

September 13, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P

RE: Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements (RIN 0938-AU42)

Howard Brown Health is the largest LGBTQ health center in the Midwest, serving more than 38,000 patients across twelve clinic locations in Chicago. It is through our many programs—including primary care, behavioral health, mental health services, HIV/STI prevention, elder services and community outreach initiatives—that Howard Brown fulfills its mission of eliminating health disparities and improving health outcomes experienced by LGBTQ individuals and residents of the Chicago area and beyond. As a Federally Qualified Health Center (FQHC), Howard Brown provides comprehensive, high quality and affordable care to all patients, regardless of ability to pay or insurance coverage.

Howard Brown appreciates the opportunity to comment on the CMS proposed rule— Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements. We support many of the provisions within the proposed rule, especially those that focus on advancing health equity for underserved populations. Additionally, we would like to share about how our experience providing services via telehealth has helped to expand access to care, especially for our LGBTQ and low-income patients.

Telehealth Flexibilities

We would first like to thank CMS for the flexibilities in telehealth coverage and reimbursement—such as making the patient’s home an originating site, enabling coverage of more services via telehealth, and allowing patients to use audio-only devices—that were extended during the pandemic. We strongly support the proposal by CMS to continue coverage of telehealth and audio-only services in RHCs and FQHCs, as well as the proposal to allow patients to receive audio-only mental health services in their homes on a permanent basis.

Like many other FQHCs, Howard Brown quickly shifted to providing services via telehealth at the start of last year to ensure that our patients could continue to receive critical physical and mental healthcare while staying safe during the pandemic. We found that telehealth has been an invaluable tool for expanding access to services, especially for people who were previously not engaged in care. For example, the ability to talk with providers from one's own home or another convenient location has made it much easier to access care for patients who lack access to transportation, patients with child-caring responsibilities, patients whose physical or psychological pain limited their access to care, and patients who are unable to take time off of work to travel to one of our clinic locations. The use of audio-only telehealth services in particular has proven to be critical for expanding access to services for older adults and people without access to stable internet.

This has been especially important for expanding access to mental and behavioral health services for our LGBTQ clients. Research consistently shows that there are stark disparities in mental health outcomes and access to care among LGBTQ people.¹ Overall, LGBTQ individuals are 2.5 times more likely to experience depression, anxiety, and substance use disorder compared to heterosexual individuals.² The Trevor Project reports that 39% of LGBTQ youth, including 54% of transgender and non-binary youth specifically, seriously considered attempting suicide in the past twelve months.³ Providing mental health services via telehealth has allowed people who lack access to LGBTQ-affirming care in their geographic area to access affirming care through Howard Brown without having to travel great distances. Telehealth may also be a better option for LGBTQ patients, especially transgender and non-binary patients, who are reluctant to travel to in-person appointments because of experiences with harassment and discrimination in public spaces.

We've found telehealth, including audio-only telehealth, to be an effective means for expanding access to physical and mental health services for our patients. For example, as a result of our transition to telehealth over the pandemic, we've noticed decreased burden for our patients living with HIV who have frequent appointments and labs, and an increase in gender affirmation service initiation from transgender and non-binary patients. In order to ensure that patients continue to have access to affirming and comprehensive telehealth services, we have the following recommendations:

- Audio-only coverage should also be expanded to include behavioral health services. Like psychotherapy, Health Behavior Assessment and Intervention (HBAI) services (codes 96156-96171) do not require patient visualization, making them suitable for telehealth visits, including audio-only, to patients in their homes.

¹ <https://doi.apa.org/fulltext/2020-41743-001.html>

² [file:///C:/Users/camillee/Downloads/Mental-Health-Facts-for-LGBTQ%20\(3\).pdf](file:///C:/Users/camillee/Downloads/Mental-Health-Facts-for-LGBTQ%20(3).pdf)

³ <https://www.thetrevorproject.org/survey-2019/?section=Introduction>

- Feedback sessions for psychological and neuropsychological testing evaluation (96130 – 96133) and the neurobehavioral status exam (96116, 96121) should also be available as audio-only services.
- An in-person visit is not needed to successfully provide mental and behavioral health services through telehealth, including audio-only. If CMS is forced to establish an interval for subsequent in-person visits for patients being treated through telehealth, the interval should be at least 12 months.
- All telehealth services, including audio-only, must be reimbursed at the same rate as if the service was furnished in-person. For Medicare this means reimbursing the service at the non-facility rate. Paying less for telehealth services will discourage their use by providers and threaten beneficiary access to needed services.

Health equity through inclusive data collection

We support the rule’s proposals to address disparities in healthcare access through stronger data collection efforts. We would especially urge for systemic and required collection of sexual orientation and gender identity (SOGI) data. As documented by the National Academies of Science, Engineering and Medicine and many other health researchers and providers, LGBTQ populations experience numerous disparities in health outcomes and healthcare access rooted in anti-LGBTQ stigma and systemic marginalization. While we do have scientific research documenting LGBTQ health disparities, the lack of consistent, reliable, population-based SOGI data makes it difficult to understand how generalizable study samples are to the greater LGBTQ community. Additionally, the lack of consistent population-based SOGI data also makes it difficult for policymakers, advocates, and public health professionals to develop, implement, and evaluate effective interventions for addressing LGBTQ health disparities.

Consistent collection of SOGI data throughout the nation would also be of great assistance to LGBTQ health centers like Howard Brown. Our physicians, other medical providers, and behavioral health specialists strive to deliver the best possible care to our patients. We operate robust community health programs that address key public health challenges, including HIV and sexually transmitted infection prevention and treatment, cancer screenings, smoking cessation counseling, drug use counseling, and mental health services. While we collect SOGI information on our own patients and clients, we need consistent, reliable data on our entire communities for benchmarking and to plan optimal community health interventions. For quality assurance and improvement (QA/QI) purposes, it is important to compare measures of our health centers’ patient health to the health of the larger population—and to health indicators for the specific communities we serve, including LGBTQ people. The lack of uniform, reliable, nationwide data on these populations to serve as a benchmark makes our QA/QI efforts more challenging. Similarly,

it is difficult to plan the best use of our limited resources for community health interventions without such data.

A common concern about SOGI data collection is that it is too intrusive and respondents will not want to answer the questions. However, this is not supported by research or the experiences of LGBTQ community health centers and other healthcare providers across the country. For example, a survey of 1,516 patients and 429 providers found that while approximately 80% of providers thought that patients would refuse to answer a sexual orientation question, only 10% of patients indicated that they would refuse to answer.⁴ Howard Brown has many years of experience in collecting SOGI data from patients and also provides technical assistance and education for other healthcare providers wanting to collect this information from patients. We've seen firsthand that the opportunity for patients to see their identities be affirmed and respected in a healthcare setting helps to build trust and increases the opportunity for meaningful, authentic healthcare interactions. Much research has been done to validate SOGI data measures for use in clinical settings and in surveys and ensure that the measures are understandable and acceptable to respondents.⁵

We thank CMS for the opportunity to provide comment. If you have any questions or feedback, please feel free to reach out to Tim Wang, Director of Policy and Advocacy, at TimothyW@howardbrown.org.

Sincerely,

David Ernesto Munar, President and CEO
Howard Brown Health

⁴ Haider A, Schneider E, Kodadek L, et al. (2017 June). "Emergency Department Query for PatientCentered Approaches to Sexual Orientation and Gender Identity: The EQUALITY Study." JAMA Intern. Med. 177(6): 819-828.

⁵ , Cahill S, Singal R, Grasso C, et al. 2014. Do ask, do tell: High levels of acceptability by patients of routine collection of sexual orientation and gender identity data in four diverse American community health centers. PLoS One, 9(9), available at <https://dash.harvard.edu/bitstream/handle/1/12987242/4157837.pdf;sequence=1>