Physician Fee Schedule for Calendar Year 2023

Comment Summary

National Council comments respond to three sections of the Proposed Physician Fee Schedule Rule for calendar year (CY) 2023.

II.D. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

National Council advocated for the continuation of crucial Medicare telehealth flexibilities beyond the PHE. Specifically, we urged CMS to:

- Expand these provisions further and consider making permanent an expanded definition of "originating site" as well as expanding the authorized utilization of audio-only telehealth.
- Narrow its interpretation of the Consolidated Appropriations Act of 2021 in order to implement the 6-month in-person requirement for certain originating site requirements that do not potentially create widespread gaps in care.
- Permit all modalities of telehealth, including audio-only, for the full spectrum of mental health and substance use services, in accordance with the patient-provider's determination of the most effective form of care.

Additionally, CMS sought comment on whether it should consider making permanent an exception to "incident to" direct supervision requirements that have been in place during the Public Health Emergency (PHE). This exception allows the use of real time, two-way/audio-video technology to meet the immediate availability requirement necessary to qualify under direct supervision for "incident to" billing. National Council urged CMS to extend this exception permanently to the full spectrum of mental health and substance use services.

II.E. Valuation of Specific Codes

CMS proposed two changes to "incident to" billing: amend the direct supervision requirement to allow mental health and substance use services to be governed by the general supervision of a physician or NPP (rather than the more restrictive direct supervision) ***and*** expand the eligible providers who perform the "incident to" service (auxiliary personnel) to include Licensed Professional Counselors (LPCs) Licensed Marriage and Family Therapists (LMFTs).

National Council expressed support for both proposed changes to the "incident to" billing provisions, emphasizing the impact of these provisions would be to help grow the mental health and substance use disorder in Medicare and expand access to mental health and substance use services in its beneficiaries.

Additional comments were made by National Council to request clarification on three unanswered questions this rule presented. First, we urged CMS to define "behavioral health services" for the purpose of this provision and encouraged the agency to do so in the broadest possible terms. Second, we suggested CMS provide guidance on the applicability of its proposed additions to auxiliary personnel. Particularly, we advocated for the inclusion of additional mental health and substance use providers (like peer support specialists and peer support recovery coaches), including those in the course of seeking full licensure (such as associate social workers, professional counselors, and marriage and family therapists). Our recommendation to CMS is to adopt, for the purposes of this provision, deference to

state licensure laws where the care is taking place (allowing providers to practice as determined by their state licensure requirements).

Additionally, CMS sought comment on how to best ensure Medicare beneficiary access to behavioral health services, particularly as it relates to provider reimbursement.

National Council emphasized the impact of decreases to the Medicare reimbursement rate (due to budget neutrality and sequestration requirements) as having debilitating consequences to already historically under-reimbursed mental health and substance use practitioners and the patients they serve. We also reinforced the potential detriment reimbursement decreases will have in exacerbating the mental health and substance use workforce crisis. Therefore, National Council urged CMS to make meaningful and substantive changes to the PFS rate-setting methodology in order to ensure the range of mental health and substance use providers are reimbursed proportionately to the market and other insurance providers and that their reimbursement levels adequately reflect standard changes to the cost of providing services.

III.F. Coverage for OUD Treatment Services Furnished by OTPs

CMS proposed the reimbursement of services provided by opioid treatment program (OTP) mobile units, in accordance with Drug Enforcement Agency (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) guidance. National Council expressed support of this proposed rule, which would include the payment for mobile services under the OTP bundled rate, so long as the reimbursement rate is sufficient. We urged CMS to ensure that the OTP bundled rate includes prospective costs for OTPs to establish mobile units as well as the continued maintenance of existing and newly established mobile units.

CMS also proposed to make permanent the initiation of treatment with buprenorphine via two-way/audio-video modality, as well as audio-only modality when two-way/audio-video is not available to the patient. National Council expressed support for this proposed rule and reinforced for audio-only circumstances that it is crucial the provider and patient collaboratively determine the audio-only modality is appropriate by maintaining access to high-quality care. We also urged CMS to expand this proposed rule to include periodic, ongoing treatment services with buprenorphine as well as periodic ongoing treatment services with methadone and other clinically effective medication assisted treatments through two-way/audio-video telehealth.