialists and expanding their role in Medicare. **We appreciate the creation of the PIN in the proposed rule.** Medicare has not traditionally allowed providers to bill for peer support specialist services, and we are grateful for CMS's recognition of this critical workforce in behavioral health. Peer support specialists are founded on core principles of recovery and empowerment; it is essential to remain faithful to these principles and core competencies of peers as the service continues to grow. However, the new PIN services confuse the role of peers by requiring peers to perform activities outside of their scope and training. **We urge CMS to review the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Model Standards for Peer Certification and only include activities within the scope of peer training.**

Moreover, ABHW urges CMS to adopt the SAMHSA definition of a peer support specialist in the final rule. CMS describes SAMHSA's definition of a peer and states its agreement with the definition. Defining peer support specialists will allow providers and payors to understand better the role peers play in supporting people living with mental health conditions.

III. Behavioral Health Requests for Information

1. Behavioral Health Integration:

ABHW is committed to improving access to whole-person care and helping address physical and behavioral health in an integrated system so that providers can collaborate to deliver and coordinate care. Since medical and behavioral healthcare coordination improves outcomes and is cost-effective, ABHW strives to work with relevant stakeholders to facilitate evidence-based, bi-directional care integration.

ABHW supports efforts to explore proposals to help augment the use and adoption of the Collaborative Care Model (CoCM) and other evidence-based integrated care models. The CoCM

is an evidence-based approach where a primary care physician, a psychiatric consultant, and a care manager work as a team to identify and provide evidence-based treatment for mental health conditions, measure patients' progress, and adjust care when appropriate. The coordination of medical and behavioral healthcare improves outcomes and is cost-effective. By increasing the utilization of the CoCM, more individuals will have access to appropriate mental health services. The CAA23 authorized grants requiring 10 percent of appropriated funds to be allocated to implementing the CoCM by primary care practices. **While we appreciate the funding in the CAA23, ABHW encourages even more financial incentives for implementing the CoCM.**

Additionally, ABHW recommends that the Centers for Medicare and Medicaid Innovation (CMMI) develop a pilot that focuses on integration between primary and behavioral health care, including providing incentives for psychiatrists to participate in the model and report quality metrics focused on care integration and common behavioral health needs, such as measures focused on depression, medication adherence, severe mental illness, substance use, and follow-up measures after hospitalization. CMMI's pilot should focus on reducing the administration burden on the providers participating in the integrated model.

Lastly, we encourage the publication of guidance on best practices for integrating behavioral health care within primary care settings and directing the development of quality measures to report the degree of integration occurring within a practice.

2. Intensive Outpatient Services:

ABHW supports expanding Intensive Outpatient Programs (IOP) furnished in settings other than those proposed in the Calendar Year 2024 Hospital Outpatient Prospective Payment Systems (OPPS) proposed rule. CMS is currently proposing establishing IOPS in hospital outpatient departments, Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs). Our members support broadening the list of eligible provider types permitted to furnish IOP services under Medicare in all community-based settings, including Outpatient Treatment Programs (OTPs). This is critical given the well-known demand for behavioral health services of all types and access challenges patients face in obtaining care. There are existing IOPs licensed and operating under state law that provide these programs and services that are not hospitals, CMHCs, FQHCs, or RHCs. We urge CMS not to preclude the access of Medicare beneficiaries to these other types of providers and IOP programs.

Please see additional details on the importance of expanding IOPs in other settings beyond what is included in the NPRM in our response to the OPPS, also submitted on September 11.

3. Increase Psychiatrist Participation in Medicare:

ABHW encourages CMS to provide more incentives for students to enter the field of psychiatry and opt into the Medicare program through increased funding to Graduate

Medical Education (GME) programs targeted at psychiatry, as well as loan forgiveness and tuition reimbursement for graduates of a psychiatry program and or those that serve in rural communities. New and increased federal assistance should also come with reforms that expand the diversity of the physician workforce.

Congress invested substantially in shoring up the psychiatric workforce by providing 200 federally supported GME positions, emphasizing residencies in psychiatry and psychiatry subspecialties. **We are grateful for this expansion and recommend CMS work with Congress to add an additional 200 slots for new Medicare-supported GME positions specifically for psychiatrists**. As these residency slots are distributed, policies should encourage establishing unique residency programs and adding slots to existing training sites with addiction medicine and psychiatrist programs focusing on community-based programs meeting the patients where they are rather than focusing these programs at large academic medical centers. Additionally, ABHW encourages establishing some of these new residency positions in community care settings, which more accurately reflect the setting care is given than in a hospital-based environment.

Physicians who opt out of Medicare do so for two years. That opt-out status automatically renews every two years unless the physician actively contacts their Medicare Administrative Contractor to change their status.[3] **ABHW encourages CMS to revisit this opt-out process and evaluate whether psychiatrists should be required to actively opt out of Medicare annually or remove the automatic renewal mechanism.**

4. Separate Coding and Payment Interventions in the Emergency Room:

ABHW supports an evidence-based continuum of crisis care and stabilization services for individuals experiencing a behavioral health crisis. Ensuring crisis response and sustaining effective crisis care is essential nationwide and critical to advancing equity. **Before creating a separate coding and payment for interventions initiated or furnished in the emergency department or other crisis setting for patients with suicidality or at risk of suicide, ABHW recommends that CMS work with SAMHSA and other stakeholders first to develop a national set of standards and definitions outlining the continuum of behavioral health crisis services. Establishing and consistently applying standards for these services will ensure that patients who need these services receive the same evidence-based care regardless of the entity that provides the service.**

5. Digital Therapies:

ABHW believes digital therapeutics can be beneficial and positively impact treating MH and SUDs. Additionally, we think it is important for digital solutions to have evidence to support their effectiveness and medical necessity. There also needs to be a solid research methodology

[3] American Psychiatric Association: *Opting Out of Medicare* (2023): https://www.psychiatry.org/psychiatrists/practice/practice-management/medicare/opting-out-of-medicare

that includes critical components such as control groups, large scale studies, research over the appropriate course of time, and addresses potential selection bias issues.

ABHW appreciates the Food and Drug Administration's development of a rigorous process that helps ensure that digital therapeutics are safe and efficacious for the conditions or symptoms they are proven to address. In addition, ABHW would like to see continued work done to identify medical necessity evidence in order to determine the most appropriate billing codes to pay for these therapies. We urge CMS to continue gathering and analyzing data on digital therapies before including them under existing remote therapeutic monitoring codes and/ or separately reimbursing digital therapies for routine care.

Thank you for the opportunity to comment on the behavioral health provisions in the CY24 PFS. ABHW is committed to working with CMS and other partners to improve access to behavioral health treatment for all Americans. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,

Pamela Greenberg, MPP
President and CEO