National Association for Behavioral Healthcare

Access. Care. Recovery.

13 September 2021

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; CY 2022 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies [CMS-1751-P]

Dear Administrator Brooks-LaSure:

The National Association for Behavioral Healthcare (NABH) respectfully submits the following comments on the Proposed Rule for the CY2022 Medicare Physician Payment Schedule and Other Part Be Payment Policies issued by the Centers for Medicare & Medicaid Services (CMS) on July 23, 2021.

NABH represents behavioral healthcare systems that provide mental health and addiction treatment across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility-based outpatient programs including medication assisted treatment centers. Our membership includes behavioral healthcare providers in 49 states and Washington, D.C.

Improved access to mental health and addiction treatment services remains critical as the Covid-19 pandemic continues. Recently released data reveal an astounding increase in drug overdose deaths—more than 90,000 deaths in 2020 —an increase of almost 30% higher than the previous year.[i] Alcohol consumption during Covid increased 14% over 2019 levels with a 19% increase among adults between the ages of 30-59 and a 41% increase in heavy drinking among women.[ii] Moreover, studies have shown significantly elevated levels of anxiety and depression and suicidal ideation, especially among children and adolescents, during the pandemic.[iii, iv, v]

The Covid-19 pandemic has magnified the need for improved access to behavioral healthcare; however, we know there are severe shortages of behavioral healthcare providers in many parts of the United States. According to the Health Resources and Services Administration, as of September 2, 2021, more than one-third of Americans (125 million people) lived in 5,788 mental health professional shortage areas.[vi] In these areas, the number of mental health providers available were adequate to meet about 27% of the estimated need.[vii] About half of U.S. counties and 80% of rural counties have no practicing psychiatrists, and more than 60% of psychiatrists are nearing retirement.[viii] By 2030, the number of psychiatrists is expected to decrease by 20%, and addiction counselors will also be in short supply.[ix] Reimbursement for psychiatric inpatient services is often inadequate to cover costs. Consequently, the number of beds has decreased by at least 64% since 1970.[x]

Recently, behavioral healthcare settings have also been struggling with workforce shortages at unprecedented levels. These shortages are so severe that states are resorting to extreme measures; for instance, Oregon had to request that the National Guard assist with staffing mental health facilities, and Virginia stopped admitting new patients in its five state mental hospitals due to its staffing crisis.[xi]

One positive outcome of the pandemic has been broadened awareness of how helpful telehealth can be for increasing access to mental health and addiction treatment in communities without local providers and for individuals who have difficulty attending in-person appointments. We applaud CMS for using emergency authorities during the pandemic to expand Medicare coverage of telehealth and waive administrative regulations to help providers adjust to social distancing and other infection control policies. On-going flexibility and expanded coverage

of telehealth will be critical as previous epidemics have shown that the impact on mental health and substance use will continue for years to come.[xii]

While we strongly support the provisions in these proposed rules to continue expanded coverage of telehealth services, we recommend below some ways to improve that coverage. Moreover, we have strong concerns about proposed decreases in Medicare reimbursement for certain behavioral healthcare practitioners at a time when the need for care is so great and capacity to address those needs is stretched so thin.

NABH strongly supports Medicare coverage of audio-only telehealth mental health services and opioid treatment program services. We urge CMS to clarify that this continued coverage includes other addiction treatment via audio-only telehealth as well.

Coverage of services provided via audio-only technology is particularly important for certain vulnerable populations, including Medicare beneficiaries who are older and/or challenged with disabilities. These individuals often face additional barriers to accessing care through the newer video-based technologies and platforms. Among Medicare beneficiaries who had a telehealth visit last summer and fall, more than half of them accessed care using a telephone only.[xiii] Our members are also concerned that many of their more vulnerable patients are unemployed or under-employed and sometimes homeless and simply do not have access to internet service to support video technology.

Moreover, access to broadband service to support video and audio technology is often very limited in rural areas, which also face the most severe shortages of behavioral healthcare providers. Coverage of telehealth services for mental health and addiction treatment can help fill those gaps by enabling people who live in those underserved areas to access specialists including behavioral healthcare providers residing in other areas. Limiting coverage to services provided via video and audio-enabled technology will limit the utility of telehealth for reaching individuals in those areas that often have very limited access to behavioral healthcare.

We support the proposal to allow opioid treatment programs (OTPs) to provide services via audio-only technology. It is not clear why this authority should be limited to OTPs. We encourage this service to be permitted for office-based buprenorphine treatment programs that are also critically important for improving access to opioid use disorder treatment, as well as other medication and behavioral treatment for addiction to other substances, such as for alcohol, which is far more prevalent, and methamphetamines, which are also growing at an alarming rate. Individuals struggling with any form of addiction face similar barriers to care as those who need mental health treatment, and often these conditions are co-occurring. We urge you to continue covering audio-only services for addiction treatment in additional settings as well as OTPs.

NABH opposes the in-person visit requirement for coverage of telehealth for mental health services

Telehealth is particularly effective in behavioral healthcare delivery, especially psychiatric and psychological services.[xiv] Examples of behavioral health services that can be delivered effectively via telehealth include depression screening, follow-up care after hospitalization, behavioral counseling for substance use disorders, medication management, and psychotherapy for mood disorders.[xv] Telehealth can also facilitate collaboration and consultation between behavioral healthcare specialists and primary care and emergency department clinicians to expand capacity to provide care for mental health and substance use disorders.[xvi] Telehealth has been found to increase retention for substance use disorder (SUD) treatment, including medication treatment, especially when treatment is not otherwise available or require lengthy travel to treatment.[xvii] In addition, there is evidence of reduced utilization of higher-cost services associated with providing access to behavioral healthcare services via telehealth technologies.[xviii] The experience of our members in delivering behavioral healthcare during this pandemic is consistent with these research findings.

Based on this evidence and experience, it is not clear why an in-person visit within the six months prior to a telehealth visit and every six months after that is necessary. It will significantly reduce the degree to which telehealth can improve access to these critically needed services, particularly for individuals facing the most challenges to accessing care, including those with severely disabling behavioral health conditions and those who are homeless or have very low incomes. Moreover, the time frame of six months seems arbitrary; it is difficult to suggest another interval for audio-only services as requested by CMS since there is no evidence to support it.

We appreciate CMS' clarification that the Medicare statute does not include an in-person visit requirement for treatment for SUDs or co-occurring mental health conditions. This requirement only applies to mental health services provided via telehealth. We also recognize that the *Consolidated Appropriations Act* (Pub. L.116-260)[xix] added the in-person visit provisions to the statute. In light of the concerns expressed above about the impact of an in-person visit requirement, we recommend that CMS implement Medicare coverage of telehealth for mental health services as consistently as possible with the coverage policy for SUD and co-occurring mental health services provided via telehealth. One alternative to requiring strictly in-person visits would be to allow visits to an originating site facility for those beneficiaries who do not live in the same geographic area as the provider. Another alternative to in-person visits could be requiring use of audio and visual technology occasionally for those accessing mental health treatment via audio-only telehealth. In addition, we urge CMS to establish exceptions to the in-person visit requirement for telehealth including audio-only telehealth, particularly for individuals experiencing a mental health or substance use crisis as discussed below.

NABH supports coverage of telehealth including audio-only telehealth for behavioral health crisis services and other high-level services without in-person visits

Telehealth can be a critical component of behavioral health crisis stabilization services and systems that the states and communities are developing across the United States to prevent individuals experiencing mental health or addiction crises from waiting days and even weeks in emergency rooms for treatment or being incarcerated for relatively minor charges simply because there is nowhere else for them to go. These developments have been energized recently by designation of 988 as a new nationwide toll-free three-digit hotline to help individuals experiencing behavioral health crises. The in-person visit requirement is particularly problematic for crisis stabilization providers including mobile crisis units. Accordingly, we also oppose CMS' suggestion to preclude coverage of audio-only telehealth for crisis psychotherapy as well as other high-level evaluation and management codes. In general, we urge CMS to allow mental health and addiction treatment providers to determine how best to employ telehealth technologies to provide care for their patients. In addition, we urge CMS to clarify that crisis psychotherapy services may be supervised or provided directly via telehealth by providers eligible to bill Medicare for these services in coordination with mobile crisis team practitioners who may not be directly eligible to bill Medicare for those services.

NABH urges CMS to clarify the statutory changes to Medicare coverage of telehealth that require reimbursement be equal to the amount paid for such services when provided in person.

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT Act) (Pub. L. 115-271)[xx] and the *Consolidated Appropriations Act* (Pub. L.116-260)[xxi] amended Title XVIII of the *Social Security Act* to extend Medicare coverage of mental health and SUD treatment services via telehealth in a beneficiary's home or community and regardless of the geographic area where the beneficiary is located. These changes also require that reimbursement for providers providing these services via telehealth be at the same rate as if these services were provided in person, although facility fees would not be provided.[xxii] It would be helpful for CMS to clarify this additional important change in order to raise awareness and encourage additional providers to participate. Behavioral healthcare providers operate generally with very low margins, and reimbursement rates for services are often much lower for behavioral healthcare than other specialty care. Reimbursement for telehealth services should consider the overhead and administrative costs of providing these services in office settings as well as the cost of

purchasing technology and training for staff. We urge CMS to maintain full reimbursement for services provided via telehealth comparable with in-person rates in order to take this unusual opportunity to improve access to behavioral healthcare that the tremendous growth in telehealth has made a reality.

NABH supports the proposal to allow services added to the Medicare telehealth list temporarily during the pandemic to remain on the list until Dec. 31, 2023.

This extension would allow more time for evaluation of whether services temporarily on the list should be added permanently after the Covid-19 public health emergency (PHE) ends. This extension will also help protect beneficiaries from suddenly losing access to critical services with uncertainty regarding when that coverage will end. The extension combined with a certain deadline allows providers and beneficiaries to plan for a potential reduction in coverage.

NABH opposes reducing reimbursement for behavioral healthcare providers to implement budget neutrality requirements.

The 3.75% reduction in the Medicare conversion factor will significantly reduce reimbursement for psychiatrists, psychologists, and licensed clinical social workers. These reductions in reimbursement will undoubtedly further strain behavioral healthcare providers at a time when reduced capacity and increased costs are already reducing access to treatment. We urge CMS to determine a method for implementing budget neutrality requirements that avoids reducing payment for and access to critical mental health and addiction treatment services while also working with Congress to address this budget neutrality issue in legislation.

NABH does not support recoupment of duplicative payments from OTPs.
CMS proposes to collect duplicative payments for naloxone, other medications, and take-home supplies for those medications. OTPs do not have the capacity to know or prevent the actions of other providers and should not be accountable for such.

NABH does not support requiring an additional modifier to certify that audio-only telehealth was delivered when audio-visual technology is not available to the patient, as this is duplicative of documentation in the patient record.

NABH encourages CMS to request comments on reimbursing for contingency management services.

From 2012 through 2018, drug overdose deaths involving cocaine more than tripled, and overdose deaths involving psychostimulants such as methamphetamine increased by a factor of 4.9.[xxiii] Contingency management (CM) is a therapeutic intervention that effectively engages stimulant-addicted individuals into care to reduce their stimulant use and initiate recovery. Importantly, it is the most effective treatment of stimulant use disorder. However, it is underused. We recommend that CMS reimburse CM and engage the public in developing appropriate financing methodologies through a request for comment.

Thank you for considering our concerns and recommendations. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs, Kirsten Beronio at kirsten@nabh.org or 202-393-6700, ext. 115.

Sincerely,

National Association for Behavioral Healthcare

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Shawn Coughlin
President and CEO

About NABH

The National Association for Behavioral Healthcare (NABH) represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C. The association was founded in 1933.

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