HANYS®
Always There for Healthcare

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September 11, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1784-P
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, etc.

Dear Administrator Brooks-LaSure:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to comment on the proposed changes to the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies for contract year 2024.

The healthcare community is responding to a tremendous surge in behavioral health needs within a historically underfunded and under-resourced behavioral health infrastructure. HANYS applauds CMS' efforts to establish payment models that will increase access to necessary holistic care for individuals seeking behavioral health services. The investments will make a profound impact. However, several proposals will also have serious unintended consequences, including unnecessary interruptions in care and exacerbated workforce shortages.

Systemic undervaluation of work estimates

CMS recognizes that there is a systemic undervaluation of work estimates for behavioral health services and proposes changes that will take into account the unique considerations for the valuation of behavioral health services. **HANYS strongly supports a valuation of behavioral health services that more accurately reflects the work involved in delivering behavioral health services.**

Behavioral health workforce

Expanded billing for behavioral health professionals
Hospitals and health systems are deploying every available strategy to recruit and retain healthcare professionals. However, thousands of positions,

especially in behavioral health, remain unfilled. In an environment where the demand for behavioral healthcare is higher than ever, people in need of services are struggling to access it. **HANYS supports CMS' proposals to expand payment for services** provided by:

- marriage and family therapists;
- mental health counselors;
- addiction counselors;
- peer support workers; and
- community health workers.

Behavioral health staff supervision requirements
For rural health centers and federally qualified health centers, CMS is proposing to continue to define "immediate availability" for the supervising practitioner as including real-time audio and visual interactive telecommunications through Dec. 31, 2024. The use of supervision using two-way, real-time audio-visual technology was conducted safely and effectively throughout the public health emergency. **HANYS strongly urges CMS to make these changes permanent** to alleviate workforce shortages and ensure ongoing access to care.

Increasing psychiatrist participation in Medicare
CMS seeks comments on how to increase psychiatrist participation in Medicare given their low rate of participation relative to other physician specialties. Disparate reimbursement rates strongly contribute to the low rates of participation. For example, Medicare reimburses a 45-minute mental health therapy session at $103.28, while a similar medical office visit is reimbursed at $185. Enduring reimbursement discrepancies for psychiatrists will continue to negatively impact patient access to these critical services. In addition to improving psychiatrist participation in Medicare, **HANYS urges CMS to ensure all behavioral health specialties are adequately and sustainably reimbursed.**

Mental health services furnished remotely

HANYS commends CMS for recognizing telehealth as an important tool for providing outpatient behavioral health services. Telehealth is critical to overcoming longstanding obstacles to mental health treatment, including stigma, shortages in local expertise and transportation. Telehealth alleviates persistent workforce challenges, especially among prescribing professionals in underserved areas.

Facility rate
In the proposed rule, CMS indicates that when beneficiaries are receiving services in their homes and not physically within a care delivery setting, care providers are not accruing all the costs associated with an in-person service. There is a common misconception that the cost to deliver telehealth services is substantially lower than in-person care.

While telehealth practice costs may be lower for clinicians employed by remote-based companies, the overwhelming majority of hospitals and health systems must also maintain the ability to provide in-person care. As a result, they incur fixed costs associated with a bricks and mortar practice and take on additional costs related to facility overhead, staff training, information technology infrastructure and telehealth technology, such as audio-visual equipment, telemedicine "carts," kiosks, remote patient monitoring equipment, Bluetooth

medical equipment and telemedicine software. Telehealth payment parity is instrumental to maintaining adequate revenue to continue providing these services. **HANYS urges CMS to reimburse remote outpatient mental health services at the same rate as services delivered in person by continuing to include the facility fee.**

Hospital clinic staff location restriction

HANYS strongly recommends that CMS not require care providers to be physically located in a hospital when providing telehealth services. One of the major successes of telehealth is the ability to connect patients to professionals in parts of the state where there is no local expertise. Rural areas will be particularly impacted as they are challenged by chronic behavioral health workforce shortages and must rely on providers in other regions to receive care. Requiring clinicians to commute to the hospital assumes that hospitals in rural and other underserved areas are able to recruit clinicians and creates a disincentive for seeking employment at hospitals, exacerbating existing statewide and national workforce shortages.

In-person visit requirements

In the CY 2023 final rule, CMS finalized a requirement that a beneficiary receive an in-person service within six months prior to the first remote mental health service and within 12 months after each remote mental health service. Subsequent legislation has delayed implementation, with the *Consolidated Appropriations Act of 2023* extending the delay until Jan. 1, 2025. **HANYS strongly urges CMS to consider removing the requirement for an in-person visit within six months prior to the initiation of telehealth services and within 12 months thereafter.**

HANYS appreciates the flexibility granted by permitting exceptions. However, requiring in-person visits will result in unnecessary obstacles to care for the many individuals who demonstrate they do not need or prefer in-person services. Multiple studies show the overwhelming success of remote mental health services during the public health emergency — when there was no in-person visit requirement.

The United States Substance Abuse and Mental Health Services Administration issued guidance for implementing telehealth services that states, "requiring in-person visits can create a barrier to seeking or accessing care, so the decision to have in-person visits should be made in collaboration with the client." Strategies to address concerns regarding the appropriate use of telehealth and capacity for in-person visits should be closely examined through a more thoughtful, deliberative process and without causing undue interruptions in care.

Audio-only requirements

Consistent with telehealth provisions in the CAA, 2023, CMS proposes extending flexibilities for certain services to be provided by audio-only technology through the end of CY 2024 or CY 2025. Beyond the CAA, 2023, provisions, CMS proposes to extend the ability for opioid treatment programs to provide periodic assessments using audio-only technology through the end of CY 2024. **HANYS strongly supports making permanent the ability to provide care through audio-only communication.**

The most vulnerable populations in our communities are often challenged to access web-based services. Many experience geographic disparities in broadband, cannot afford the cost of high-speed internet or lack the technological proficiency to access video services. Audio-only telehealth services increase access to care and are an essential tool for behavioral health equity.

Behavioral health services

Caregiver training services
In the proposed rule, CMS acknowledges that there may be circumstances when the physician or practitioner directly involves the caregiver in developing and carrying out a treatment plan and requests input for a payment methodology. **HANYS strongly supports this proposal and urges CMS to build in flexibility as definitions are established.** CTS are currently being provided routinely, especially in behavioral health. Allowing billing for CTS services would allow for holistic care of the patient with their caregiver(s) and also provide opportunities for practitioners, like physicians and advanced practitioners, to focus more time on providing clinical care in an environment where there are severe behavioral healthcare shortages.

Behavioral health emergency department interventions
CMS seeks comment on whether there is a need for separate payment for interventions initiated or furnished in the ED or other crisis setting for patients with suicidality or at risk of suicide. **HANYS urges CMS to establish payment for such services, including safety planning interventions and/or telephonic post-discharge follow-up contacts.** Existing payment mechanisms are wholly insufficient to support furnishing such interventions when indicated. Payment would help ensure EDs are able to fully provide these necessary, but currently unreimbursed, interventions.

Mobile crisis services
Upon the direction of CAA, 2023, CMS proposes two new codes for mobile crisis psychotherapy services. **HANYS supports payment for mobile crisis services.**

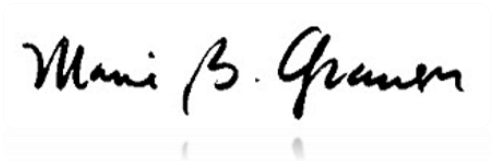
New behavioral health service models
In the proposed rule, CMS seeks feedback on ways to increase access to behavioral health integration services. The rule also includes a request for information for digital therapies. **HANYS applauds CMS for exploring new ways to advance behavioral healthcare.** Hospitals and health systems across New York state have made tremendous investments in innovative behavioral healthcare models and many receive no reimbursement or partial reimbursement for services that make tremendous patient care impacts while saving healthcare dollars. Payment for innovative care models would allow hospitals and health systems that would otherwise be unable to make such investments to also offer these services.

Examples of such models include:

- collaborative care models with behavioral health specialists, such as licensed social workers, embedded in primary care settings and hospitals for rapid access to behavioral healthcare for patients who would otherwise experience prolonged delays in access to advanced practitioners due to persistent workforce shortages;
- hospital behavioral health staff that engage with and train staff in post-discharge care settings, in-person, for up to a week to facilitate a seamless transition for patients with complex care needs; and
- transitional care housing linked to hospitals, with behavioral health staff that travel with the patient to facilitate transitions back to the community and outpatient care settings.

If you have questions, please contact Cristina Batt, senior vice president, federal relations, at cbatt@hanys.org or 518.202.1272 or Victoria Aufiero, vice president, insurance, managed care and behavioral health, at 518.431.7889 or vaufiero@hanys.org .

Sincerely,



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