September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
P.O. box 8016
Baltimore, MD 21244-8016
Sent via regulations.gov

RE: Proposed Rule – CY 2023 Revisions to Payment Policies Under the Physician Fee Schedule 2and Other Revisions to Medicare Part B

Dear Administrator Brooks-LaSure:

United States of Care is pleased to submit the following comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed updates to the Medicare Physician Fee Schedule (PFS) for calendar year (CY) 2023.

United States of Care (USofCare) is a non-partisan non-profit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level, in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. After listening to people tell us about their needs for their health care, USofCare recently released a set of twelve concrete and achievable aims to help us build a fairer system.

These twelve aims are derived from four goals for the health care system that continuously rose to the top when talking to people around the country about what works and what is lacking in their health care. Two of these goals for the health care system are that people ought to have health care they can depend on as life changes and care that can be personalized for when and how they need it. Certain policies included in the proposed updates to the PFS would allow people to take steps towards achieving those goals for their health care. The various telehealth provisions will allow providers to meet people where they are and address their health care needs via the clinically appropriate modality that works for their specific lifestyles in a timely manner. We have seen health care needs shift since the onset of the COVID-19 pandemic, with an increasing need for behavioral health services thrust into the spotlight. Additionally, the expansion of coverage for medically necessary dental health services grants Medicare beneficiaries the security that they can depend on their coverage for all of their needs, including oral health care.

USofCare has reviewed these proposals and asks CMS to prioritize advancing policies that promote increased access to care for all people, particularly in the following areas:

- **Telehealth Services.** We support the continuation of telehealth flexibilities and encourage CMS to continue to build on the flexibilities allowed during the pandemic and ensure people have access to necessary care via the appropriate care modality, whether this be in-person or through virtual care technology. We also ask CMS to continue coverage of audio-only services beyond the public health emergency (PHE).
- **Behavioral Health Services.** We support the proposals to increase access to behavioral health care services and promote care integration in the wake of the pandemic and the increased demand for behavioral health care.
- **Dental Care Services.** Access to oral health care is essential to supporting positive health outcomes. We support the proposal to increase coverage of medically necessary dental care for Medicare beneficiaries, supporting access to whole-person care.

We respectfully submit the following comments for your consideration.

Leveraging Telehealth to Deliver Care When and How People Need it

At USofCare, we believe that a well-designed approach to virtual care—including synchronous video and audio-only telehealth services, asynchronous remote patient monitoring, and other digital forms of communication—has the potential to break down long-standing barriers to health care access. However, without careful attention to people-centered strategies and solutions, the overnight revolution that the pandemic unleashed in how we access health care virtually could leave certain people and communities further behind that need it the most.

A number of the flexibilities that will continue with the implementation of the provisions of the Consolidated Appropriations Act under this rulemaking align with our recommendations for people-centered virtual care for policy and system change. Most people prefer a mix of in-person and virtual care, and the removal of virtual care flexibilities would make it harder for people to access the health care services they need. Through our listening work with people about their experiences with virtual care, we have identified several actions policymakers can take to provide long-term flexibility in how providers and patients give and receive care.

- **Blend in-person and virtual care.** When clinically appropriate, people should have the flexibility to choose when and whether to receive in-person or virtual care.
- **Maximize locations for patients receiving virtual services.** Patients should be able to receive care virtually in locations like their homes, community centers, and schools. This helps relieve barriers such as scheduling and transportation difficulties and gives paths to care to more people.
- **Expand broadband in rural and underserved areas; allow audio-only care and remote device monitoring.** Years of lagging internet speeds impede people's ability to use features like video visits and have left many without the technical expertise needed to navigate virtual care systems. Without adequate access, these communities are being left behind in myriad ways.

Our listening work focused on people's experiences with virtual care during the pandemic demonstrates a desire for a blended care system.

"I liked [my experience with virtual care] a lot…and I hope they continue it after COVID is done. You know, for certain situations. Maybe one time a year you would go in for the physical and lab work, but the rest could be virtual. It's been a very good experience."

- Woman with a disability

There is significant interest in enacting longer-term or permanent extensions of telehealth flexibilities at both the state and federal levels. For example, 40 states and counting have made virtual care reimbursable via private insurance and at least 27 states have permanently authorized Medicaid payment for virtual care services. There continues to be momentum at the federal level to extend Medicare telehealth flexibilities for an additional two years, through December 2024, with near unanimous House passage of the Advancing Telehealth Beyond COVID-19 Act of 2021. Through our extensive listening work, we have seen consistent trends in patient satisfaction with virtual care throughout the pandemic, particularly among older adults. Among those who have used virtual care, the majority find it safer and more convenient than in-person visits and report that it saves time and fits into their schedules.

Our intensive listening work highlights the benefits of utilizing virtual care to meet people where they are for their care needs.

"Well, I liked it because [virtual providers] worked with my father during COVID. I didn't have to take him and they literally took the time. They weren't rushing - actually, at that time when my dad got sick, he was actually at home. [The provider] was calling his patient from home."

- Black female with Medicare & private insurance, SC

The implementation of this short-term extension of Medicare telehealth flexibilities will create opportunities, such as data collection efforts to support permanency of flexibilities, which is an important step in supporting access to care when and how people need it; however, there is more to be done. In particular, we ask CMS to continue to assess the benefits of allowing providers to bill for audio-only services that can address disparities in access to video-based services due to broadband challenges. Specifically, we oppose the proposal to sunset coverage and payment of audio-only services after the end of the PHE and ask CMS to maintain current coverage for audio-only services. We encourage CMS to further expand virtual care flexibilities on a longer-term basis to promote certainty around access to clinically appropriate care when and how people need it.

Expanding Access to Behavioral Health Care

The COVID-19 pandemic exacerbated existing behavioral health care access challenges for children, youth, and adults in the United States. Prior to the pandemic, less than half of adults with mental illness received treatment, while facing a number of barriers including coverage limitations and behavioral health provider shortages. Black, American Indian, and Alaska Native people use mental health services at significantly lower rates than white American individuals, due in part to lower rates of insurance coverage and geographic barriers that limit access to behavioral health providers. In addition, people with mental health challenges face disproportionately high rates of poverty, housing, and employment discrimination. We support the proposed provisions that aim to promote care integration and address access issues.

Supporting behavioral health integration. We commend the Administration's commitment to primary and behavioral health integration, as demonstrated by the increase in funding for care integration included in the President's fiscal year 2023 budget and CMS's behavioral health strategy. This commitment continues to be demonstrated by the proposal to establish a process to code and bill for behavioral health integration (BHI) for care management services performed by a clinical psychologist or clinical social worker to account for monthly care integration. Proposing to pay psychologists and social workers to help manage behavioral health needs as part of the primary care team will expand another care access point for behavioral health care services.

The first stop for many individuals seeking behavioral health care is their primary care provider. For example, 40 percent of adults receive mental health or substance use disorder treatment from their primary care provider. Primary care is the preferred point of entry for health care for racial and ethnic minority populations and individuals with limited English proficiency. As such, it has become an important care access point for identifying undiagnosed or untreated behavioral health disorders. Actions such as the creation of the BHI that promote care management and primary and behavioral health integration also support investments in whole-person care.

Based on USofCare's intensive listening work, we know people value accessing primary care that treats the whole person, especially mental health.

"We're pretending over here. And we are also not dealing with wellness. We are not addressing issues early enough whether their mental health, physical health, spiritual health, emotional health, whatever kind of health you want. We're not dealing with them from preborn to the grave."

- Black woman with private insurance, SC

Relaxing supervision requirements. We support the proposal to allow certain behavioral health providers to practice to the fullest extent of their licenses without direct supervision. Providers that will be impacted under this proposal include marriage and family therapists,

licensed professional counselors, and certified peer specialists, among others. As CMS notes in the proposed rule, by 2025, shortages are projected nationally for a variety of providers, including psychiatrists, clinical psychologists, mental health and substance use social workers, school counselors, and marriage and family therapists. Providing latitude on supervision requirements will make strides to address the growing behavioral health workforce shortage. Lack of access is a root cause of the mental health crisis, resulting in increased use of the emergency department (ED) and the need for inpatient hospital admissions, increasing wait times and cost, and impacting outcomes. Mental health and substance use-related ED visits increased more than 44 percent between 2006 and 2014, with suicidal ideation visits growing by nearly 415 percent. Recent studies have found that ED visits for mental health-related visits likely increase after COVID 19-surges, particularly for young adults and some racial and ethnic minorities. Reports have also found there continues to be an increase in the number of pediatric mental health ED visits during the course of the pandemic, creating a call to action for early identification and expanded evidence-based prevention and intervention strategies. Early identification of behavioral health challenges and proper subsequent referral can mitigate the need for costly crisis care services in an inpatient or emergency department setting.

Payment for behavioral health services. CMS is specifically requesting comments on effective behavioral health payment strategies. There are several existing models that can potentially be expanded or replicated to promote sustainable reimbursement for virtual consultation services between primary care and behavioral health providers. Examples include the Collaborative Care Model to promote integrated care and HRSA's Pediatric Mental Health Care Access Program, which was expanded to provide grant opportunities to all 50 states under the American Rescue Plan Act in recognition of the need for increased access to behavioral health consultation services in the wake of the COVID-19 pandemic. We encourage CMS to review our set of policy recommendations that explore how virtual care technology can be leveraged to address barriers to accessing behavioral health services and support care integration, including for identified workforce challenges that impede care access.

Expanding Coverage of Medically Necessary Dental Services

We support the proposed expansion of coverage of medically necessary dental care services. Oral health disparities that disproportionately impact low-income older adults and communities of color, such as Black and Hispanic populations, are perpetuated without proper oral health care. Opportunities for Medicare to expand dental coverage have important implications for addressing these disparities and improving health equity.

The provisions proposed in this rule would allow for greater flexibility for what dental services are deemed medically necessary. The expansion of coverage beyond limited services is critical for preventing and alleviating the burden of oral health outcomes that are closely linked to physical health. About half of all Medicare beneficiaries lack dental coverage and approximately two-thirds of all beneficiaries suffer from periodontal disease, which is closely linked to chronic and systemic conditions. Including coverage of "medically necessary" dental care services will be an important step for Medicare beneficiaries to get the care that they need and promote whole-person health.

We appreciate the opportunity to provide comments on the CY 2023 updates to the Medicare PFS. People consistently share with us their desire for a health care system that is dependable and personalized to their unique needs. The proposals outlined in this rule make strides to implement long-term, sustainable policy change that builds off the flexibilities leveraged during the COVID-19 pandemic and support care integration, coordination, and the delivery of necessary physical, behavioral, and oral health care.

Please consider our team at United States of Care a resource and please do not hesitate to reach out to Liz Hagan, Director of Policy Solutions, at ehagan@usofcare.org with questions regarding these comments.

Natalie Davis
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United States of Care