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AAHD - *Dedicated to better health for people with disabilities through health promotion and wellness*

LAKESHORE

September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1770-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via regulations.gov

Re: Medicare Programs: Calendar Year 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; CMS-1770-P

Dear Administrator Brooks-LaSure:

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

We have joined the coalition comments of: (#1) Consortium for Constituents with Disabilities, CCD; (#2) Coalition to Preserve Rehabilitation (CPR); and (#3) No Health without Mental Health (NHMH) and partners. We are also a member of the National Health Council (NHC). We also support two additional comments submitted by the American Psychological Association. We further support a Mental Health America proposal on peer support services (and included in the CCD and NHMH comments). We were actively engaged in drafting text with CCD and NHMH. Our comments below highlight some of these issue comments.

Medically Necessary Oral Health Services:

CCD, NHMH: Many other national organizations such as Families USA and Center for Medicare Advocacy, just to name two, 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 applaud CMS for recognizing the need to maximize its authority to cover "medically necessary" dental care in Medicare. Medicare's lack of dental coverage not only leaves oral health care unaffordable for millions of Americans, it also exacerbates underlying racial, geographic and disability-related health and wealth disparities. Improved Medicare coverage for medically necessary dental care would help millions of people get healthy without having to make impossible financial tradeoffs and would mitigate some of these health inequities.

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.

General Behavioral Health Integration

APA and NHMH: We applaud CMS for proposing to add new G code GBHI1 for the provision of behavioral health integration (BHI) services furnished by clinical psychologists and clinical social workers. BHI services improve patient outcomes by coordinating care of patients'

interrelated physical and behavioral health needs. By providing access to behavioral health and health behavior services within primary care settings, BHI services can be particularly helpful in addressing treatment disparities affecting members of racial and ethnic minorities, and those living in underserved and vulnerable communities with inadequate access to mental and behavioral health specialists.

The proposed GBHI1 code captures 20 or more minutes of the clinician's time spent on BHI each month, including BHI furnished by auxiliary staff "incident to" the services of a psychologist under general supervision. BHI services must include an initial assessment or follow-up monitoring, behavioral health care planning, facilitating and coordinating treatment, and continuity of care.

Behavioral Health Integration Services in RHCs; FQHCs; Primary Care Settings

CCD and NHMH: We 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 clinical social workers (CSWs) 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 wholistic, coordinated, efficient, value-producing, and patient-centered. 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. We support proposed enhanced behavioral health-primary care codes for the purpose of integration.

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 patients with complex and co-occurring health conditions.

"Incident To" Provisions

CCD, NHMH, APA: 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 peer support specialists and peer recovery support specialists) may be reimbursed as incident to physician and psychologist services. This phrasing recognizes the two most common terms used in state government certifications. This terminology is proposed by Mental Health America.

Medicare Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs

CCD and NHMH: We support the CMS proposed initiative.

Expansion of Telehealth under the Physician Fee Schedule

CCD, CPR, NHC, APA: Thank you for continuing to expand the provision of telehealth in the Medicare program by extending the duration of time that services are temporarily included on the telehealth services list during the PHE (but not those that have been added on a Category I, II, or III basis) for 151 days following the eventual end of the PHE. CMS notes that this aligns Medicare policies with the requirements of the Consolidated Appropriations Act, 2022. CMS is also extending certain flexibilities for the same period of time, including the waiver allowing telehealth to be furnished in any geographic area and any originating site setting (including the beneficiary's home); allowing the provision of audio-only telehealth for certain services; and allowing a wider range of providers (including physical and occupational therapists, audiologists, and speech-language pathologists) to furnish telehealth services. However, CMS does not discuss additional permanent action to expand telehealth beyond the end of the 151-day post-PHE period.

We note that, as in past years, the telehealth proposals in the Proposed Rule are necessarily limited by the authority CMS currently possesses to expand telehealth beyond the duration of the PHE. However, as the Medicare population remains accustomed to the widespread adoption of telehealth over the last two years, we also recognize that Congress is in the process of considering permanent extensions of CMS' authority, or even mandating a longer-term or permanent expansion of telehealth in the Medicare program. Accordingly, we encourage CMS to consider our comments below not only with regard to the policies in the Proposed Rule, but for future rulemaking impacting telehealth in the Medicare program.

The rapid expansion of telehealth has allowed many Medicare beneficiaries to more safely and easily access medically necessary health care, not only by limiting the threat of infection from COVID-19, but avoiding numerous other complications and difficulties that have always been associated with in-person medical care. For example, many beneficiaries with mobility impairments have seen tremendous benefit from their ability to receive virtual evaluations and other services, given the complications associated with planning, transportation, and accessibility of in-person visits. Mobility impairments themselves limit physical access to in-person visits to health care providers. Telehealth can dramatically ease the burden of mobility impairment while preserving access to care.

Similarly, many patients in need of cognitive and psychological rehabilitation services have found that virtual services may be more accessible and even potentially more effective, with the

potential to cut down on distractions associated with receiving care in an unfamiliar environment. We also note that the proliferation of telehealth may allow patients to receive more stable, continuing access to therapy and other important services, with telehealth visits occurring between intermittent in-person visits in order to maintain the level of care available to the patient.

Even as the PHE expires and the threat of COVID-19 eventually lessens, telehealth will continue to provide these benefits which are particularly valuable for beneficiaries with disabilities and in need of rehabilitation. We therefore support increased access to care through the expanded use of telehealth past the expiration of the PHE to ensure that patients are able to benefit from advances in technology that make virtual care possible.

However, it is critical that expansion of telehealth services does not come at the expense of in-person care, especially when the services needed by the patient are more effectively and efficiently provided in-person. Beneficiaries with illnesses, injuries, disabilities, and chronic conditions often need the highest levels of medical care in order to maintain, regain, and/or improve their health and function. It is crucial that beneficiaries receiving rehabilitation care are able to access the most appropriate care in the most appropriate settings.

New regulations expanding telehealth must ensure that telehealth is utilized only when clinically appropriate and that beneficiaries who need in-person care do not face additional barriers to access as a result of telehealth adoption.

Medicare Shared Savings Program – ACOs and Health Equity

NHC: We join the NHC commending CMS for the initiatives in the proposed rule to help advance equity for those receiving care through Accountable Care Organizations (ACOs).

The proposed advanced investment payment program will help build out ACOs in underserved areas and for underserved communities. It is particularly important that these funds are available for ACOs to address social drivers of health. Shared savings models can incentivize attention to social drivers of health by creating value for preventative and social services.

The health equity quality score adjustment will also help drive more care to underserved individuals and areas. By incentivizing ACOs to proactively seek to serve more marginalized and underserved individuals, it will increase health equity. We also support including screenings for social determinants of health and the screen positivity rate for social drivers of health in future measures development.

Patient Access to Health Information Measure—Request for Information

NHC: The RFI asks how CMS or HHS can facilitate individuals' ability to access all their health information in one place/portal. This is a common patient complaint and one that should be addressed. While portals are all designed differently, many are using the same back-end data/electronic health records to populate the portal. We would encourage CMS to consider convening thought leaders to explore the barriers and opportunities to information sharing between portals so whatever portal a patient enters, their individual health information is populated based on unique identifiers while still assuring safety and privacy.

Incorporating Health Equity into Public Reporting

NHC: In this RFI, CMS asks about information to include in its compare tools to help drive health equity. The first question is whether information about translation and language services should be available, including sign language. This information would be valuable to patients and help increase health equity. Information not only about what other languages are available in an office, but also about tools a provider might use to enable communication like virtual translators, will help patients seek out providers that will enable the best care for them. In addition, we would encourage the compare tools to include information about accessibility of facilities and equipment and other accommodations available for people with disabilities.

Proposal to Allow Audiologists to Furnish Certain Diagnostic Tests Without a Physician Order

CCD**:** We support the removal of the physician order requirement for audiology assessment services. CCD and others have observed: Without adjusting the proposal to reflect the practical challenges it creates, CMS will not achieve its goal of better understanding the impact from removing the physician order requirement nor will it increase beneficiary access to care. CCD, ASHA, and others have suggested possible adjustments in the rule.

Caregiver Behavior Management Training

APA - we join APA and ask CMS to reconsider its decision that Caregiver Behavior Management Training (CBMT) is not eligible for Medicare coverage and reimbursement because the service does not directly benefit the patient. In fact, management of the patient's mental and/or physical health issues are the focus of CBMT. CBMT teaches the patient's parent or caregiver evidence-based interventions and strategies. CBMT has been found to help patients stay in private homes longer, thus reducing the cost of placing them in nursing homes. CBMT lowers healthcare costs and improves patient outcomes. Given the role that family members often play in caring for patients in underserved communities and for individuals with disabilities, establishing coverage of CBMT would help in addressing health inequities for these populations.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkeross10@comcast.net.

Sincerely,

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And
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