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September 21, 2022

Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Submitted electronically to WMdem.submission@mail.house.gov

RE: Markup of Worker and Family Support and Health Legislation

Dear Chair Neal, Ranking Member Brady, and Members of the Ways and Means Committee,

Thank you for the opportunity to submit a statement for the record to the Ways and Means Committee (the Committee) in support of worker and family support and health legislation. The Legal Action Center (LAC) is a non-profit organization that uses legal and policy strategies to fight discrimination, build health equity, and restore opportunity for people with substance use disorders, arrest and conviction records, and HIV/AIDS. LAC convenes the Medicare Addiction Parity Project, which seeks to improve Medicare's coverage of substance use disorder (SUD) treatment equitably and comprehensively. LAC also works with partners in states and nationally level to fight for fair insurance coverage of mental health (MH) and SUD treatment through robust enforcement of the federal Mental Health Parity and Addiction Equity Act and state parity laws.

Thank you for all of your work to strengthen access to MH and SUD services and care. We write to express LAC's strong support for each of the bills subject to markup today and urge you to further strengthen the legislative package in the following ways before it is finalized.

A. Committee Print 117-1. Improvements to Medicare Inpatient and Outpatient Mental Health Services

Section 1. Improvements to Medicare Prospective Payment System for Psychiatric Hospitals and Psychiatric Units

LAC supports the Committee's proposal to collect additional data and information on psychiatric hospitals and psychiatric units and to revise payment rates based on a review of this data. We further encourage the Committee to:

- Require the Secretary to collect data on patient experience of care for both individuals with psychiatric diagnoses in psychiatric units of general hospitals and individuals in psychiatric hospitals. Currently, individuals with

psychiatric diagnoses are excluded from general hospital surveys (HCAHPS) and there are no patient experience measures for psychiatric hospitals quality review (IPFQR), despite evidence attesting to inpatient psychiatric patients' ability to evaluate their experiences of care and the opportunity to capture nuanced information on patient safety and quality of care.[1] Such data should also be used to revise payment rates.

- Require the Secretary to gather data on patient lengths of stay as well as the number and percentage of patients who hit the 190-day lifetime limit on inpatient psychiatric care.
- Require the Secretary to collect data on the co-morbidities of patients with mental health and substance use disorder diagnoses in the proposed 42 U.S.C. 1395ww(s)(4)(E)(ii)(IV), given the significantly high rate of these co-morbid conditions.[2]
- Amend the proposed 42 U.S.C. 1395ww(s)(5)(B)(iii) to use the correct terminology for substance use disorder treatment and reflect the most current evidence-based treatment. Instead of "detoxification services for substance abuse," we encourage the Committee to use "withdrawal management for substance use disorder and initiation of treatment, including medication for opioid use disorder."

Section 2. Ensuring Adequate Coverage of Outpatient Mental Health Services Under the Medicare Program

LAC also supports the Committee's proposal to amend the definition of partial hospitalization (PHP) services to establish coverage of intensive outpatient (IOP) services under Medicare. We are especially appreciative that coverage of IOP is not dependent on a physician certifying that the patient would otherwise need inpatient treatment. We also commend the Committee for including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as settings where IOP can be furnished. LAC further encourages the Committee to:

- At a minimum, include a directive to the Centers for Medicare and Medicaid Services (CMS) to revise its regulations to ensure that both IOP and PHP are effectively covered for individuals with a primary diagnosis of a SUD, consistent with the American Society of Addiction Medicine (ASAM) Criteria. As written, we are concerned that patients with a principal SUD diagnosis do not have sufficient access to PHP and may not be able to access the proposed IOP services either. By ensuring that the coverage requirements are consistent with the ASAM Criteria, the Medicare-authorized providers currently delivering PHP and IOP to individuals with SUD will be able to meet their licensure and certification requirements and provide life-saving care to their patients enrolled in Medicare.[3]
- Authorize IOP services to be delivered in opioid treatment programs (OTPs) and other settings as determined appropriate by the Secretary, in addition to those proposed in this draft. We further encourage Congress to authorize PHP services to be delivered in these

[1] Morgan C. Shields, et al., *Patient Safety in Inpatient Psychiatry: A Remaining Frontier for Health Policy*, Health Affairs (Nov. 18), https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0718,
[2] William J. Parish, et al., *Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers*, American Journal of Preventative Medicine (Aug. 2022), https://www.sciencedirect.com/science/article/abs/pii/S0749379722001040.
[3] For specific comments on the barriers to IOP and PHP treatment for beneficiaries with SUD, see LAC's comments to CMS's proposed CY 2023 Physician Fee Schedule rule, https://www.lac.org/assets/files/LAC-Comments_PFS-2023-2022.09.01.pdf.

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settings as well as FQHCs and RHCs, to align with the proposed IOP definition and to promote greater continuity of care.

- Remove the requirement that the treating physician must determine the need for both IOP and PHP not less frequently than monthly. Such a requirement is inconsistent with other Part B benefits, and the "not less frequently" may give Medicare Administrative Contractors (MACs) and Medicare Advantage (MA) plans too much latitude to require authorization even more frequently. We believe this type of authorization requirement will deter practitioners from offering IOP based on the burdensome administrative requirement.

B. Committee Print 117-2. Improvements to the Medicare Program Related to Physician Services and Education

Section 1. Coverage of Marriage and Family Therapists and Mental Health Counselor Services Under Part B of the Medicare Program

LAC supports the Committee's proposal to authorize coverage of Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) as Medicare providers. We further encourage the Committee to:

- Refer to MHCs as "Licensed Professional Counselors" (LPCs), which is the broader and more commonly used term by counselors, and it also includes MHCs.[4]
- Include individuals who are licensed or certified as substance use disorder counselors – including addiction counselors and alcohol and drug counselors – as MHCs/LPCs under the proposed 42 U.S.C. 1395x(lll)(4)(B), and that the required degree under (4)(A) and the two years of clinical supervised experience under (4)(C) include mental health "or substance use" counseling.
- Revise the reimbursement rate at the proposed 80% of the lesser of the actual charge for the services or 75% of the amount determined for payment of a psychologist to be, at the very minimum, comparable to those for non-physician practitioners on the medical side. Non-physician medical practitioners are reimbursed at 80% of the lesser of the actual charge or 85% of the physician fee schedule. As the Committee tries to remedy issues in the Social Security Act that perpetuate discrimination against individuals with MH and SUD – and to fight the ongoing workforce shortage, MH crisis, and opioid public health emergency – we urge the Committee to set adequate rates for MH and SUD practitioners that are on par with those for medical practitioners. Recognizing that this is also an issue for clinical social workers under Medicare, LAC encourages Congress to amend that reimbursement rate as well.
- Ensure that MFTs and MHCs are not excluded from inpatient settings and skilled nursing facilities as proposed, and ensure clinical social workers can also work in these settings.

[4] For example, CMS's proposed CY 2023 Physician Fee Schedule rule used LPC rather than MHC when proposing changes to "incident to" billing supervision requirements: https://www.govinfo.gov/content/pkg/FR-2022-07-29/pdf/2022-14562.pdf. The American Counseling Association also uses the term LPC to refer to the broadest range of counselors, including MHCs, and its state licensure requirement report reflects that LPC is the most commonly used term by States: https://www.counseling.org/knowledge-center/licensure-requirements. We encourage the Committee to ensure that all of these types of professional counselors that are recognized by States and meet the minimum criteria established in the proposed legislation are authorized to bill under Medicare.

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Section 2. Provider Outreach and Reporting on Certain Behavioral Health Integration Services

LAC supports the Committee's proposal to require the Department of Health and Human Services (HHS) to conduct outreach to providers on general behavioral health integration and submit reports to Congress. As a technical amendment, we note that the identified codes are "CPT" codes, not HCPCS. We further encourage the Committee to:

- Make such outreach ongoing, rather than the proposed "one-time" education initiative.
- Expand such outreach and education to include the office-based bundled payments under the Physician Fee Schedule for SUD treatment (G2086-G2088)

Section 3. Outreach and Reporting on Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs

LAC supports the Committee's proposal to require HHS to conduct outreach to providers and beneficiaries on billing and eligibility for OTP services and submit reports to Congress. We further encourage the Committee to:

- Make such outreach ongoing, rather than the proposed "one-time" education initiative.
- Expand such outreach and education extend to all practitioners who can deliver opioid and other SUD treatment services, rather than the limited focus on OTPs. Fewer than 1 in 5 of the 1.1 million Medicare beneficiaries with an opioid use disorder (OUD) received medications for OUD, though the vast majority (73%) received medication from office-based settings rather than OTPs.[5] As such, there is a dire need to expand outreach and education both to OTPs and office-based settings to ensure that all Medicare beneficiaries can access this evidence-based care.

Section 4. Exception for Physician Wellness Programs

LAC supports the Committee's proposal to authorize physician wellness programs as a permissible compensation arrangement under Medicare. During the ongoing MH and SUD workforce shortage and at a time when burnout is so high, it is vital that all practitioners – not just physicians – have access to counseling, MH services, or SUD prevention and treatment for the purpose of preventing suicide, improving MH and resiliency, or providing training in appropriate strategies to promote the MH and resiliency of such practitioners.

Section 5. Review of Safe Harbor Under the Anti-Kickback Statute for Certain Contingency Management Interventions

LAC supports the Committee's proposal to require the Office of the Inspector General of HHS to conduct a review of whether to establish a safe harbor for evidence-based contingency management incentives and the parameters for such a safe harbor, and to issue a report on its findings. Contingency management is a scientifically established clinical intervention that is effective in reducing stimulant (i.e. cocaine and methamphetamine) use to a far greater degree than any other treatment intervention, and has also demonstrated efficacy in the treatment of

[5] U.S. Dep't of Health & Human Services Office of Inspector General, *Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue to be Concerns for Medicare Beneficiaries* (Sept. 2022), https://oig.hhs.gov/oei/reports/OEI-02-22-00390.pdf.

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opioid, alcohol, marijuana, and tobacco/nicotine use. As the overdose death toll now exceeds 100,000 deaths per year and as rates of SUD continue to grow in Medicare, we support the Committee's efforts to increase SUD treatment options available to Medicare beneficiaries.

C. Committee Print 117-4. Improved Information in Provider Directories, Plan Definitions, and Crisis Services for Private Insurance Plans

Section 1. Provider Directory Improvements to Enhance Enrollee, Participant, and Beneficiary Access

LAC supports the Committee's proposal to require health pan directories to identify whether providers or facilities are accepting new patients and whether they are doing so via in-person, telehealth, or both types of appointments. This proposal will make important strides towards resolving issues with "ghost networks" and help families find providers more easily. We further encourage the Committee to:

- Require that such information be updated every 90 days, rather than "at least annually," by removing the timeframe in the parentheses, to be consistent with the existing verification timeline and to ensure that beneficiaries have more accurate information at the time when they are seeking MH and SUD care.
- Update information about whether providers are using telehealth, in-person, or both types of appointments for all providers, not just those who are accepting new patients.
- Make the information subject to public posting available by States, such as through state-specific portals, in addition to the Federal Government.

Section 2. Ensuring Mental Health and Substance Use Disorder Benefits are Defined Pursuant to External Benchmarks Based on Nationally Recognized Standards

LAC supports the Committee's proposal to establish a uniform definition of MH and SUD conditions, consistent with nationally recognized standards. In addition to defining these terms, we encourage the Committee to address the need for group and individual health plans and coverage to follow generally accepted standards of care for making medical necessity determinations on treatment for MH and SUD. One way to achieve this goal would be to require the Secretary to provide guidance – under paragraph (a)(7) of the Public Health Service Act, Internal Revenue Code, and Employee Retirement Income Security Act – on the generally accepted standards of care for MH and SUD treatment based on external evidence-based benchmarks of care. Those benchmarks would include the ASAM criteria for SUD treatment, LOCUS for MH treatment, and other evidence-based standards of care.

Section 3. Outreach and Report on Access to Mental Health and Substance Use Disorder Crisis Services Under Group Health Plans and Health Insurance Coverage

LAC supports the Committee's proposal to require the Secretaries of HHS, Labor, and the Treasury to initiate a joint public outreach campaign to inform individuals covered under group and individual health plans and coverage of the federal requirements relating to benefits for mental health and substance use disorder crisis services, including the availability of and the limitations on imposing additional financial requirements or treatment limitations on such

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benefits. We especially appreciate the joint focus of the report to Congress on coverage of both MH and SUD crisis services, the attention to barriers to crisis services, and the attention to unexpected billing issues.

D. Committee Print 117-5. Improved Information for Network Coverage and Plan Documents in Private Insurance Plans

Section 1. Requiring Disclosure of Percentage of In-Network Participation for Certain Provider Types

LAC supports the Committee's proposal to require group health plans and health insurance issuers to make available information about the number and percentage of in-network providers for behavioral health providers and facilities and SUD providers and facilities. We further encourage the Committee to clarify that telehealth providers be counted separately, to the extent that they are serving plan members in a specific service area, to ensure that such providers are appropriately counted but do not mask network and accessibility problems for individuals who need in-person or hybrid MH and SUD services.

Section 2. Improved Access to Group Health Plan and Health Insurance Coverage Summary of Benefits and Coverage Explanation

LAC supports the Committee's proposal to make summaries of benefits and coverage available to the Secretary and the public and to issue a report on the accessibility of such documents. As previously discussed, we encourage the Committee to make this information available on State websites and portals, as well as the Federal Government website.

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Thank you again for the opportunity to submit comments in support of the worker and family support and health legislation and for your leadership on these important issues. We look forward to working with you to continue to improve access to SUD and MH services for Medicare beneficiaries and consumers of private health insurance.

Sincerely,

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