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September 6, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1770-P

Submitted via Regulations.gov

RE: Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts (CMS-1770-P)

On behalf of the Community Behavioral Health Association of Maryland, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed calendar year (CY) 2023 Physician Fee Schedule (PFS) rule and other policy changes. The Community Behavioral Health Association of Maryland is an association representing 105 Maryland-based providers of addiction and mental health services. Below, we have associated our comments with the numbered topic section used in the Proposed Physician Fee Schedule for CY2023 (hereinafter "Proposal"), and we have placed our comments in the order in which topics appear in the Proposal.

II.D. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

E. Implementation of Telehealth Provisions of The Consolidation Appropriations Acts, 2021 and 2022

The Community Behavioral Health Association of Maryland applauds the swift and timely actions that CMS has taken throughout the course of the COVID-

19 public health emergency (PHE) to ensure continuity of mental health and substance use care for Medicare beneficiaries, particularly through the provision of medically necessary services via telehealth. At the onset of the PHE, we quickly pivoted toward serving patients via telehealth in an effort to maintain access to critical, lifesaving mental health and substance use services. Even as the COVID-19 pandemic becomes less invasive to public life, services furnished through telecommunication modalities remain in high demand. Telehealth, as a service delivery modality, is essential for Medicare beneficiaries' continued access to mental health and substance use services today and undoubtedly into the future.

However, many of the PHE telehealth flexibilities provided in the Consolidation Appropriations Acts of 2021 and 2022 are only temporary, leaving millions of patients at risk of experiencing gaps in care when the PHE ends.ⁱ Importantly, mental health and substance use disorder services are a substantial portion of the telehealth visits in Medicare.ⁱⁱ In May 2020, National Council for Mental Wellbeing, in partnership with Qualifacts, conducted a survey of behavioral health providers that found prior to the PHE, 93% of survey respondents indicated they provided less than 20% of their care in a virtual setting.ⁱⁱⁱ The same survey demonstrated that in the span of just weeks the figure soared, with 60% of respondents indicating they were offering up to 80% of care virtually.^{iv} Additionally, survey respondents cited the expansion of services that may be delivered via telehealth as one of the most impactful policy changes in facilitating the transition to virtual care.^v Similarly, a Department of Health and Human Services study found that in 2020 alone, behavioral health comprised a third of total Medicare telehealth visits, compared to 8% for primary care services and 3% for other specialists.^{vi}

The use of telehealth as a modality through which to deliver mental health and substance use services has proven successful. Not only has telehealth expanded access to mental health and substance use services, but it maintains (and can improve) quality of care, offers unique benefits to people with certain diagnoses, and creates new pathways to better address health disparities and reduce the impact of stigma.^{vii} Innovators in the health care and technology industries continue to reshape telehealth, helping to reduce barriers and improve access to care across populations.^{viii} Federal programs, such as efforts to increase access to broadband, have been instrumental in helping individuals access telehealth services. Additionally, the ease and privacy of virtual health care—and in particular, of mental health and substance use services furnished via telehealth—have permanently shaped consumers' expectations and preferences for modalities through which they can access quality care. During the initial months of the PHE and amidst stay-at-home orders, telehealth enabled mental health and substance use organizations to provide a critical connection to consumers. The efficiency and clinical effectiveness of telehealth for Medicare mental health and substance use services on a longer-term basis has become increasingly clear during the COVID-19 pandemic.

During the PHE and in response to the COVID-19 pandemic, Congress passed legislation that expanded telehealth capabilities to keep both patients and providers safe. In the Consolidated



Appropriations Act of 2021 (hereinafter “CAA 2021”), Congress authorized CMS to implement telehealth capabilities in Medicare, and in the Consolidated Appropriations Act of 2022 (hereinafter “CAA 2022”) authorized the extension of certain flexibilities for a 151-day period after the PHE ends. In the proposed CY 2023 PFS, CMS proposes advancing provisions that implement the CAA 2021 and CAA 2022. The flexibilities that would extend beyond the PHE for only 151 days include: the lifting of geographic and originating site restrictions on telehealth services, the requirement for an in-person visit within 6 months prior to the initial telehealth visit for mental health services, and the coverage and payment of telehealth services via audio-only telecommunication modality.

In general, the Community Behavioral Health Association of Maryland supports the proposed extension and implementation of the PHE flexibilities for a 151-day period after the PHE is designated to end as well as maintaining the availability of services on the Medicare Telehealth List, Category 3 through the end of CY 2023, as established in the CAA 2022. In particular, the Community Behavioral Health Association of Maryland supports the following provisions to be sustained during the 151-day period: allowing providers to bill to the originating site for a telehealth service as if it were in-person (CAA 2022), delaying the 6-month in-person visit requirement (CAA 2021), and allowing coverage of certain mental health services through audio-only telecommunications (CAA 2022).^{ix} Moreover, the availability for the provision of certain services through telehealth during CY 2023 will help CMS to collect the data and information necessary to evaluate and subsequent advance rulemaking for high-quality, effective telehealth service options.

These proposals will maintain, though temporarily, crucial access expansions for mental health and substance use services. This 151-day period will provide the opportunity for patients to collaborate with their providers to determine proactive steps to be taken at the conclusion of the PHE and the 151-day period to ensure continuity of care. For example, Medicare beneficiaries, when all requirements are met, will have the ability to utilize audio-only telecommunications from their home during the 151-day period after the PHE emergency, delaying potential gaps in care. This extension not only gives patients and their providers more time to adapt to the differences in service modalities that will occur at the end of the PHE, but is vital to help close potential gaps in coverage for patients who may need extra time, help, or support in transitioning between the modalities for care they have been experiencing for two years during the PHE to in-person requirements associated with certain services.

The Community Behavioral Health Association of Maryland urges CMS to expand Medicare beneficiaries’ access to telehealth for mental health and substance use services on a long-term basis. While the temporary extension of the flexibilities described above is critical, permanent expansion of telehealth flexibilities is required to ensure continued access to high-quality mental health and substance use services for Medicare beneficiaries. The Community Behavioral Health

Association of Maryland urges CMS to consider permanently expanding the following flexibilities beyond the 151-day period post-PHE:

- (a) Encompass a patient’s home as well as locations outside of the patient’s home in the definition of “originating site facility”, such as spaces where individuals may go to access computers, the internet, or privacy, including taking into account when individuals are homeless or live in non-traditional housing. Specifically, the Community Behavioral Health Association of Maryland urges CMS to expand the definition of “the patient’s home” to broadly include homeless shelters, group homes, or other settings that the beneficiary identifies as their home or residence, whether permanent or temporary.
- (b) Apply the 6-month in-person visit as narrowly as is statutorily authorized, rather than overly broad, to prevent thousands of patients, without the ability to travel to an office or clinic, from losing access to care immediately upon expiration of the 151-day period post PHE.

The 6-month in-person requirement implemented by the CAA 2021 Section 123 was not designed by Congress as a general condition for coverage of Medicare mental health services furnished via telehealth, but instead, more narrowly, as a condition for the waiver of certain originating site requirements. Notably, if Congress in the future acts to remove the telehealth originating site requirements at Section 1834(m)(4)(C) of the CAA 2021 entirely—a legislative change that the Community Behavioral Health Association of Maryland strongly supports—the waivers and conditions of originating site requirements contained in the CAA 2021 Section 123 and the Support Act Section 2001 (reflected in the law at Section 1834(m)(7)) would be effectively repealed, and there would be no remaining in-person visit prerequisite for furnishing Medicare mental health services via telehealth to consumers located in their homes. Accordingly, we urge CMS to implement CAA 2021 Section 123 in the narrowest manner that both reflects the intent of and fulfills the requirement of Congress.

- (c) Permit audio-only telecommunications for all mental health and substance use services, allowing the flexibility for patients who do not have access to, are not comfortable utilizing, or do not know how to utilize two-way, video-audio services.

CMS proposes to allow audio-only services for “certain behavioral health counseling and educational services” during the 151-day period after the PHE. The Community Behavioral Health Association of Maryland suggests that CMS broaden this scope to include services for the diagnosis, evaluation, and treatment of all mental health and substance use services. Doing so would allow the entire spectrum of mental health and substance use services to be furnished via audio-only technology to patients in their homes. The importance of allowing a patient and their provider to collaboratively determine the best modality for care cannot be understated. Several factors can impact a patient’s ability to meet this requirement.

Therefore, the best way for a patient to access the most effective, high-quality care is to collaborate with their provider to determine the appropriate modality.

We note that in implementing the revision of the regulation to allow for audio-only services, CMS focused on the linkage between this provision and the provisions of Section 1834(m)(7) of the CAA 2021 allowing for in-home telehealth for certain behavioral health services. Expanding the regulation to allow audio-only services for substance use would be consistent with this goal, given that Section 1834(m)(7) allows for both substance use (via SUPPORT Act Section 2001) and mental health (via CAA 2021 Section 123) services to be furnished to patients when the “originating site” is the home.

For these reasons, the continuation of Medicare telehealth flexibilities beyond the PHE are crucial. We urge CMS to expand these provisions further and consider making permanent an expanded definition of “originating site” as well as expanding the authorized utilization of audio-only telehealth. Further, we urge CMS to interpret the 6-month in-person mandate narrowly. CMS should narrow its interpretation of the CAA 2021 in order to implement the 6-month in-person requirement for certain originating site requirements that do not potentially create widespread gaps in care. Finally, we encourage CMS to permit all modalities of telehealth, including audio-only, for the full spectrum of mental health and substance use services, in accordance with the patient-provider’s determination of the most effective form of care.

2. Other Non-Face-To-Face Services Involving Communications Technology Under The PFS:

A. Expiration of PHE Flexibilities for Direct Supervision Requirements

CMS requests comment on whether it should consider making permanent an exception to the “incident to” direct supervision requirement for immediate availability through the use of real time, two-way/audio-video technology. The Community Behavioral Health Association of Maryland supports this effort. If this exception were implemented, it would create more flexibility for providers who bill “incident to” a physician or non-physician practitioners (NPP) but are not always in the same facility as the supervising practitioner. In the behavioral health sector, where workforce shortages are prevalent, permitting this format of supervision under “incident to” care is critical in order to facilitate the provision of medically necessary telemental health services. The Community Behavioral Health Association of Maryland urges CMS to extend this exception permanently to the full spectrum of mental health and substance use services, as it would drastically increase access to desperately needed mental health and substance use services across the country.

We recognize CMS’s concern that permanent virtual supervision may impact patient safety in the case of a crisis during which the supervising clinician cannot be physically available to respond.

However, while we recognize that this may be a legitimate concern in the case of some physical health disciplines, the Community Behavioral Health Association of Maryland notes that behavioral health providers can be successfully supervised remotely without impact to patient safety. CMS notes this very point in section II.E. Valuation of Specific Codes, under its revisions of the "Incident to" regulation (subsection 34), stating "that any risk associated with [the proposed change to require only general supervision for behavioral health services under the "incident to" provision] would be minimal, since the auxiliary personnel providing the services would need to meet all of the applicable requirements to provide incident to services, including any applicable licensure requirements imposed by the State in which the services are being furnished."

Valuation of Specific Codes (section II.E.)

(34) Proposed Revisions to the "Incident to" Physicians' Services Regulation for Behavioral Health Services

CMS is proposing to amend the "incident to" direct supervision requirement (42 CFR § 410.26) to allow behavioral health services to be governed by the general supervision of a physician or NPP, rather than the more restrictive direct supervision. This proposal, CMS reinforces, only applies to behavioral health services, particularly due to the significant workforce shortage of mental health and substance use providers. CMS defines general supervision as "the service delivered under the overall direction and control of the billing practitioner, and that doesn't require their physical presence during provision of services," but "the service must be performed under his or her overall supervision and control."^x Additionally, CMS proposes to allow physicians and NPPs supervise licensed professional counselors and licensed marriage and family therapists under the general supervision requirement of "incident to" billing, two providers which are not currently eligible to receive direct reimbursement under Medicare.

Our country faces a striking and devastating behavioral health workforce shortage. While the country faced the dire realities of COVID-19, a record number of individuals began seeking mental health and substance use care at the same time as the workforce faced unprecedented burnout and continued shortages. The COVID-19 pandemic only exacerbated the national workforce shortage that already existed in the mental health and substance use sector. In 2021, the National Council for Mental Wellbeing surveyed its member organizations, finding that nearly all respondents (97%) were experiencing difficulty with employee recruitment and retention due to occupational burnout from the COVID-19 pandemic, administrative barriers, and historically low compensation rates.^{xi} Moreover, recent data found almost 150 million people live in mental health professional shortage areas.^{xii}

Taking into account these challenges, we must consider the mental health and substance use disorder needs of Medicare beneficiaries. The number of Americans over the age of 65 is projected to nearly double in the next decade and nearly one-in-five older adults experience a mental health

challenge or substance use disorder.^{xiii} In order to meet the growing needs of Medicare beneficiaries and the demand for mental health and substance use services, we urge CMS to adopt policies that will help grow the mental health and substance use workforce in Medicare and expand access to mental health and substance use disorder services in its beneficiaries.

The Community Behavioral Health Association of Maryland applauds CMS for proposing this expansion and supports the proposal to allow behavioral health providers to bill “incident to” a physician or NPP under general, rather than direct supervision. Direct supervision requires the supervising physician or NPP to be physically present at the office or clinic to provide assistance or direction while the non-supervising provider (or auxiliary personnel) is performing the “incident to” services.^{xiv} The physical presence requirement can create restrictive circumstances for supervising providers who travel between clinics and offices or conduct telehealth from a secondary location, further limiting the accessibility of beneficiaries to receive care from providers through the “incident to” billing process.

The Community Behavioral Health Association of Maryland also applauds CMS for expanding the eligible providers who perform the “incident to” service (auxiliary personnel) to include Licensed Professional Counselors (LPCs) Licensed Marriage and Family Therapists (LMFTs). Upon the implementation of this rule, LPCs and LMFTs will be considered auxiliary personnel when they are being supervised by a physician or NPP within their scope of practice, meet the requirements to provide “incident to” services (such as state licensure), and are eligible for indirect reimbursement under Medicare.^{xv} The immediate impact of this rule is to grow the Medicare behavioral health workforce, specifically LPCs and LMFTs under the “incident to” billing provision. Because Medicare does not consider LPCs or LMFTs as eligible providers for direct reimbursement, Medicare beneficiaries have not been able to access services from these providers. The exclusion of these providers in Medicare has created access barriers to behavioral health care – barriers that individuals with Medicaid or private insurance are unlikely to experience. Allowing Medicare beneficiaries to access LPCs and MFTs will expand community-based mental health and substance use treatment services and reduce costly hospitalizations for Medicare beneficiaries. The addition of these providers in Medicare will support beneficiaries experiencing mental health and substance use challenges and help fill the access gap, especially for those who age into the Medicare program and subsequently lose access to a subset of providers who they previously had access to but are unable to seek any kind of reimbursement from Medicare.

We acknowledge that the statutory authority to add LPCs, MFTs, and other subspecialties of clinicians who provide mental health and substance use services as reimbursable providers in the Medicare program lies with Congress. However, we urge CMS to continue to exercise its authority to indirectly expand the behavioral health workforce in Medicare, much like it has proposed to do in this rule by incorporating LPCs and LMFTs into the Medicare behavioral health workforce through

the “incident to” billing provision. Currently, CMS defines auxiliary personnel under Medicare as “any individual who is acting under the supervision of a physician,” regardless of whether they are an employee but “meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished.”^{xvi} CMS should consider expanding the providers eligible to be auxiliary personnel under the “incident to” billing provisions further to include other mental health and substance use subspecialty clinicians that are not eligible for direct reimbursement under Medicare but provide lifesaving medically necessary services (such as Peer Support Specialists, Peer Support Recovery Coaches, or Licensed Master Social Workers) Expanding the behavioral health workforce in Medicare by opening up “incident to” billing to LPCs and LMFTs is an important first step. Allowing for the provision of additional mental health and substance use services through addition of provider types in Medicare, without Congressional action, through “incident to” general supervision, like CMS has proposed to do here with LPCs and LMFTs, will help to reduce barriers to access, grow the workforce, and meet the needs of patients who seek vital, lifesaving care.

While the Community Behavioral Health Association of Maryland fully supports this proposal, the rule CMS proposed for CY 2023 leaves three important questions unanswered. First, for the purposes of this change in regulation, CMS does not define “behavioral health services.” In the proposed rule, CMS makes clear that it is limiting the rule’s scope to “behavioral health services” only. However, CMS fails to specifically specify which services are considered “behavioral health services,” — though it does provide obvious examples like the treatment of anxiety, depression, trauma- and stress-related disorders, sleep-wake disorders, obsessive-compulsive and related disorders, and substance-related and addictive disorders. The Community Behavioral Health Association of Maryland encourages CMS to define “behavioral health services” under the broadest terms possible for the purposes of this provision in the CY 2023 PFS final rule.

Second, it is unclear whether this regulatory change includes behavioral health clinicians in the course of seeking full licensure, following the requirements of their state, (e.g., associate social workers, professional counselors, marriage and family therapists) as auxiliary personnel for the purposes of this provision. Circumstances may arise where clinicians, under the authorities provided by the state, practice under the supervision of a physician or NPP and meet all the requirements under Medicare. However, the proposed rule does not provide guidance on whether these providers are eligible to bill under the “incident to” provision. National Council notes that under Medicare’s partial hospitalization program, CMS defaults to state licensure laws on which providers are eligible to provide care. Therefore, we encourage CMS to adopt, for the purposes of this provision, deference to state licensure laws where the care is taking place. We urge CMS to consider this question and provide guidance on other provider types that can be considered auxiliary personnel for the purposes of this provision.

Finally, CMS has not provided guidance in this proposed rule on the impact to dual eligible beneficiaries. The concerns here are unique to dual eligible beneficiaries, who receive health care

coverage from both Medicare and Medicaid. For dual eligible beneficiaries, Medicare is the primary payor and Medicaid is typically the secondary payor or the payor of last resort.^{xvii} When Medicare does not cover a service, such as direct care from an LPC or LMFT, Medicaid would cover the cost of this service (through a billing mechanism called a crossover payment). However, not all dual eligible beneficiaries received full benefits, where Medicaid covers many of the services that Medicare does not cover.^{xviii} Some Medicare beneficiaries are only entitled to a limited Medicaid benefit through Medicare cost-sharing, in which Medicaid helps cover Medicare co-insurance and premiums.^{xix} In order for Medicaid to cover a service via a crossover payment, Medicare must first deny the claim. This becomes complex, however, because each state has chosen the denial threshold for crossover payments. Moreover, the “rendering provider” standard is different for purposes of the Medicare primary claim than the Medicaid secondary claim. For a Medicare primary claim, the rendering provider would be the supervising clinician, while the Medicaid secondary claim may require the auxiliary personnel providing the services directly to the patient as the rendering provider (or in cases where the Medicaid claim is billed as an institutional claim, the attending provider).^{xx}

Taking this into account, CMS has not provided guidance in this proposed rule on the operational issue of a dual eligible beneficiary billing for services provided by a LPC or LMFT, including the processes for both full-benefit eligible dual beneficiaries and partial-benefit beneficiaries. Medicare covers service furnished by LPC or LMFT “incident to” care of physician or NPP, whereas Medicaid program independently covers for the LPC or LMFT service. For behavioral health providers of dual eligible beneficiaries, this distinction in billing may cause confusion in addition to the complexities that occur when states use an automated crossover claims process for dual eligible claims. We urge CMS to provide clarity and guidance on how behavioral health providers and states address the complexity of billing for dual eligibles in this context.

(41) Comment Solicitation on Payment for Behavioral Health Services Under the PFS

CMS requests comment on how to best ensure Medicare beneficiary access to behavioral health services, acknowledging that the Biden-Harris Administration and CMS has made access to lifesaving mental health and substance use services a priority. We applaud CMS and the Biden-Harris Administration’s commitment to expanding access and removing barriers to evidence-based, person-centered behavioral health care. In this request, CMS recognizes that rate-setting methodologies and budget neutrality impact behavioral health services, particularly CMS highlights primary therapy and counseling services for mental health and substance use disorders.

As CMS notes, the PFS must be budget neutral from 2020 to 2025, required by the Medicare Access and CHIP Reauthorization Act (MACRA) and triggered by the American Rescue Plan Act of 2021.^{xxi} The temporary increase of PFS payment rates during the PHE (3.75% in 2021 and 3% in 2022), required by the CAA 2021, was and remains greatly appreciate but was a small, temporary reprieve

for a historically under-reimbursed sector of behavioral health professionals. For CY 2023, CMS proposes to decrease the overall conversion factor, which will result in a rate reduction of 4.4% in order to meet the neutrality mandate of MACRA, consisting of a 1.55% reduction in proposed changes to relative value units (RVUs). Further, additional decreases to Medicare rates must take place due to sequestration requirements on federal spending (mandating cuts when federal spending reaches a certain threshold under the Statutory Pay As You Go (PAYGO) Act of 2010 and the Budget Control Act (BCA) of 2011), directly impacting the rates providers and clinicians are reimbursed by Medicare.^{xxii} Between April and July 2022, Medicare reimbursement to clinicians and providers decreased by 1% and since July 1, by 2%.^{xxiii} An additional 4% reduction will take place beginning in January 2023, the result of a PAYGO sequestration mandated in the Protecting Medicare and American Farmers from Sequester Cuts Act of 2021.^{xxiv}

These decreases to the Medicare reimbursement rate for 2023 will have debilitating consequences to already historically under-reimbursed mental health and substance use practitioners and the patients they serve. Behavioral health organizations increasingly struggle to hire and retain qualified clinicians. As CMS notes, the Health Resources and Services Administration expects widespread shortages across behavioral health clinician types by 2025, including psychiatrists; clinical, counseling, and school psychologists; mental health and substance use social workers; school counselors; and marriage and family therapists.^{xxv}

Further, not only will these reimbursement decreases exacerbate the mental health and substance use workforce crisis, but the timing of these decreases occurs almost simultaneously as critical telehealth flexibilities are expected to lift and commercial insurance reimbursement rates demonstrate the ability for providers to receive higher pay in the private sector, creating disincentives for providers struggling under thin margins to accept Medicare. The combination of these circumstances will continue to compromise the ability for individuals who need mental health and substance use services to receive behavioral health care. While the Community Behavioral Health Association of Maryland appreciates that this is largely a legislative issue, it is nonetheless a topic of grave concern, and we urge CMS to take any feasible action to support adequate Medicare payment under the PFS for mental health and substance use disorder providers.

The Community Behavioral Health Association of Maryland is deeply concerned that proposed changes to Relative Value Units (RVUs), resulting in negative adjustments for clinic psychologists (-2%) and clinical social workers (-2%) has the distinct potential to exacerbate an already existing workforce shortage in the behavioral health sector where demand for services has and is predicted to rise at unprecedented rates.^{xxvi} Particularly given escalating rates of mental health and substance use challenges among the Medicare beneficiary population, the inadequacy of individual provider payment rates is of utmost concern to the Community Behavioral Health Association of Maryland who strive to continue to provide high quality behavioral health services to Medicare beneficiaries as quickly as possible and without the disruption of the excessive wait times being experienced across the country.^{xxvii} Medicare beneficiaries require unfettered access to mental health and

substance use services, as nearly one-in-five older adults experience a mental illness or substance use disorder.^{xxviii} The demand for these services is likely to grow as the number of Americans over the age of 65 is projected to nearly double in the next decade and the national experiences a significant behavioral health workforce crisis.^{xxix} The need for mental health and substance use disorder services in Medicare is urgent, but in order to meet the demand CMS must increase the Medicare reimbursement rate to be competitive with commercial insurers and expand its workforce to include additional providers, such as Licensed Professional Counselors (LPCs), Marriage and Family Therapists (MFTs), Peer Support Specialists, and Peer Support Recovery Coaches.

Community behavioral health providers, as the nation's behavioral health outpatient safety net, serve large numbers of Medicaid and dual eligible beneficiaries. Moreover, the cost to clinicians to provide care increases annually, in a time of mental health and substance use disorder workforce shortages, will only impair the mental health and substance use crises our country is facing. To incentivize current and new providers to serve Medicare beneficiaries, the rate of reimbursement must fully reflect the costs to providers of providing those invaluable services—services that have historically and are currently reimbursed at insufficient rates.

CMS must make meaningful and substantive changes to the PFS rate-setting methodology to ensure the range of behavioral health providers are reimbursed proportionately to the market and other insurance providers and that their reimbursement levels adequately reflect standard changes to the cost of providing services. Adequate Medicare payment is critical to ensuring that invaluable behavioral health providers are able to continue providing access to lifesaving mental health and substance use services. We urge CMS exercise its existing statutory authority to adjust its PFS rate-setting methodology to cover the full costs of behavioral health services and to expand the Medicare's behavioral health workforce.

Coverage for OUD Treatment Services Furnished by OTPs (section III.F.)

Mobile Components Operated by OTPs

CMS proposes to allow opioid treatment programs (OTPs) to seek reimbursement from Medicare for services furnished by mobile units to beneficiaries, in accordance with Drug Enforcement Agency (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) guidance. Services provided by OTP mobile units will be included in the OTP bundled payment codes and add-on codes so long as the services are medically reasonable and necessary. Mobile unit payments will be determined by the locality adjustments as if the services were provided at the OTP location.

The Community Behavioral Health Association of Maryland supports this rule. Allowing Medicare reimbursement for services furnished by OTP mobile units is essential to expanding lifesaving access and filling detrimental treatment gaps. Further, mobile units will increase access to care

exponentially for individuals who lack timely access to treatment, as well as localities experiencing high overdose rates or experiencing OTP workforce shortages. Providing for coverage of OTP mobile units under Medicare will allow individuals receiving medication assisted treatment for opioid use disorder (OUD) substantially easier access to needed treatments on a daily basis. For example, mobile units may begin to help close treatment gaps for individuals living in residential treatment programs, those experiencing homelessness, or people living in rural areas that lack convenient and/or realistic access to an OTP. Individuals whose location is prohibitive to accessing an OTP, as well as those who do not have access to transportation or are experiencing mobility constraints, will be less likely to experience access gaps when Medicare-covered mobile units are dispatched to deliver care to them where they reside. Additionally, mobile units create space for individuals concerned about accessing care due to perceived stigma. Going to a clinic for treatment may dissuade someone from seeking the treatment services they need. However, mobile units provide an opportunity to reach hesitant individuals and increase access to substance use disorder (SUD) and recovery services.

Further, we support the proposal to include payment for mobile services under the OTP bundled rate *so long as* the bundled rate is sufficient. As noted above, the Community Behavioral Health Association of Maryland is concerned that the decreases in reimbursement under Medicare due to sequestration requirements will be detrimental to the access and availability of behavioral health care. In particular, we are concerned these decreases will impact elevated costs associated with operating mobile units. For example, mobile units will have costs related to obtaining transportable supplies, fuel, and maintenance of mobile equipment. Therefore, we urge CMS to ensure that the OTP bundled rate includes prospective costs for OTPs to establish mobile units as well as the continued maintenance of existing and newly established mobile units.

Flexibilities for OTPs to Use Telecommunications for Initiation of Treatment with Buprenorphine

CMS is proposing to allow the initiation of treatment with buprenorphine via two-way/audio-video modality, as well as audio-only modality when two-way/audio-video is not available to the patient (such as in circumstances where the patient does not have the capability or has not consented to two-way/audio-video technology). CMS also requests comment on whether it should allow periodic treatment via audio-only technology after the PHE ends for treatment services with buprenorphine as well as for methadone and naltrexone.

As noted above, the demand for telehealth services is unlikely to decline for behavioral health services. The availability and accessibility of telehealth for substance use disorder services has grown particularly significant to the behavioral health sector as the country faces a devastating

overdose crisis, with overdose deaths tragically rising at alarming rates over the past several years.^{xxx} From 2019 to 2020, overdose deaths rose 30% (from 71,130 to 92,478), and in 2021 there were over 107,000 deaths, up 15% percent from 2020 and the highest ever recorded.^{xxxi} Experts estimate less than 40% of individuals with OUD receive treatment.^{xxxii} The need for easier access to and initiation of medication assisted treatments is a key component to expanding access to treatment services to individuals who need them the most. While this is only one avenue to help curb the overdose crisis, it is a critical one.

The Community Behavioral Health Association of Maryland supports and applauds the proposal to permanently allow treatment with buprenorphine, in accordance with DEA and SAMHSA guidance, to be initiated utilizing two-way interactive audio-video communication and audio-only telecommunications, when all other requirements are met. We support the use of audio-only services in this context when two-way/audio-video modality is not an option and the provider and patient collaboratively determine it is an appropriate modality that maintains access to high-quality care. The ability to initiate opioid use disorder treatment via telehealth modalities is of critical importance to individuals who have limited access to attend in-person appointments or who are disincentivized to do so due to perceived stigma. To further treatment flexibilities, we urge CMS to expand this rule beyond the initiation of treatment to include both periodic, ongoing treatment services with buprenorphine, including audio-only when video is not available, and the provider and patient have engaged in the aforementioned collaborative decision-making process.

Further, CMS requests comment on whether it should allow periodic ongoing treatment via audio-only technology for treatment services with methadone and naltrexone after the PHE ends. The Community Behavioral Health Association of Maryland urges CMS to include periodic ongoing treatment services with methadone and other clinically effective medication assisted treatments through two-way/audio-video telehealth. The Community Behavioral Health Association of Maryland also supports the use of telehealth in circumstances when the provider and patient have together determined that the patient would individually benefit from telehealth services and a high-quality of care is maintained. The success of flexibilities extended during the PHE, such as take-home methadone, have illustrated that the ability to apply substance use disorder services via telehealth modalities, along with the demand for these services, is within reach.^{xxxiii} Therefore, we encourage CMS to expand flexibilities for substance use services via telehealth to allow providers and patients to decide collaboratively the best modality for individualized care.

The Community Behavioral Health Association of Maryland appreciates the opportunity to provide these comments. We welcome any questions or further discussion about the recommendations

described here. Please contact Shannon Hall at Shannon@mdcbh.org. Thank you for your time and consideration.

Sincerely,



Shannon Hall, J.D.
Executive Director

ⁱ <https://www.hhs.gov/about/news/2021/12/03/new-hhs-study-shows-63-fold-increase-in-medicare-telehealth-utilization-during-pandemic.html#:~:text=Taken%20as%20a%20whole%2C%20the,Island%2C%20New%20Hampshire%20and%20Connecticut.>

ⁱⁱ <https://www.hhs.gov/about/news/2021/12/03/new-hhs-study-shows-63-fold-increase-in-medicare-telehealth-utilization-during-pandemic.html#:~:text=Taken%20as%20a%20whole%2C%20the,Island%2C%20New%20Hampshire%20and%20Connecticut.>

ⁱⁱⁱ <https://www.thenationalcouncil.org/news/statement-from-national-council-for-mental-wellbeing-president-and-ceo-chuck-ingoglia-on-the-new-role-of-virtual-care-in-behavioral-health-report-in-conjunction-with-qualifacts-systems-inc/>

^{iv} <https://www.thenationalcouncil.org/news/statement-from-national-council-for-mental-wellbeing-president-and-ceo-chuck-ingoglia-on-the-new-role-of-virtual-care-in-behavioral-health-report-in-conjunction-with-qualifacts-systems-inc/>

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^{ix} 2023 PFS Proposed Rule.

^x <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

^{xi} <https://www.thenationalcouncil.org/wp-content/uploads/2022/02/Immediate-Policy-Actions-to-Address-the-National-Workforce-Shortage-and-Improve-Care-.pdf>, https://www.thenationalcouncil.org/wp-content/uploads/2022/04/NCMW-Member-Survey-Analysis-September-2021_update.pdf

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- xv 42 CFR 410.26(a)(1); CMS, Local Coverage Article, [Psychological Services Coverage under the Incident to Provisions for Physicians and Non-Physicians](#) (A52825) (rev. 1/1/17)
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