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September 3, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1809-P

Submitted via regulations.gov

RE: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities (CMS-1809-P)

On behalf of the Community Behavioral Health Association of Maryland (CBH), thank you for the opportunity to comment on the Centers for Medicare & Medicaid (CMS) proposed rule addressing changes to the calendar year (CY) 2025 Payment Policies under the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment System and other proposed policy changes ("the Proposed Rule"), at 89 *Federal Register* ("FR") 59186 (July 22, 2024). CBH is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 89 members serve the majority of those accessing care through the public behavioral health system. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

Overall, CBH is grateful for CMS' continued work to implement partial hospitalization program (PHP) and intensive outpatient program (IOP) benefits for mental health and substance use care, thereby strengthening the continuum of services for Medicare beneficiaries. However, we wish to share that we are concerned barriers exist that impede community mental health organizations' ability to offer IOP and PHP services under Medicare. Over the years, the number of Community Mental Health Centers (CMHCs) has appeared to decrease. For example, one study found that between 2014-2017, the number of CMHCs decreased nationally by 14 percent and in SAMHSA's 2023 National Directory of Mental Health Treatment Facilities, there appear to be slightly over 1,700 CMHCs currently.[1, 2] We fear that provider organizations that may be equipped to provide PHP and IOP services, may not do so because of the overly burdensome Conditions of Participation (CoPs) that apply to all individuals being

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7183673/
[2] https://www.samhsa.gov/data/report/2023-national-directory-of-mental-health-treatment-facilities

served at the organization, regardless of whether the professional services are paid under a different statutory benefit category. Discussed later below, we note that National Council for Mental Wellbeing's Medical Director Institute issued a brief earlier this year highlighting issues regarding parity and evidence-based practices in the current CoPs and it suggests updates to improve beneficiary access to services.[3] We urge CMS to further examine availability of this benefit at organizations and potential barriers to furnishing programs to further improve access for beneficiaries and look to solutions that clarify and smooth billing processes and reduce administrative burden for provider organizations.

Below, we have associated our comments with the numbered topic section used in the Proposed Rule, and we have placed our comments in the order in which topics appear.

<u>VIII. Payment for Partial Hospitalization and Intensive Outpatient Services</u>

B. Coding and Billing for PHP and IOP Services Under the OPPS

For CY 2025, CMS is not proposing to add any new services not described at §§ 410.43(a)(4) or 410.44(a)(4) to the list of PHP and IOP services.

Generally, as with CY 2024, CBH is supportive of CMS' approach to adding and maintaining IOP and PHP services under these benefits. As we noted last year, we continue to support evaluation and addition of new codes for payment of PHP or IOP through subregulatory guidance and we further urge CMS to comprehensively review this question after more data is available to consider whether there are some added services that may be particularly appropriate for either PHP or IOP, but not both.

Furthermore, CBH was grateful to see caregiver and training services and Principal Illness Navigation (PIN) services recognized as PHP and IOP services as discussed in the CY 2024 OPPS final rule (88 FR 81823-81825). However, as raised last year, we urge CMS to reconsider its position and allow the provision of PIN and caregiver-related services to qualify in determining the number of services furnished per day to determine which ambulatory payment classification (APC) payment the provider is entitled that would have meaningfully value for the services rendered. CMS could then reconsider cost and claims data after several years of experience to determine if the addition of the service resulted in changes warranting adjustments to the rates. Also as discussed in the CY 2024 final rule (88 FR 81825), PIN codes were adopted that describe the set of services that peer support specialists provide. CBH strongly supports the inclusion of peer services in PHP and IOP services. Peer services can play a vital role in an individual's care and recovery.[4] Specifically, one study showed that peer services as a part of care was correlated with decreased patient hospitalization and emergency room visits.[5] Thus, we further urge CMS to count such services in the evaluation of the 3-service or 4-services day payment for PHP or IOP. Moreover, adequately valuing PIN services and discharge support that lends to a successful transition is particularly important in PHP and IOP. These programs form a spectrum of care and targeted support for "stepping up" or "stepping down" from one level of care to the other is crucial and

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[3] https://www.thenationalcouncil.org/wp-content/uploads/2024/07/Proposed-MDI-TP-position-statement_7.22.24-FOR-WEB.pdf

[4] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf

[5] https://www.sciencedirect.com/science/article/pii/S0740547220305055

requires effort to ensure continuity of care is in place within the community for the individual. Specifically regarding discharge, CMHCs are already required in their CoPs to address discharge planning in the comprehensive assessment (42 CFR Part 485 Subpart J) and ensuring this work is adequately valued will help strengthen successful transitions that promote positive health outcomes for individuals.

C. Proposed CY 2025 Payment Rates for PHP and IOP

CMS is proposing to maintain the current rate structure for PHP and IOP. For CY 2025, CMS is proposing to use the latest available cost information, from cost reports beginning three fiscal years prior to the year that is the subject of the rulemaking, and CY 2023 OPPS claims to update the payment rates for the four PHP APCs and the four IOP APCs finalized in the CY 2024 OPPS/ASC final rule. In accordance with the methodology finalized in the CY 2024 OPPS/ASC final rule, CMS proposes to base the payment rate for each PHP APC on the geometric mean per diem cost for days with 3 services and 4 or more services, calculated separately for CMHCs and hospital outpatient departments. Lastly, CMS proposes that if more recent data subsequently become available after the publication of this proposed rule, CMS would use such updated data, if appropriate, to determine the CY 2025 payment rates for the four PHP APCs and the four IOP APCs finalized in the CY 2024 OPPS/ASC final rule. For beneficiaries in a PHP or IOP, CMS proposes to apply the four-service payment rate (that is, payment for PHP APCs 5854 for CMHCs and 5864 for hospitals, and IOP APCs 5852 for CMHCs and 5862 for hospitals) for days with 4 or more services. For days with three or fewer services, CMS proposes to apply the three-service payment rate (that is, payment for PHP APCs 5853 for CMHCs and 5863 for hospitals, and IOP APCs 5851 for CMHCs and 5861 for hospitals), which is consistent with the policy CMS established in the CY 2024 OPPS/ASC final rule. Table 68 of the Proposed Rule demonstrates the APCs and calculated geometric mean per diem costs for the CY 2025 OPPS/ASC proposed rule (89 FR 59385).

As discussed in our CY 2024 comment, generally, CBH supports CMS' approach to a two-tiered structure for payment under the OPD PPS for PHP/IOP, according to the intensity of the service day. However, we continue to disagree with CMS' use of separate PPS rates for (i.e., designate separate APC codes with different values for) services provided by CMHCs, than for the same services provided by Hospital Outpatient Departments (OPDs), FQHCs, or RHCs. We are concerned this current policy creates arbitrary incentives toward the provision of PHP and IOP services in settings other than CMHCs. A single site-neutral rate for PHP and IOP would help make these services more available in community-based settings and provide for an initial period for IOP cost/claims experience to develop (potentially with a wider array of enrolled CMHC providers). CMS could then consider that cost and claims experience in a future year in designing refinements to the payment methodology. Furthermore, in the CY 2025 Physician Fee Schedule proposed rule's discussion on IOP in FQHCs and RHCs, CMS notes that it believes that parity should be provided for IOP services across various settings with site neutral payments while continuing to monitor access to these services (89 FR 61793). CBH strongly urges application of this belief to apply to payments to CMHCs as well.

D. Proposed Outlier Policy for CMHCs

For CY 2025, CMS proposes to maintain the calculations of the CMHC outlier percentage, cutoff point and percentage payment amount, outlier reconciliation, outlier payment cap, and fixed dollar threshold according to previously established policies to include PHP and IOP services.

As noted above, CBH continues to urge CMS to use site-neutral payment rates for all providers of PHP and IOP services. In taking a site-neutral approach, the use of a distinct methodology to trim CMHC outlier costs and claims could be reevaluated as an outlier-trimming procedure would likely have a negligible effect on payment rates in this case, as CMHCs form a small portion of the overall cost and claims experience CMS used in developing the averages set out in Table 46 in the CY 2024 OPPS proposed rule (88 FR 49711). As noted last year, we suggest that the dramatic variation in CMHC costs may result in part from the fact that so few facilities are enrolled in Medicare as CMHCs. Once CMS has additional years of cost and claims data to evaluate for purposes of PHP and IOP rate-setting, CMS will be well-equipped to take into account any trends in CMHC PHP and IOP claims and costs and make any corresponding decisions regarding differences in payment rates between CMHCs and OPDs for PHP and IOP services.

X. Nonrecurring Policy Changes

A. Remote Services

2. Periodic In-Person Visits for Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in Their Homes

Section 4113(d) of the CAA, 2023, extended the delay in implementing the in-person visit requirements until January 1, 2025, for both professionals billing for mental health services via Medicare telehealth and for RHCs/FQHCs furnishing remote mental health visits. In the CY 2024 OPPS CMS reiterated that CMS believes it is important to maintain consistent requirements for these policies across payment systems; therefore, CMS finalized delaying the in-person visit requirements for mental health services furnished remotely by hospital staff to beneficiaries in their homes until January 1, 2025. As such, these in-person visit requirements are currently set to take effect for services furnished on or after January 1, 2025 (88 FR 81874). However, to the extent that these in-person visit requirements are delayed in the future for professionals billing for mental health services via Medicare telehealth, CMS anticipates that they would align the requirements for mental health services furnished remotely to beneficiaries in their homes through communications technology with mental health services furnished via Medicare telehealth in future rulemaking.

CBH supports policies that promote access to quality mental health and substance use services, avoid gaps in care, and empower client-provider decision-making so that the right modality of care can be used to meet the individual's needs. **[Org name or shorthand if used]** recognizes the benefits telehealth can bring in regard to access and ameliorating mobility challenges a beneficiary may experience. And simultaneously we also recognize the critically important opportunity for beneficiaries to receive stronger interpersonal communication benefits that can come with in-person interactions; something that literature shows may be particularly true for older adults and their wellbeing.[6,7] We affirm support for consistency across telehealth billing requirements for professionals furnishing mental health services remotely in CMS' rulemaking to ensure clarity and consistency for providers and beneficiaries, and we strongly urge CMS to provide additional support and guidance prior to expiration of telehealth

[6] https://journals.sagepub.com/doi/full/10.1177/10748407211031980

[7] https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.13667

extensions to providers in making any transition to in-person requirements for serving Medicare beneficiaries in order to mitigate risk for gaps in care.

3. Proposed HOPD Payment for Telemedicine Evaluation and Management Services

The CPT Editorial Panel created 17 new codes describing audio/video and audio-only telemedicine E/M services. Further discussion of these 17 new codes and CMS' related proposals are addressed in section II.E.4.18 of the CY 2025 Physician Fee Schedule (PFS) proposed rule (89 FR 61650). Given the similarities between the new telemedicine E/M code set and the office/outpatient E/M code set, CMS believes that the telemedicine E/M codes fall within the scope of the hospital outpatient clinic visit policy because the predecessor codes (the office/outpatient E/M code set) would be reported by hospitals using HCPCS code G0463. Under the hospital outpatient clinic visit policy, the CPT codes describing office/outpatient E/M visits are not recognized under OPPS and instead hospitals report HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) when billing for the facility costs associated with an outpatient E/M visit. Therefore, CMS proposes not to recognize the telemedicine E/M code set under OPPS. CMS is, however, seeking comment on the hospital resources associated with the telemedicine E/M services, particularly any resource costs that would not be included in the payment for HCPCS code G0463. CMS is also seeking comment, should CMS finalize separate payment for these telemedicine E/M codes under the PFS, on the resource costs that would be associated with these services for hospitals and whether CMS should develop separate coding to describe the resource costs associated with a telemedicine E/M service.

CBH believes that generally furnishing telehealth for behavioral healthcare services would not incur associated costs that would differ greatly between hospitals and outpatient clinics. In consideration of rendering such telehealth services, we are concerned with separating levels in cost and wish to raise the importance of ensuring access to all different modalities as an option for the patient's care that best and most appropriately meets their needs.

XVIII. Medicaid Clinic Services Four Walls Exceptions

CMS is proposing to add three exceptions to the four walls requirement at § 440.90, for the reasons set forth in section XVIII.B of this proposed rule (89 FR 59477). In sum, CMS proposes to 1.) add an exception for clinic services furnished by IHS/Tribal clinics, 2.) add an exception for clinic services furnished by a clinic that is primarily organized for the care and treatment of outpatients with behavioral health disorders, including mental health and substance-use disorders, and 3.) add an exception for clinic services furnished by a clinic located in a rural area (and that is not an RHC, which could already provide services covered under a separate Medicaid benefit). CMS proposes to make the exception for clinic services furnished by IHS/Tribal clinics a mandatory component of the clinic benefit and to make the exceptions for clinic services furnished by behavioral health clinics and clinics located in rural areas optional for States. Additionally, CMS proposes to include language in this exception specifying that services subject to the exception would have to be furnished under the direction of a physician.

CBH strongly supports CMS' proposal to add the three exceptions to the four walls requirement at § 440.90. Overall, the current four walls requirement has been an issue raised by our members who have shared the challenges this requirement can create for the workforce and beneficiary access to care. We agree with CMS that by authorizing additional clinic services to be furnished outside of the four walls, the proposed exceptions would be expected to help improve access to care. Furthermore, CBH agrees with CMS that because the proposal would authorize payment at the generally higher facility-based clinic services payment rates for the excepted services, it would help to incentivize providers to furnish these services, and thereby meet beneficiaries where they are located and help to ensure access to necessary and often lifesaving care. This underscores the importance of adequate valuation of mental health and substance use services in improving access to care for beneficiaries. In a 2022 report, the Government Accountability Office (GAO) cited low reimbursement rates for mental health services as a contributing factor to service access challenges, and as CMS has noted in previous rulemaking, they believe there has been systemic undervaluation for work for behavioral health services (88 FR 52320).[8] Finally, we also greatly appreciate and support CMS' attention aiming to mitigate operational burden under this proposal.

Specifically with regard to CMS' proposal to add a new paragraph (d) to § 440.90 to authorize an exception to the four walls requirement for clinic services provided outside the four walls by personnel of behavioral health clinics, CBH supports the proposal to include behavioral clinic types that are recognized nationally, such as Community Mental Health Centers, and other behavioral health clinics organized in a state, inclusive of organizations that are nationally accredited and state licensed. Given our earlier discussion on the decreased number of CMHCs, we believe this proposal is responsive to the variety of entity types that can meaningfully provide such services and improve beneficiary access. Overall, CBH believes that making this exception will allow states to improve access to evidence-based models of care that reach beneficiaries outside the four walls of the clinic, such as Assertive Community Treatment (ACT),[9] wraparound services,[10] supportive housing and supported employment,[11, 12] psychosocial rehabilitation outside the clinic,[13] and mobile crisis teams.[14] Moreover, we urge CMS to make this exception mandatory for behavioral health clinics. Doing so would make providing such care more accessible for beneficiaries in need across our country, help to strengthen states' workforces, and more effectively enable providers to meet clients in need where they are.

Finally, CBH thanks CMS for their explicit clarification that the Consolidated Appropriations Act, 2024, Division G, Title I, Section 209 (P.L. 118-42) amended section 1905 of the Act to establish a certified community behavioral health clinic (CCBHC) services benefit effective March 9, 2024; and

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[8] https://www.gao.gov/assets/gao-22-104597.pdf
[9] https://store.samhsa.gov/sites/default/files/pep23-06-05-003.pdf at p. II.
[10] https://www.samhsa.gov/sites/default/files/grants/pdf/sm-15-002_0.pdf at p. 58.
[11] https://store.samhsa.gov/sites/default/files/englishbrochure-psh.pdf
[12] https://store.samhsa.gov/sites/default/files/sma08-4364-buildingyourprogram.pdf at p. 3.
[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7114046/
[14] https://dphhs.mt.gov/assets/BHDD/CrisisResponse/MobileCrisisTipSheet.pdf

that CCBHC services benefit is distinct from the clinic services benefit and there is no four walls requirement for the CCBHC services benefit under Federal Medicaid law.

XIX. Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process

The CMS Interoperability and Prior Authorization final rule (89 FR 8758) requires impacted payers to send prior authorization decisions as expeditiously as the enrollee's health condition requires or as the beneficiary's health condition requires but no later than 72 hours for expedited requests and seven calendar days for standard (that is, non-urgent) requests. In this Proposed Rule, CMS is still considering the impact of aligning their expedited review decision timeframe with the expedited review decision timeframe in the CMS Interoperability and Prior Authorization final rule because, depending on when the expedited request is submitted, it may take longer for OPD provider to receive a decision using the 72-hour timeframe than our current expedited timeframe of 2-business days. CMS notes that the goal of changing the standard review timeframe is not only to align the timeframe across the prior authorization programs but also to reduce the time beneficiaries wait to access the care they need. Since changing the expedited review decision timeframe from 2-business days to 72 hours would not reduce beneficiaries' wait time in all circumstances, CMS is not proposing to conform that timeframe with the one in the CMS Interoperability and Prior Authorization final rule at this time, but CMS may address this issue in future rulemaking.

With regard to this discussion, CBH wishes to uplift the recently issued position paper from National Council for Mental Wellbeing's Medical Director Institute on documentation requirements for comprehensive treatment plans.[15] Prior authorization requirements for mental health and substance use services that include presenting a comprehensive treatment plan for services authorized can be more restrictive, lengthy, and complex compared to briefer assessment and planning requirements for medical-surgical healthcare services. Additionally, the paper highlights issues with parity and evidence-based practices in the current CoPs for psychiatric hospitals and Medicare CMHCs and suggests updated revisions that would help to improve beneficiary access to services.

XX. Provisions Related to Medicaid and the Children's Health Insurance Program (CHIP)

A. Continuous Eligibility in Medicaid and CHIP (42 CFR 435.926 and 457.342)

CMS is proposing to amend existing regulations to conform to the continuous eligibility (CE) requirements imposed by the CAA, 2023. Specifically, CMS proposes to specify that a state must

[15] https://www.thenationalcouncil.org/wp-content/uploads/2024/07/Proposed-MDI-TP-position-statement_7.22.24-FOR-WEB.pdf

provide CE for the specified 12-month period, to remove the option to limit CE to an age younger than 19, and to revise § 435.926(c)(1) to remove the option to limit CE to a period of time of less than 12 months. Finally, CMS proposes to revise § 435.926(d)(1) to remove the option of ending a CE period for a person when they reach the state-specified maximum age, as now all States must provide CE to children until they reach age 19.

CBH generally supports CMS' proposal for continuous eligibility in Medicaid and CHIP as aligned with statutory changes provided by the CAA, 2023. CMS notes that children who have continuous health insurance throughout the year are more likely to have better health outcomes.[16,17,18] Uninterrupted services for youth is particularly vital given the mental health and substance use challenges young people across our nation continue to face.[19]

XXIII. Individuals Currently or Formerly in the Custody of Penal Authorities

A. Medicare FFS No Legal Obligation To Pay Payment Exclusion and Incarceration (Revisions to 42 CFR 411.4)

Under the "no legal obligation to pay" payment exclusion and Medicare regulations, Medicare is prohibited from paying for items or services for individuals who are in custody of penal authorities. For CY 2025, CMS is proposing to bolster Medicare access by narrowing this definition of "custody" in § 411.4(b) to no longer include individuals who are under supervised released or required to live under home detention, and proposes to strike the phrase "or confined completely or partially in any way under a penal statute or rule." CMS notes that if finalized, this modification would remove the presumption that Medicare is prohibited to pay for health care items or services for this population, thereby aiming to facilitate better access to care and payment. CMS also proposes to redesignate the special conditions that are specified in §§ 411.4(b)(1) and 411.4(b)(2) as §§ 411.4(b)(1)(i) through 411.4(b)(1)(iii). Under the proposal, the rebuttable presumption in § 411.4(b)(1) would apply to all items or services furnished to individuals in custody of penal authorities, regardless of who provides the items or services. CMS is seeking comments on whether the scope of the rebuttable presumption in proposed § 411.4.(b)(1) should be limited to items or services furnished by the penal authority or by a third party with which the penal authority has arranged to provide the items or services. Were CMS to limit the scope of the rebuttable presumption in this way, the rebuttable presumption in proposed § 411.4(b)(1) *would not* apply to items or services furnished to individuals in custody of penal authorities by third parties *who do not* have an arrangement or

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[16] https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html
[17] https://pubmed.ncbi.nlm.nih.gov/34525877/
[18] https://aspe.hhs.gov/sites/default/files/documents/5b52fb410eb22517d4fc1bc4cac834bd/aspe-childrens-continuous-eligibility.pdf
[19] https://www.kff.org/mental-health/issue-brief/recent-trends-in-mental-health-and-substance-use-concerns-among-adolescents/

contract with the penal authority to provide the items or services. CMS is also seeking comments on whether individuals in custody of penal authorities are permitted to arrange for their own health care with third parties who do not have an agreement with the penal authority to provide the items or services. Additionally, CMS also notes that nothing in the proposed modification of the special condition at § 411.4(b) would affect the scope of the general rule at § 411.4(a). Thus, if an individual on bail, parole, probation, or home detention has no legal obligation to pay for a health care item or service, the general rule at § 411.4(a) would continue to prohibit Medicare from paying for such a service, regardless of the scope of the description of "custody" in § 411.4(b)(3). For example, if a State or local government requires substance use disorder counseling as a condition of parole, and the State or local government does not charge all parolees for such services, then the parolee has no legal obligation to pay for such service under § 411.4(a); therefore, Medicare is prohibited under § 411.4(a) from paying for the service.

CBH generally affirms support for the intention of this proposal to improve Medicare coverage for individuals in this population. A person is at the highest risk for an overdose during the first two weeks following release from incarceration and recently released individuals are roughly 12.7 times more likely than the general population to die of a drug overdose during this time.[20] Equipping individuals with timely access to substance use, mental health, and other health-related services before release will facilitate the transition to care that is necessary to mitigate risk of recidivism and to prevent death and other avoidable harms. However, if this proposal is finalized, ensuring that beneficiaries who are eligible for coverage are able to successfully enroll with no gaps in coverage is of the utmost importance. Because there is a lag when Social Security benefits are paid after release from incarceration,[21] it is possible that someone who is on supervised release or home detention and in need of critical mental health and/or substance use care would be obligated to pay for such services under this proposal but may not have coverage or ability to pay, thus hampering access to lifesaving services at a critical and vulnerable time. While related to Medicaid coverage but raised here relatedly for consideration, CBH believes CMS' effort at hand underscores the importance of Congress passing two critical, bipartisan pieces of federal legislation, the Due Process Continuity of Care Act (H.R.3074/S.971) which would permit Medicaid payment for medical services furnished to individuals held in custody prior to adjudication (i.e., having not been tried or convicted of a crime), and the Reentry Act of 2023 (H.R.2400/S.1165) which would allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding the individual's release. For dual-eligible beneficiaries, because Medicaid is the payer of last resort and challenges exist with gaining Medicaid coverage after release from incarceration, ensuring people who are eligible are enrolled in Medicare is of the utmost importance. Overall, aligning the definition of custody under Medicare regulations with post-incarceration coverage policies in the Marketplace and Medicaid will help to strengthen access to services during a time where access to care is particularly essential.

[20] https://healthandjusticejournal.biomedcentral.com/articles/10.1186/s40352-020-00113-7
[21] https://www.cms.gov/training-education/look-up-topics/special-populations/incarcerated-medicare-beneficiaries

Additionally, as noted in our comments on the CY 2025 PFS, we find that Medicare does not cover the full array of CCBHC services. If an individual in this circumstance is only enrolled in Medicare, we are concerned they may face coverage barriers for critically needed services that Medicaid would otherwise pay for. This underscores the importance of establishing a definition for CCBHCs under Medicare statute and allowing Medicare to cover and pay for the full range of services under CCBHCs.

Regarding CMS' discussion on limiting the scope of the rebuttable presumption in proposed § 411.4.(b)(1) to items or services furnished by the penal authority or by a third party with which the penal authority has arranged to provide the items or services, CBH recommends not limiting the rebuttal presumption to only services provided by the penal authority or third party with an arrangement or contract. We are concerned that doing so would impose undue challenges to access and administrative burden for providers in confirming if someone is in custody, per the proposed definition. By not imposing this limitation, providers are better positioned to serve individuals in what is often a particularly vulnerable and crucial time to access care, and individuals are able to have greater access to provider organizations, thereby strengthening their choice in the right treatment and care for them.

In the Sequential Intercept Model, key components in Intercept 5 (during the time when a person is on probation or parole) include specialized community supervision caseloads of people with mental health needs, medication assisted treatment (MAT) for people with substance use disorder, and access to recovery supports, benefits, housing, and competitive employment.[22] Notably, CCBHCs have played an important role in improving access to services for people in the criminal legal system and provide services to individuals in need in the community, regardless of ability to pay.[23] In the most recent 2024 CCBHC Impact Report, 98 percent of Medicaid CCBHCs and established grantees reported having actively engaged in one or more innovative activities with law enforcement and criminal justice agencies to improve outcomes for people who have criminal legal system involvement or are at risk of being involved with the criminal legal system.[24] Moreover, in this report, 27.7 percent of respondents reported that they embed services within parole/probation agencies or coordinate with these agencies. While the extent of CCBHCs' relationships with community supervision has not been fully documented, where CCBHCs have such partnerships, they include corrections staff, such as external probation and parole offers, on treatment teams to create a plan to support successful outcomes for individuals with mental health and/or substance use needs.[25] Furthermore, CCBHCs must ensure MAT and mental health medications are part of

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[22] https://www.thenationalcouncil.org/resources/2021-ccbhc-and-justice-systems-report-certified-community-behavioral-health-clinics/
[23] https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
[24] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[25] https://www.thenationalcouncil.org/wp-content/uploads/2021/09/2021-CCBHC-and-Justice-Systems-Report.pdf

individuals' treatment plans where necessary. The majority of CCBHCs offer direct access to MAT (with the remainder partnering with other organizations to deliver this service), compared with only 56 percent of substance use treatment facilities nationwide.[26] Moreover, CCBHCs create community partnerships with organizations that provide job training, housing, and other needed supports within their communities – as is critical to Intercept 5 in serving individuals on probation or parole. Finally, the 2021 report found that 70 percent of CCBHCs coordinate with local jails to provide prerelease screening, referrals, or other activities to ensure continuity of care upon individuals' reentry to the community from jail.[27] In navigating the reentry process, it is also important to note that CCBHCs have engaged peers as community navigators or reentry specialists and offer peer-provided career or legal support. Overall, such efforts at CCBHCs are particularly important to the discussion here as these partnerships can work to help enroll or re-enroll individuals into benefits to ensure their services are covered and support warm hand-offs from correctional settings to community-based settings to reduce risks of harms, including overdose, suicide, or other adverse events.

B. Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals

The Consolidated Appropriations Act, 2021 provided the authority to establish Medicare Part A and B special enrollment periods (SEP) for individuals due to exceptional conditions. Under the current version of this SEP, beneficiary advocate groups raised concerns about the possibility for scenarios where an individual is not able to enroll when their items and services could be covered by Medicare, or they are able to enroll (and pay monthly premiums) but Medicare is not able to pay for their services. CMS is proposing to amend the Medicare special enrollment period (SEP) to better align eligibility criteria with the criteria used by the Social Security Act (SSA) to determine whether an individual is incarcerated and to include formerly incarcerated individuals based on the new definition of "custody." CMS notes that under this proposal, as originally intended with the SEP, individuals will have a clearer understanding of how to access this enrollment opportunity to ensure they do not have any gaps in coverage or any LEPs as they leave incarceration.

As discussed above, timely enrollment and Medicare coverage for eligible beneficiaries is crucial and particularly important as the population of incarcerated older individuals grows.[28] CBH affirms support for efforts that help individuals have a clearer understanding of how to access their enrollment opportunity and mitigate unnecessary gaps in coverage; a component that is fundamental for access to care if the proposal in the previous section is finalized.

[26] https://www.thenationalcouncil.org/resources/2021-ccbhc-and-justice-systems-report-certified-community-behavioral-health-clinics/
[27] https://www.thenationalcouncil.org/resources/2021-ccbhc-and-justice-systems-report-certified-community-behavioral-health-clinics/
[28] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10129364/

September 3, 2024

CBH appreciates the opportunity to provide these comments. We welcome any questions or further discussion about the recommendations described here. Please contact Shannon Hall at shannon@mdcbh.org. Thank you for your time and consideration.

Sincerely,

Shannon Hall
Executive Director