September 6, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services,
P.O. Box 8016,
Baltimore, MD 21244-8016

Re: CMS-1770-P

Dear Administrator Brooks-LaSure,

On behalf of Children's Wisconsin (Children's), I appreciate the opportunity to comment on the Medicare Physician Fee Schedule proposed rule for calendar year 2023 (CMS-1770-P). Changes to the Medicare program often have a downstream effect on the Medicaid program, which is a critical source of health care coverage for children, as well as for private payers. We appreciate the opportunity to provide comments on how the proposed rule may have direct or indirect implications for child health, most specifically related to mental and behavioral health services.

Children's is the state's only independent health system dedicated solely to the health and well-being of kids. We serve children and families in every county across the state, with inpatient hospitals in Milwaukee and the Fox Valley and more than 30 primary, specialty and urgent care clinics. We care for every part of a child's health, from critical care to routine checkups, and focus on all aspects of pediatric well-being by providing a multitude of services and programs to support kids and families. At Children's, we believe caring for a child's developmental, mental and behavioral health is just as important as caring for their physical health. Our expertise on mental health runs wide and deep: we treat thousands of kids with mental and behavioral health challenges every year at our primary care and specialty clinics, through our foster care and adoptive services and in schools and communities throughout the state.

As reflected by the Surgeon General's recent Advisory and the declaration of a "national health emergency in child adolescent mental health" by leading pediatric health care organizations, including Children's Wisconsin, there is an urgent need to address the nation's youth mental health crisis. Prior to the pandemic, Wisconsin, like the rest of the country, was experiencing alarming rates of mental health hospitalizations, suicide rates and depression among children and adolescents. The pandemic has hit children's well-being hard and directly, exacerbating what was already a growing crisis. Our primary care offices and urgent care clinics continue to experience increases in the number and acuity of kids who present with primary and secondary mental and behavioral health complaints. And, reflecting what others are reporting across the country, since 2020, visits to Children's Emergency Department and Trauma Center (EDTC) for mental and behavioral health concerns have increased by 40 percent. Between 2019 and 2021, call volumes to our Mental and Behavioral Health (MBH) Access Center tripled.

Acknowledging the impact of the national kids' mental health crisis, we offer the following comments:

<u>"Incident To" Physician Services Regulation for Behavioral Health Services</u>
We support the proposed policy to allow auxiliary personnel, including licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs), to provide behavioral health services under

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Kids deserve the **best.**

general (rather than direct) supervision of a physician or non-physician practitioner (NPP). These auxiliary personnel play a critical role in providing behavioral health services and should be recognized accordingly. It is important to remove regulatory barriers so that these professionals are available to care for kids, particularly in collaboration with primary care providers. We agree that risks associated with this change would be minimal due to applicable state licensure requirements. We believe, and have found through our integrated care work across our health system, that access to these trained professionals is often the appropriate intervention for most kids. Importantly, we will not be able to address this crisis if we do not remove regulatory barriers to ensure that children have access to a diverse range of provider types – from navigators to therapists to psychiatrists – who can offer the appropriate intervention at the right time.

However, there may be additional barriers with "incident to" billing that hinder the delivery of mental and behavioral health services. For instance, when providing mental and behavioral health care, it is not uncommon to uncover new diagnoses during follow-up or subsequent care. Providing behavioral and mental health services is very different than following a care plan to take blood pressure, change a dressing or give an injection. Providers, such as LPCs and LMFTs, that are providing "incident to" services need to be able to address concerns identified during an encounter in a timely manner. In certain settings, such as when a behavioral health provider is integrated into a primary care practice, they may have more training or expertise to recognize and address mental and behavioral health issues that were not initially identified by the general provider. We believe that providing some additional flexibilities to support the identification of concerns and delivery of mental and behavioral health services under "incident to" may help better address patient needs, in addition to the proposed change from direct to general supervision.

<u>New Coding and Payment for General Behavioral Health Integration billed by Clinical Psychologists and Clinical Social Workers</u>

Children's support the creation of the new GBH1 code and efforts to support integration and coordination of developmental, behavioral and mental health care. As detailed in the proposed rule, we agree that clinical social workers and clinical psychologists can and, in many instances, should be serving as the primary practitioner that "integrates medical care and psychiatric expertise."

To ensure broader access to these behavioral health integration services, we recommend the Agency consider a wider range of initiating codes, beyond 90791 (psychiatric assessment code), in order to best meet the needs of children who would benefit from the GBH1 care management services. Specifically, we encourage CMS to consider adding the following initiating codes:

CPT code 96156: This code covers behaviors related to medical conditions which sometimes require ongoing intervention/therapy by a mental health provider. In a primary care setting, this code better supports mental health providers' collaborative work with a primary care provider to identify concerns and conditions and provide the appropriate follow-up to prevent escalation.

CPT code 90832: This code is often used in integrated primary care behavioral health models to focus in on an area of concern identified by the primary care provider. There are situations where it is more appropriate for the patient to receive a focused intervention for a specific concern in a 16-30 minute session; however, the patient would still benefit from subsequent care management services as described in GBH1. Allowing this initiating code will allow the provider the flexibility to provide services according to the patient's identified need and provide the appropriate care management services.

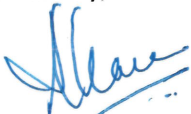
Conclusion

At Children's, we are working to ensure that mental health is addressed as part of every encounter and check-up. One way we are doing that is integrating Master's-prepared therapists to work alongside pediatricians in every Children's primary care office and urgent care location. This new integration effort will allow therapists and pediatricians to collaborate on-the-spot to address timely concerns such as anxiety, depression, trauma and suicidal ideation, as well as attention difficulties, sleep challenges and disruptive behaviors. Doing so will ensure kids have immediate access to expert help and ease the burden of the current process of lengthy waits for referrals and mental health appointments. In contrast to other care models, this is a prevention- and population health-based model. It's an integration model that is led by therapists and is more than just co-locating mental and behavioral health services, but actually "changing-the-check-up" to holistically care for a child's physical, developmental and behavioral needs in one visit.

Our current regulatory and payment systems—such as codes for services and which providers are authorized to bill—do not always reflect the way our system needs to change to improve access to care to confront this national crisis. For example, many mental health codes first require a psychiatric diagnosis, however often times there is care provided prior to any potential psychiatric diagnosis because the condition has not yet presented. Additionally, many codes are time-based and require in-depth history taking. In our integrated behavioral health model, the clinician is focusing in on one or two concerns with frequent and brief follow-ups. We look forward to sharing more details about our model of care and outcomes and encourage the Administration to continue to explore ways to update our payment and regulatory systems to support new innovative models of care.

In the meantime, we continue to support changes to current codes and regulations, such as those described above, that recognize the importance of the entire care continuum of providers and integrated coordinated care models to prevent, detect and treat kids' developmental, mental and behavioral health needs.

Sincerely,



Smriti Khare, MD
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Children's Wisconsin