JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

September 27, 2019

Submitted electronically to https://www.regulations.gov

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
P.O. Box 8016
Baltimore, Maryland 21244

**RE: CMS-1715-P (CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies)**

Justice in Aging appreciates the opportunity to provide a response to the proposed Physician Fee Schedule and Changes to Part B Payment Policies for 2020. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

Our comments are limited to the sections on Medicare coverage for opioid use disorder treatment (II.G) and enhancing information for patients under the Quality Payment Program (III.K.).

**Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs**

We support efforts to expand access to the full range of opioid use disorder (OUD) treatment services to all Medicare beneficiaries, including those dually eligible for Medicare and Medicaid. We appreciate that Congress has established a Part B benefit category for OUD treatment services furnished by an opioid treatment program (OTP), which will authorize Medicare to begin covering methadone for medication-assisted treatment (MAT) in outpatient settings.

In some instances, Medicare coverage may even open up treatment for dually eligible beneficiaries, allowing them to access OTPs and MAT which was not available to them before in their state Medicaid program. We are also hopeful that this opportunity will encourage more providers to become certified OTPs, which should increase access to methadone as MAT not only for Medicare beneficiaries, but also for individuals with Medicaid and other types of

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insurance. More generally, we encourage CMS to work with SAMHSA to increase access to OTPs especially in rural and frontier areas (noting that Wyoming does not have any OTPs and South Dakota only has one).[1]

CMS asks for comment on whether other Part B items and services should be covered under the definition of OUD treatment services. We agree with the proposal to allow certain services to be delivered via telecommunication subject to SAMHSA's data security and privacy guidance. We encourage CMS to add intake activities, such as a physical exam and preparing a treatment plan, and periodic assessments, and also ask CMS to consider including HIV and Hepatitis C screenings, because of the particular risk among people with OUD.

We strongly support the proposal to set the copayment at zero for OTP services. As CMS notes, this will minimize barriers for beneficiaries to access these vital services. Particularly for dual eligible beneficiaries, this will ensure the broadest provider access because providers will get the full Medicare payment. This will avoid access issues that dual eligibles and Qualified Medicare Beneficiaries (QMBs) face with other Part B services that have co-insurance requirements. CMS has documented that dual eligibles and QMBs find significant barriers to Part B services with co-insurance.[2] Frequently Medicare providers refuse to provide services to dual eligibles and QMBs because the providers are prohibited from collecting co-insurance or they illegally demand payment.[3]

We do have concerns about the transition of coverage for dually eligible beneficiaries who are already receiving MAT through Medicaid. In particular, we ask CMS to ensure there are measures in place to avoid any disruptions or delays in treatment. We know that duals often have difficulty navigating services such as durable medical equipment for which Medicare and Medicaid coverage overlaps but does not completely align. We urge CMS to work to avoid these same issues in the OUD context. For example, an individual who is receiving treatment through a Medicaid provider who is not a Medicare provider must be allowed to continue that treatment with the same provider. In addition, measures should be taken to ensure that dually eligible individuals who do not have access locally to a Medicare enrolled OTP are still able to immediately access any providers and treatment services available to them under Medicaid. Such measures could include an expedited process for receiving a Medicare denial; guidance to states on what OUD treatment services Medicare does and does not cover; and an up-to-date listing of Medicare enrolled OTPs in each state. We also know that dual eligibles are sometimes improperly denied coverage of transportation to Medicare covered services. Therefore, guidance should also remind states that they must cover transportation under the NEMT benefit to these new Medicare covered OUD services.

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[1] https://dpt2.samhsa.gov/treatment/

[2] CMS, Access to Care Issues among Qualified Medicare Beneficiaries, (July 2015), www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

[3] *Id.*

More generally, advocates who have helped dually eligible individuals access SUD services through Medicaid report that providers need both rigorous training and oversight to ensure that services are delivered in line with medical practice standards and that these services are coordinated with other ongoing treatment an individual is receiving. We believe that SAMHSA's accreditation requirements for OTPs address many of these concerns and urge CMS to take an active role in coordinating with SAMHSA to ensure ongoing and rigorous oversight of OTPs.

On the other hand, we also urge CMS to ensure support for the important values and approaches in the non-medical models for SUD services in both the new OUD benefit and existing covered services for OUD. Peer-to-peer support services and crisis management are elements of non-medical models have demonstrated therapeutic value.[4] It is important that payment policies fully support and in no way inhibit holistic support in SUD services, including peer support as well as housing-related assistance (such as housing locator services & case management related to maintaining housing stability), mobile crisis teams, and supported employment.

Finally, with respect to Medicare's large role in combatting the opioid crisis, we note that it is important for payment policy to support and ensure access to non-opioid pain treatment such as physical therapy.

**Enhancing Information for Patients under the Quality Payment Program**
We generally support focusing on and using more patient reported data measures. However, to make this data as useful and accurate as possible, we urge CMS to ensure it is collecting information in a way that adequately includes patients who have limited proficiency in English and those with disabilities. This requires, for example, translating questionnaires and creating them in accessible formats.

Thank you for the opportunity to submit comments. If you have any questions or would like to discuss our comments in more detail, please contact Natalie Kean, Senior Staff Attorney, at nkean@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Deputy Director

[4] SAMHSA, Value of Peers 2017, www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf.