Telemental Health: Benefits, Limitations, Payment Policy Recommendations

October 12, 2023

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Agenda

- Welcome and Introductions
- Tardive Dyskinesia and Telehealth
- Telemental Health Payment Policy
- **Mental Health Office Manager Practice Expense Survey**
- Closing Thoughts/Discussion

Neurocrine Biosciences Attendees

- Aaron Cohen, Vice President, Government Affairs and Public Policy
- Morgan Boname, Senior Director, Public Policy
- Andrew Parker, Director, Reimbursement Policy
- Shannon Belmont, Senior Manager, Public Policy
- Kimberly Brandt, Tarplin, Downs & Young, LLC, Consultant
- Jennifer Young, Tarplin, Downs & Young, LLC, Consultant

Tardive Dyskinesia and Telehealth

Tardive dyskinesia (TD) is a persistent, irreversible, and often debilitating drug-induced movement disorder that presents with involuntary movements of the jaw, face, mouth, torso, and extremities.[1-3]

- TD is associated with prolonged exposure to dopamine receptor blocking agents (DRBAs) such as antipsychotics (both first and second generation) and the GI agent metoclopramide.[4]
- Research suggests the overall prevalence of TD following prolonged treatment with antipsychotics is up to 30%.[5]
- More than half of TD patients experience meaningful emotional, social and psychological impacts, including job performance, low self-worth, and isolation.[6]

Diagnosis of drug-induced movement disorders like TD often requires an **in-person appointment**.

- Diagnosis of TD requires both a thorough patient history examination and careful visual assessment for involuntary, abnormal movements such as writhing, twisting, thrusting, or grimacing in the face, trunk, or extremities.
- Clinicians often want to examine the patient in-person to ensure an accurate diagnosis.[7,8]
- Telehealth limits the ability to prescribe and monitor medication, such as evaluating movement disorders and the ability to test muscle tone.[9,10]
- Clinical practice guidelines recommend that for patients living with schizophrenia taking antipsychotics, assessments for TD should occur at least every six months in high-risk patients and at least once every 12 months in other patients.[11]

1. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition.
2. Mental health medications. National Institute of Mental Health website. Updated October 2016.
3. Fahn S. Principles and Practice of Movement Disorders. 2nd ed. New York, New York: Saunders; 2011.
4. Metaclopramide, an Increasingly Recognized Cause of Tardive Dyskinesia (J Clin Pharmacol, 2008).
5. Carbon, M, et al. Tardive Dyskinesia Prevalence in the Period of Second-Generation Antipsychotic Use: A Meta-Analysis. J Clin Psychiatry. 2017;78(3):e264-e278.
6. https://www.takeontd.com/ Source: IQVIA's SMART Audit, Quarterly Data for Antipsychotic Class
7. Bera et al. 2023. *Neuropsychiatr. Dis. Treat.* Clinician Perceptions of the Negative Impact of Telehealth Services in the Management of Drug-Induced Movement Disorders and Opportunities for Quality Improvement: A 2021 Internet-Based Survey.
8. Can the AIMS Exam Be Conducted Via Telepsychiatry? (Psych Congress Network, Dec 2019)
9. Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders (SAMHSA, Jun 2021, p. 17).
10. Telemedicine in Movement Disorders: Leçons du COVID-19 (Movement Disorders, Nov 2020).
11. APA Practice Guideline for the Treatment of Patients with Schizophrenia, Third Edition (2020) (see Table 2, p. 26).

2024 PFS NPRM: Telehealth Payment Policy Proposals

- Effective January 1, 2024:
  1. reimburse for telehealth services provided to beneficiaries at originating sites at the lower, facility PFS rate (consistent with pre-PHE telehealth payment policy); and
  2. reimburse for telehealth services **provided to beneficiaries in their homes at the higher, non-facility PFS rate.**
- Telemental health services comprise most telehealth services permitted to be provided to beneficiaries in their homes; therefore, **this proposal is most impactful to telemental health services.**
- In the NPRM, CMS states that:
  - Non-facility rate payment for telemental health services **best reflects the practice expenses (PEs)** required to furnish these services.
  - Non-facility rate payment will **protect access to mental health services**.

Non-Facility-Rate Payment for Telemental Health Services May Compromise Quality

- Neurocrine **strongly supports** CMS's goal of **increasing access to/quality of** mental health services for Medicare beneficiaries.
- We believe, however, that non-facility-rate payment for telemental health services may **incentivize use of telehealth when clinically suboptimal**, due to generally lower practice expenses (PEs) in the telehealth setting.
- To ensure setting-of-care decisions are driven **by clinical, not financial, factors**, we urge CMS to reconsider its proposal to establish non-facility-rate payment for telemental health services.

CMS Behavioral Health Strategy

Example: Facility vs. Non-Facility PE RVUs and Impact to Payment for 99213†

	Work RVU	PE RVU	Malpractice Insurance RVU		Conversion Factor		Payment Rate
Facility Setting	1.30	0.55	0.10	✖	33.8872	=	$66.08
Non-Facility Setting		1.28					$90.82

†Low complexity, established patient office/outpatient visit E/M service

Mental Health Office Manager Practice Expense Survey

Study Objective

Neurocrine conducted a survey study in the US to determine the differences in PEs between mental health visits conducted in-person, via audio-video telehealth (A/V TH), and via audio-only telehealth (A/O TH).

Office managers (OMs) were interviewed live to identify PEs with maximum precision.

Clinician Type	Office Managers	N Clinicians Represented
Psychiatry	2	8
Neurology	4	19
Clinical Psychologist	2	2
Clinical Social Worker	3	18
Total	**11**	**47**

Methodology

- 45-minute interview capturing direct cost data from qualified respondents:
  - OMs of psychiatry, neurology†, clinical psychology, and clinical social work practices;
  - must have at least 10% of patients with Medicare as primary payer; and
  - must have detailed understanding of practice costs related to mental health visits
- Psychiatry and neurology OMs were asked to provide in-person, A/V TH, and A/O TH direct costs for **a typical mental-health-related medication management visit billed with E/M CPT 99213.**
- Clinical psychologist and clinical social worker OMs were asked to provide in-person, A/V TH, and A/O TH direct costs for **a typical 45-minute psychotherapy service billed with CPT 90834.**
- Interviews identified direct cost inputs across categories of labor, supplies, and equipment for a typical mental health service.
- **Direct costs were fed into a model designed to simulate CMS's PE relative value unit (RVU) methodology, to calculate total PE RVUs for the service.**

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†Neurologists may manage patients with mental health diagnoses who are prescribed mental-health medications, and therefore may provide *mental health services* per the definition used by CMS for purposes of telemental health payment policy.

Mental Health Office Manager Practice Expense Survey: Labor, Supply, and Equipment Costs

- Labor, supply, and equipment cost categories included in the discussion guide and model were based on:
  1. those currently reflected in the direct PE calculation for 99213 and 90834,†
  2. those reasonably considered to be related to mental health services (e.g., psychometrist), and
  3. those that might typically be considered indirect PEs, but could be considered direct PEs if incurred expressly for the provision of telehealth services (e.g., computers, tablets, webcams, etc.).
- Interviewees were provided open-ended "other" prompts, to ensure complete accounting of labor, supply, and equipment costs.
- **Interviewees described these costs for mental health services delivered in person, vs. A/V TH, vs. A/O TH.**

Direct Cost Inputs Included in Interview Discussion Guide

Labor Costs

- Registered Nurse
- Licensed Practice Nurse
- Medical/Technical Assistant
- Psychometrist
- Behavioral Health Care Manager
- Other

Supply Costs

- E/M Visit Tray/Pack/Kit
- Patient Worksheet
- Assessment/Monitoring Instruments (e.g. PHQ-9 Questionnaire)
- Surgical Mask
- N95 Mask
- Sanitizing Cloth
- Surface Disinfectant
- Other

Equipment Costs

- Computers
- Tablets
- Webcams
- Microphones
- Virtual Visit Software
- Internet Access
- IT Costs for Remote Access to EHRs
- Exam table
- Otoscope-ophthalmoscope
- Stand-on Scale
- Couch and Chairs
- Other

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†Per CY 2023 PFS Final Rule Direct PE Inputs, Updated 01/06/23, available at: https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1770-f

Mental Health Office Manager Practice Expense Survey: Total PE RVU Calculation

- Neurocrine developed a model designed to simulate CMS's current PE RVU methodology.†
- Direct cost inputs for labor, equipment, and supplies gleaned from each interview were fed into this model to estimate PE RVUs for a mental-health medication management visit (99213) and a 45-minute psychotherapy visit (90834).

PE Model Screenshot (Total PE RVU Calculation)
(For illustrative purposes; populated with inputs from a single interview)

CPT Code: 99213

Direct Costs - Telehealth Audio Visit

Category	Direct costs	RVUs
Labor (TeleHealth Audio)	$0.00	0.000
Medical Equipmen	$1.92	0.055
Medical Supplies	$0.00	0.000
TOTAL	$1.92	0.055

Indirect Costs - Telehealth Audio Visit

Work RVU	Direct PE RVU	Service level Indirect PE %	Service Level Direct PE %	Indirect Allocator	Indirect Adjustment	Indirect PE Adjustment	Indirect Practice Cost Index	Indirect PE RVU	Adjusted Indirect PE RVU
1.3	0.055	0.75	0.25	1.466	$0.39	0.573	1.1	0.631	0.741

TELEHEALTH AUDIO - TOTAL PE RVU: 0.796

Direct Costs - Telehealth Video Visit

Category	Adjusted costs / telehealth video visit	RVUs
Labor (TeleHealth Video)	$0.00	0.000
Medical Equipmen	$1.92	0.055
Medical Supplies	$0.00	0.000
TOTAL	$1.92	0.055

Indirect Costs - Telehealth Video Visit

Work RVU	Direct PE RVU	Service level indirect PE %	Service level direct PE %	Indirect Allocator	Indirect Adjustment	Indirect PE Adjustment	Indirect Practice Cost Index	Indirect PE RVU	Adjusted Indirect PE RVU
1.3	0.055	0.75	0.25	1.466	$0.39	0.573	1.1	0.631	0.741

TELEHEALTH VIDEO - TOTAL PE RVU: 0.796

Direct Costs - In-person Visit

Category	Adjusted costs / in-person visit	RVUs
Labor (In-person)	$0.00	0.000
Medical Equipmen	$3.18	0.092
Medical Supplies	$3.43	0.099
TOTAL	$6.60	0.191

Indirect Costs - In-person Visit

Work RVU	Direct PE RVU	Service level indirect PE %	Service level direct PE %	Indirect Allocator	Indirect Adjustment	Indirect PE Adjustment	Indirect Practice Cost Index	Indirect PE RVU	Adjusted Indirect PE RVU
1.3	0.191	0.75	0.25	1.872	$0.39	0.732	1.1	0.805	0.946

IN-PERSON - TOTAL PE RVU: 1.137

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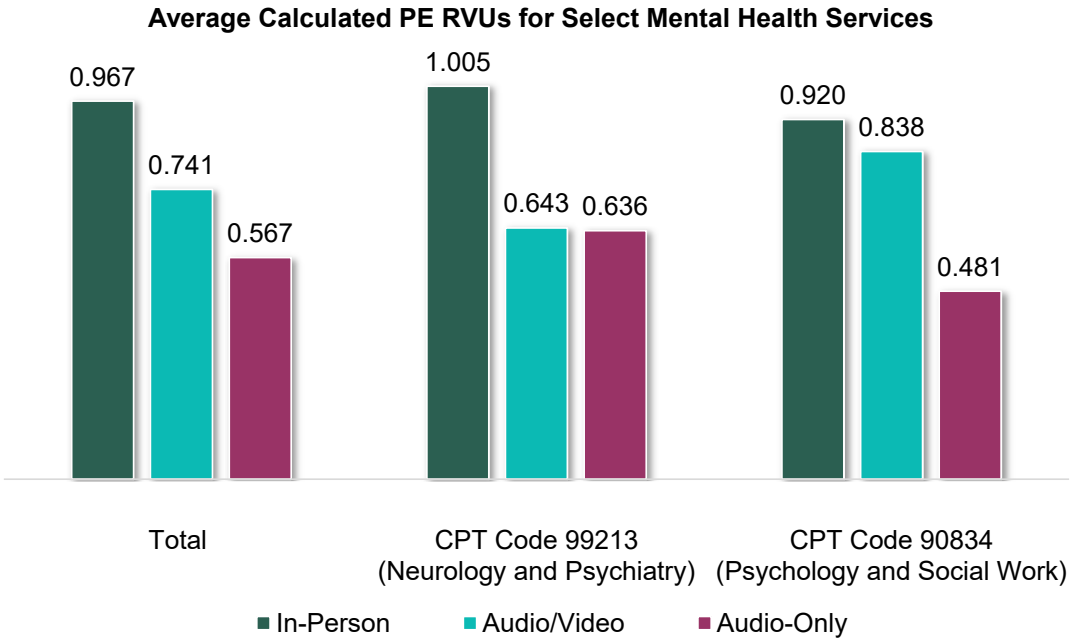
†Modeled after process described in CY 2023 PFS Final Rule Calculation of PE RVUs Under Methodology for Selected Codes, available at: https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1770-f

Mental Health Office Manager Practice Expense Survey: Findings and Recommendation

- Overall, in-person PE RVUs are higher than A/V TH PEs, expenses, which are in turn greater than A/O TH PEs.
  - The difference between in-person and A/V TH is greater for mental-health medication management visits (99213), compared to psychotherapy services (90834).
- This analysis supports the hypothesis non-facility rate payment for certain telemental health services **may distort incentives to encourage telehealth when clinically suboptimal.**



We encourage CMS to consider delaying implementation of final payment policy for telemental health services. We believe additional study of the relative resource costs of telemental health services is required to ensure this policy improves access *and* quality of mental health services received by beneficiaries.

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Note: One neurology practice surveyed does not conduct video visits. Another neurology practice does not conduct phone visits. One clinical social work practice also does not conduct phone visits.

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Closing Thoughts/ Discussion

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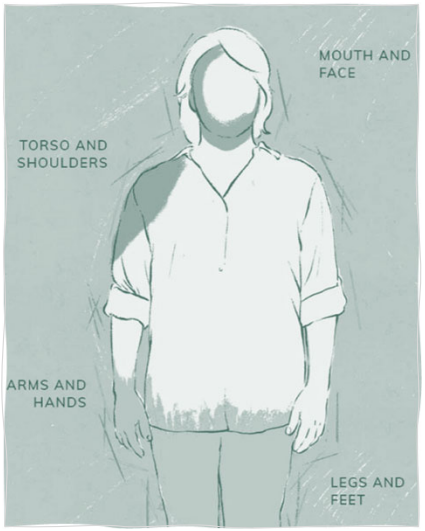
Appendix

What is Tardive Dyskinesia?

- Tardive dyskinesia (TD) is a persistent, irreversible, and often debilitating drug-induced movement disorder that presents with involuntary movements of the jaw, face, mouth, torso, and extremities[1-3]
- TD is associated with prolonged exposure to dopamine receptor blocking agents (DRBAs) such as antipsychotics (both first and second generation) and the GI agent metoclopramide[4]
- Research suggests the overall prevalence of TD following prolonged treatment with antipsychotics is up to 30%[5]
- More than half of TD patients experience meaningful emotional, social and psychological impacts, including job performance, low self-worth, and isolation[6]



Although it's not known why some patients develop TD, risk factors include many criteria relevant to Medicare and Medicaid patients

- ✓ Antipsychotic treatment for a few months or longer[7-8]
- ✓ Having a mood disorder, such as depression or bipolar disorder[9]
- ✓ Older age (55+)[10]
- ✓ Substance abuse[11]
- ✓ Post-menopausal women[12]
- ✓ African race[13]

1. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition.
2. Mental health medications. National Institute of Mental Health website. Updated October 2016.
3. Fahn S. Principles and Practice of Movement Disorders. 2nd ed. New York, New York: Saunders; 2011.
4. Metaclopramide, an Increasingly Recognized Cause of Tardive Dyskinesia (J Clin Pharmacol, 2008).
5. Carbon, M, et al. Tardive Dyskinesia Prevalence in the Period of Second-Generation Antipsychotic Use: A Meta-Analysis. J Clin Psychiatry. 2017;78(3):e264-e278.
6. https://www.takeontd.com/ Source: IQVIA's SMART Audit, Quarterly Data for Antipsychotic Class
7. Predicting the long-term risk of tardive dyskinesia in outpatients maintained on neuroleptic medications (J Clin Psychiatry, 1993).
8. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. (American Psychiatric Society, 2013:712)
9. Prospective study of tardive dyskinesia in the elderly: rates and risk factors (Am J Psychiatry, 1998).
10. Clinical correlates of tardive dyskinesia in schizophrenia: baseline data from the CATIE schizophrenia trial (Schizo Res, 2005).
11. Interaction of sex, age, and neuroleptic dose (Compr Psychiatry, 1983).
12. APA Practice Guideline for the Treatment of Patients with Schizophrenia, Third Edition (2020).

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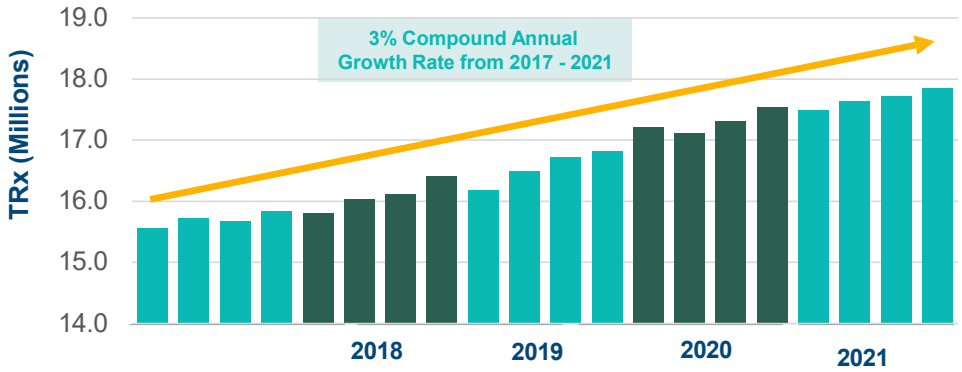
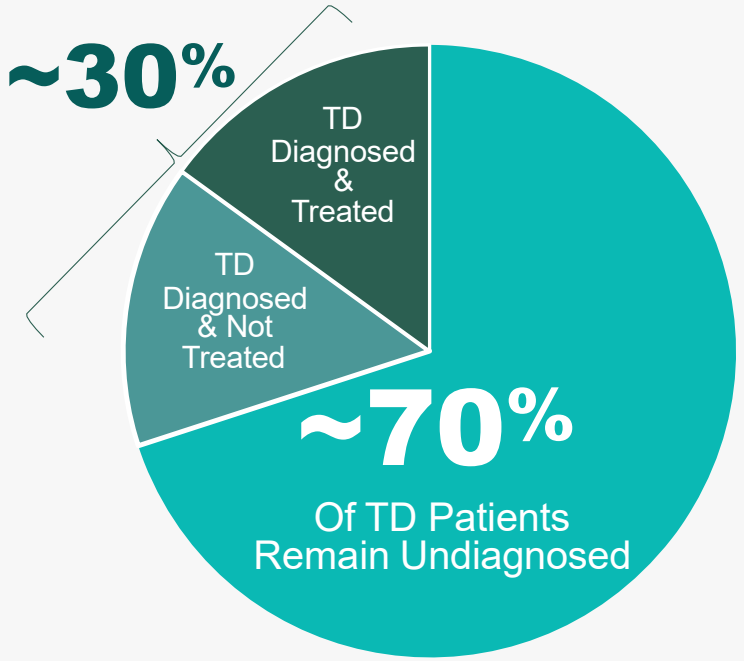
Vast Majority of Tardive Dyskinesia Patients Remain Undiagnosed

Increasing Antipsychotic Prescriptions (U.S.)



Approximately 30% of TD Patients Diagnosed

Only half of diagnosed patients receive treatment for TD with a VMAT2 inhibitor



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Source: Neurocrine Biosciences Quarterly Data
VMAT2 = Vesicular Monoamine Transporter 2

Balancing Cost, Access, and Quality in Telemental Health Policy

Medicare policy can help telemental health realize its promise of expanding access to care, while also ensuring that patients receive high quality care in a way that manages program costs

Telemental Health Reimbursement Rates

1. Return to reimbursing telemental health services at the PFS facility rate, consistent with pre-PHE payment policy.
2. Determine differences in practice expenses depending on setting of care.
3. Conduct additional study to determine optimal long-term reimbursement policy for audio-only telemental health services.

Audio-Only Telemental Health

1. Consider stricter guardrails for audio-only telemental health coverage, including limiting to situations in which beneficiaries have no other option to receive care, and limiting to lower-acuity patients/lower-complexity services.
2. Closely monitor for fraud, waste, and abuse of the audio-only telemental health coverage policy, once in effect post-PHE.

Telemental Health Quality and Safety

1. Retain in-person visit requirements for telemental health services. Consider shorter interval for beneficiaries living with serious mental illness and/or at risk of movement disorders.