National Association for Behavioral Healthcare

Access. Care. Recovery.

**SUBMITTED VIA: www.regulations.gov**

Ms. Seema Verma, M.P.H.
Administrator, Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

27 September 2019

Dear Administrator Verma:

The National Association for Behavioral Healthcare (NABH) is pleased to submit comments on the Medicare Physician Fee Schedule (PFS) proposed rule (CY 2020) that implements the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act.

Founded in 1933, the National Association for Behavioral Healthcare (NABH) advocates for behavioral healthcare and represents provider systems that are committed to delivering responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Nationwide, our member organizations own or manage more than 1,000 facilities and programs in almost every state, and at all care levels, serving individuals with mental health and substance use conditions. Our membership represents approximately one-quarter of the OTP providers in the country.

NABH fully supports Medicare's stated goals of improving payment for services, accountability, and efficiency under the Physician Fee Schedule (PFS), as well as alignment with broader Trump Administration goals of improving access, quality, affordability, empowerment, and innovation.[1] Our comments will focus on assisting CMS with meeting each of these goals.

**Bundled Rate Approach**

Broadly, the value of a payment bundle is to simplify payment mechanisms such that treatment providers receive adequate compensation for treatment services and each individual patient receives the care he or she needs in the right setting, at the right time, and with appropriate treatment intensity. That is, bundles are ideally constructed to account for a range of services of variable intensity over time and across patient populations without being overly prescriptive about the provision of clinical services to any one individual patient. The expectation of a bundle is that some individuals will receive a higher level of service and some will receive a lower level of service, and that a consistent payment methodology will account for both situations.

Bundles that are highly prescriptive tend to disempower providers by directing medical decision-making. At the same time, highly prescriptive bundles disempower patients by forcing them to engage in unnecessary and potentially burdensome care. From an organizational perspective, overly specific

[1] *Proposed Policy, Payment, and Quality Provisions Changes to Medicare Physician Schedule for Calendar Year 2020,* July 29, 2019. CMS.gov.

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

**Phone:** 202.393.6700
**Email:** nabh@nabh.org
**Web:** www.nabh.org

service requirements can impose a rigidity that interferes with evolving innovations to the service model over time. High specificity undermines the administrative efficiency of payment bundles and essentially becomes a fee-for-service model that is formalized into bundle *requirements*; in the end, the bundle methodology becomes a more restrictive, not a less restrictive, payment model.

While we recognize and appreciate the *intent* to provide more flexibility rather than less, we believe the existing CMS approach of bifurcating the bundle into a partial and full bundle approach is overly complex, administratively and clinically difficult to manage, and focused on service-counting, rather than on individually driven treatment plans focused on quality of care. This can lead to inordinate clinical and administrative burdens and inefficiencies, and also potentially stimulate fraud by incentivizing upcoding. This defies the intent of bundled payments generally, and specifically the Trump administration's overall stated goals.

**Bundled Rate Calculations**

NABH engaged Remedy Partners, a consulting firm with expertise in bundled payments for healthcare and addiction services, to model CMS' proposed services for OTP *non-drug* services. The table below shows the application of the 2019 CMS PFS (unless otherwise indicated) to the CMS proposed professional services.

- An adjustment was included for the psychotherapy time intervals. The CMS assumption of 15 minutes for individual therapy (G96152) and 15 minutes for group therapy (G6153) significantly underestimates the time for these services. Typically, these services are provided for 45 minutes (individual therapy) and 75 minutes (group therapy). The time intervals are empirically demonstrated within CMS' own limited data set.
- An .85 multiplier was applied for non-physician providers, providing a range of the total costs for these required services, depending on the professional who provides them.

| | **CMS Proposed** | | **NABH Modeled** | | | | |
|---|---|---|---|---|---|---|---|
| ***Non-drug component*** | CMS (Tricare) Proposed | Frequency | Proxy CPT | 2019 FS (Physician) | 2019 FS (NPP) | Time Mins | Proxy CPT Descriptions |
| Dispensing | 10.50 | Weekly | NA | 10.50 | 10.50 | | |
| SUD Counseling | | | G0396 | 36.40 | 30.94 | 30 | Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes |
| Individual Therapy | | | 96152 | 63.78 | 54.21 | 45 | Health and behavior intervention, each 15 minutes, face-to-face; individual |
| Group therapy | | | 96153 | 25.25 | 21.45 | 75 | Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients) |
| Toxicology | | | G0480 | 28.61 | 28.61 | | Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC |
| **Total** | **110.96** | **Weekly** | | **164.54** | **145.71** | **150** | **Weekly** |
| | | | | **48%** | **31%** | | **Difference** |

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

**Phone:** 202.393.6700
**Email:** nabh@nabh.org
**Web:** www.nabh.org

As you can see, the CMS proposed bundled rate of $110.96 is far below what the *existing* Medicare fee schedule would pay to cover the proposed professional services, by 31 percent to 48 percent (depending on the level of the professional staff). In other words, the CMS proposed bundled rate does not cover the service (valuation) model CMS is proposing. Consequently, this is a financially unsustainable proposal.

The proposed valuation is service-intensive and disproportionately reliant on psychotherapy services. We don't believe it will meet the changing needs of individual patients. In fact, such frequency of care could very well deter many patients from obtaining services at all. Patients need a range of services and intensity of those services, based on their unique clinical situations. This warrants a more flexible approach for clinical decision-making.

**Bundled Rate Staffing Model**

The *SUPPORT Act* provided statutory requirements to include psychotherapy into the OTP bundle. CMS operationalized these requirements into a more service-intensive model than OTPs currently provide. Our familiarity with on-the-ground operations indicates, clearly and consistently, that the proposed service model outstrips the capacity of the existing behavioral health workforce; this is also borne out by federal agency data. *We request the CMS more broadly construe 'psychotherapy' such that counseling may be provided. This is critical.*

Our data modeling indicates that for 100 Medicare beneficiaries, the total number of hours for substance use counseling and therapy alone (not including group, dispensing, or toxicology), would require an additional four full-time employees (FTEs). Given CMS estimates of two million beneficiaries with OUD, the demand for qualified counselors and therapists would be close to 80,000 FTEs. According to the Bureau of Labor Statistics,[2] there were slightly more than 300,000 substance abuse, behavioral disorder, and mental health counselors in the United States in 2018. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA) projected a deficit of more than 250,000 behavioral health workers by the year 2025.[3]

As such, to implement the CMS proposal, one quarter of the nation's counselors and therapists would have to be usurped just to manage Medicare beneficiaries. This would create shortages for other patient populations and further destabilize the behavioral health workforce at a time when states and local governments are also attempting to increase access to OUD treatment. The federal government is attempting to address the shortages within the behavioral health workforce through grants, training programs, and other measures. However, these and other measures will not expand the workforce in time for the implementation of the OTP bundle. The CMS proposed service elements would, in effect, disrupt overall access to care for patients across the country, undermining the Trump administration's goal of improving and expanding access to OUD treatment services.

---

[2] https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm

[3] Health Resources and Services Administration/National Center for Health Workforce Analysis; Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation. 2015. National Projections of Supply and Demand for Behavioral Health Practitioners: 2013-2025. Rockville, Maryland

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

**Phone:** 202.393.6700
**Email:** nabh@nabh.org
**Web:** www.nabh.org

Even greater workforce shortages and higher level of opioid overdose and death rates exist in rural areas. Specifically, there were 20 deaths per 100,000 in rural counties in 2017. Exacerbating the problem, is the inadequate number of OTPs in 88.6 percent of the larger rural counties.[4] There is a dangerous gap between service capacity and treatment need, and it must be bridged if the federal government is to improve access and quality of care and reduce national rates of opioid overdose and death.

Unfortunately, the infrastructure does not exist to provide the CMS proposed service model, even with the proposed telehealth provisions in the PFS rule. Given that the CMS proposed service model exceeds workforce capacity, the CMS proposal *would put all OTPs at risk of not complying with the terms of the bundle and threaten the existing infrastructure and constrict treatment capacity at a time when more treatment is needed.*

**Additional Bundled Rate Considerations**

The proposed cost structure does not address a broad spectrum of additional overhead, indirect, and direct functions and services that OTPs provide routinely.

- Above and beyond the direct treatment services, our members manage monitoring and oversight for regulatory and accreditation requirements; medication inventory, management, and documentation.
- Additional direct services include intake and admission services; re-evaluations; call backs; HIV and Hepatitis C services; community engagement, including in-reach to criminal justice settings; and more.

**NABH Bundled Rate Recommendations**

1. To align the CMS proposed services with the CMS proposed bundled rate of $110.96, and to address workforce shortages related to counselors and therapists, the payment structure valuation should be based on the following and considered the 'basic bundle' of services:
   - One counseling service (not psychotherapy) per week, either individual or group; and
   - One additional counseling (not psychotherapy) per month, either individual or group
   - One toxicology sample (collection/sending) per month.

2. To allow for greater service intensity as indicated by the individual treatment plan, the bundle should allow 'add-ons' for:
   - More than one counseling service a month (individual or group);
   - Individual or group psychotherapy;
   - More than one toxicology (per above) monthly based on doctor's order—this can be costly but is not atypical with chronic conditions where symptoms recur;
   - Case management; and
   - One health physical annually.

[4] https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2019/02/opioid-use-disorder-challenges-and-opportunities-in-rural-communities

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

**Phone:** 202.393.6700
**Email:** nabh@nabh.org
**Web:** www.nabh.org

3. To compensate for overhead, indirect, and additional direct services costs that OTPs incur routinely, the bundle should include an additional weekly fee of 20 percent. This would bring the *total non-drug* bundle to approximately 133/week, with the understanding that Medicare regional adjustment are applied on top of this within the Physician Fee Schedule.

4. Under this proposed valuation model, and in order to increase the efficiency of administering the OTP bundle, allowing for individualized patient care, and avoiding patient drop-out due to rigid service requirements, CMS should remove the 51 percent approach to the bundled rate, and instead offer one bundled rate for the non-drug services performed in OTPs. Under this scenario, some patients will receive more services or less services over time, the justification for which will be documented in their treatment plan. By this we mean that each of the services in the basic bundle should not be *required*, but rather constitute the *model upon which the bundle is valued*, and with the understanding that more and less intensity of services will be provided, as clinically appropriate. Clarity on this issue will be important for auditing purposes.

5. To stimulate additional treatment in high need rural areas, we recommend that in addition to the telehealth enhancements CMS proposed, an additional 17 percent be offered to OTPs who develop new facilities in federally designated rural counties. This is consistent with the rural adjustment in the CMS Inpatient Psychiatric Facility Prospective Payment System.

6. To allow programs to hire additional staff, procure additional space, upgrade payment systems, and implement other modifications, CMS should establish a phased-in approach to the Medicare OTP bundle. Incremental change is necessary to maintain stability in service delivery and treatment capacity through the transition to the new payment structure. *CMS should not underestimate the impact of this shift to the OTP community.*

**Additional Comments**

NABH supports the proposal to implement zero cost-sharing for OTP patients. We encourage CMS to think beyond considering this only for a time-limited basis. Any individual who requires the services of an OTP, regardless of whether there is an opioid epidemic across the nation, will have difficulty making co-payments. While the frequency of services in an OTP may change over time, they are still more frequent than other healthcare services and can be a financial drain. There is ample evidence that even small healthcare co-pays result in service-avoidant behaviors by individuals. This is especially true for individuals with addictions who are often unemployed and, as with all chronic conditions, struggling to sustain their commitment to recovery.

NABH supports the inclusion of telehealth codes for counseling and therapy services, as well as the removal of geographic limitations on originating sites. This will expand access to care that is critically needed.

NABH does not support designating OTP under a ‘high-risk’ category. These are highly regulated programs subject to regulations from SAMHSA and the Drug Enforcement Administration. Such a designation would impose additional and unreasonable burden on program entities that have demonstrated their capability for decades.

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

**Phone:** 202.393.6700
**Email:** nabh@nabh.org
**Web:** www.nabh.org

National Association for Behavioral Healthcare

Access. Care. Recovery.

**Conclusion**

Supporting these efforts, NABH has offered a practical, flexible, and realistic approach to using bundled payments to reimburse for a basic package of OTP services, while allowing for more intensive services as appropriate to each individual. Our proposal maintains the viability of the existing treatment infrastructure, provides for reasonable and fair approaches to expanding access to care, and allows for a glide path to ease the transition to this new and more clinically-informed payment structure.

We are pleased at the progress being made in our country to address the needs of individuals with substance use disorders and appreciate federal efforts to expand access to care through Medicare. Thank you for taking our proposal under consideration.

Sincerely,

Mark Covall
President and CEO

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

**Phone:** 202.393.6700
**Email:** nabh@nabh.org
**Web:** www.nabh.org