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September 2, 2022

Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1770-P
P.O. Box 8016 Baltimore, MD 21244-8016

Submitted electronically to: http://www.regulations.gov

Re: CMS-1770-P
CY 2023 Physician Fee Schedule Proposed Rule Comments re Integration of Behavioral Health in Medical Settings and related

Administrator Brooks-LaSure,

The Centers for Medicare & Medicaid (CMS) has been highly instrumental in driving policy change with development, testing and spread of many behavioral health integration approaches. We are hopeful this will continue with the important inclusion of meaningful collaboration with consumers, families, and providers.

#1: Proposed Rule re Behavioral Health Integration Services in RHCs and FQHCs:

The undersigned organizations support the proposed rule policy changes related to payment for behavioral health integration (BHI) services provided in RHCs and FQHCs. Namely that clinical psychologists (CPs) and licensed clinical social workers (LCSWs) are acknowledged to be practitioners that can provide services, for which they will be reimbursed, in rural health centers (RHCs) and federally qualified health centers (FQHCs) as long as they work as part of a patient's primary care team.

We also, however, urge CMS to address this specific policy change with a wider lens, i.e. keeping in mind the larger context: i.e. of a larger, evolving transformation of our entire health system to make it more holistic, coordinated, efficient, value-producing, and patient-centered. Our following remarks speak to the contextual aspect of the proposed rule policy change.

CP and LCSW provider services can be game-changing in primary care practice. A wide variety of evidence-based psychosocial interventions exist for treating BH conditions. Research studies on establishing evidence-based standards for psychosocial interventions, defined those interventions as: interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social or environmental factors with the aim of reducing symptoms and improving functioning or well-being. Examples include: brief counseling interventions to reduce alcohol misuse, forms of psychotherapy such as cognitive behavioral therapy or psychodynamic treatment for depression, and multicomponent team interventions, such as Assertive Community Treatment. These BH providers can add greatly to PC care.

Yet, the challenge is much work needs to be done across our entire healthcare system to support and incentivize the building of new, integrated medical-behavioral care teams in the primary care setting working seamlessly in the primary care clinic setting. HHS/CMS strategies should purposefully work to construct, step-by-step, a medical-BH workforce, trained, prepared and held accountable to deliver evidence-based care as part of integrated care teams. BH professionals must be adequately trained in how to practice in the primary care work environment and their BH services need to be seamlessly implemented into the clinical care workflow.

Integrated medical-behavioral care team members must be open and flexible to building a new integrated care culture that is based on teamwork, rigorous data collection, tracking, monitoring of measurement-based care, and stepped care to adjust when improvements are not achieved. These integrated medical-behavioral care teams will need to demonstrate flexibility, creativity and shared accountability. There should be established mechanisms of shared accountability across the silos of current organizational, regulatory and financial structures.

And most importantly, these integrated medical-behavioral care teams must focus on those complex, multi-morbid patients who are the most challenging and costly to primary care practices, and, as regards cost, the nation as a whole (Milliman, 2018).

Federal health agencies policy change should set a goal of advancing primary care practice to an advanced level of practice in which behavioral health is a core element of care delivery. And be constantly asking the question: Do BH services in primary care improve health outcomes (and costs)? For this reason, we would urge HHS/CMS to support primary care services delivery research and ensure that behavioral health care delivery is a core element of that research.

Because the sad reality is that today, despite substantial primary care clinicians' support for behavioral health integration in their practices, behavioral health is still of

secondary importance in primary care. This even though 70% of American patients with behavioral health conditions go only to primary care for their health needs. Behavioral health should not have to wait for other primary care delivery priorities, important as they are, to be met. Behavioral health should be acknowledged and supported, through consistent federal health policy reform, as a core element of quality primary care practice.

#2: Proposed Rule re 'Incident To' Provisions:

We support the CMS proposal to "relax supervision requirements' for incident to behavioral health services. The purpose of the relaxation rule is to better use the clinical workforce and deal with the shortage of BH providers. The supervision requirements are related to "auxiliary personnel"; "criteria for qualifying incident to services"; and "general vs direct supervision."

We recommend that providers of peer support services (also known as certified peer support specialists and certified peer recovery support specialists) may be reimbursed as incident to physician and psychological service. This phrasing recognizes the two most common terms used in state government certifications.

#3: Proposed Rule re Medicare Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs:

We support the CMS proposed initiative.

#4: CMS 2022 Behavioral Health Strategy Goal re Strengthening Quality in Behavioral Health Care:

The undersigned organizations support the related CMS Behavioral Health Strategy Goal of Strengthening Quality in Behavioral Health Care, specifically improving quality measurement in behavioral health. Quality measures are essential for developing quality health care. They have many uses among the most important of which are providing data for consumer and purchaser (health insurers and government) decision-making. When measures are used for 'high stakes' accountability purposes such as public reporting or value-based purchasing, there are even greater expectations for quality measures. Despite the broad availability of measures to assess BH care, many have not been subjected to nor are likely to meet requirements for national endorsement and use in federal programs.

Further, measures focused on BH make up only about 5% of the CMS Quality Measures Inventory. There is insufficient representation of this issue across CMS

programs. For example, the Medicare Advantage health plan 'star rating' program has only one BH measure.

Strategies to address the BH quality measurement issue could include:

(1) expansion of outcomes measurement with a special emphasis on engaging patients and families in evaluating healthcare, and prioritizing development of quality measures that incorporate patient-reported outcome/performance measures (PRO-PMs); there is a great deal of so far untapped opportunity in having effective integrated care teams include involving patients/consumers more meaningfully in their own care and in the design and improvement of the healthcare system. Increasing emphasis is being placed on developing care quality measures that incorporate patient-reported outcomes (PROs). For instance, incorporating the recovery concept could expand care quality/performance metrics from just traditional clinical outcomes focused on symptoms to areas such as quality of life, functional quality of life, achievement of life goals, economic stability, personal empowerment and engagement in community. Further, engaging consumers in measuring aspects of their care through the use of mobile and web application will ensure consumers are not only asked for data but receive the benefit of information collected.

(2) structural approaches focused on enhancing the capacity of organizations and providers to provide effective care likely to achieve favorable outcomes. We support recent reform efforts to improve quality related to accreditation, certification, recognition, and payment programs;

#5: <u>CMS 2022 Behavioral Health Strategy Goal Utilizing Data for Effective Impact on Behavioral Health</u>:

The undersigned organizations support the CMS Behavioral Health Strategy Goal re utilizing data for effective action actions and impact on behavioral health. In fact, the 'new' integrated workforce, able to work seamlessly as part of integrated care teams, must be supported by modernized and upgraded data systems.

CMS should prioritize development of detailed, integrated electronic data systems supportive of measurement-based, stepped care approaches, as an essential requisite for delivering quality integrated medical-behavioral health care. The data sources used must contain critical information to measure the quality of care. Ensuring integrated practices have EHRs with the capacity to incorporate specific elements of behavioral health treatment as structured fields will be important for measuring the quality of the integrated care provided. Structured fields would need to be defined in a way that captures the most essential elements of evidence-based treatments, while also incorporating structured assessments such as PHQ-9, GAD-7, AUDIT-C or other

behavioral health assessments. This will help behavioral health providers identify behavioral health problems and track outcomes, as well as capturing both BH and physical health information.

#6: <u>Comment re Necessity of Building an Integrated Healthcare SYSTEM</u>:

Behavioral health must become part of total health, i.e. provided and paid for in the medical setting, with specialty BH sector reserved to serve individuals with serious mental illness (SMI). We must work to phase out the bifurcated healthcare delivery approach in our country of payment for, and delivery of, BH care solely in the specialty BH sector. It no longer makes any sense that today a BH provider cannot get paid directly for working in the medical setting. We unequivocally acknowledge and would expect that a standalone specialty BH sector will always be needed for the delivery of BH treatment of patients with SI. And that such specialty BH sector should be the primary worksite for scarce psychiatrists. But for all other BH patients, treatment should be available in medical settings – including outpatient, inpatient, ER, and post-acute care. And be paid for wholly from 'medical' benefits.

The undersigned organizations would like to see the HHS Strategy lean in on advancing a broad base of evidence-based integrated care delivery interventions through implementation and spread projects and through a pipeline of federal funding of integrated care delivery research. The collaborative care model is one, proven, value-added model of integrated care in the medical setting. However, there are also other evidence-based, value-adding approaches such as the primary care behavioral health (PCBH) or Behavioral Health Consultant (BHC) model, the SBIRT model and the Behavioral Medicine model. BH professionals should be paid for delivering those BH interventions in medical settings. All evidenced-based integration approaches should be actively supported by CMS.\

#7: <u>Proposed Rule re Medically Necessary Oral Health Services</u>:

We strongly support the proposed expansion of Medicare coverage for medically necessary dental services outlined in the Proposed Rule. We commend CMS for recognizing that medically necessary dental care can be necessary in order to properly treat other diagnosed medical conditions. We urge CMS to also consider coverage for medically necessary dental care originating from mental health condition care. We cite the instance of the game-changing medication Clozaril/Clozapine effectively used in the treatment of paranoid chronic schizophrenia which however has the negative side-effect of loss of nearly all teeth. As this evidence-based treatment for serious mental illness may necessitate medically-necessary dental care, we urge CMS to recognize that Medicare coverage of this dental care would be consistent with CMS's larger priority to advance the integration of medical-behavioral care, as embodied in

other policy changes in the CY 2023 Proposed Rule, and also as highlighted in the CMS 2022 Behavioral Health Strategy.

With best regards,

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