COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

August 28, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P

Submitted via regulations.gov

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS-1784-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 Physician Fee Schedule (PFS) and other proposed policy changes ("the Proposed Rule"), at 89 *Federal Register* ("FR") 61596 (July 31, 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.

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.

Determination of PE RVUs (section II.B)

3. Adjusting RVUs To Match the PE Share of the Medicare Economic Index (MEI)

As CMS discussed in the CY 2024 PFS final rule, CMS continues to monitor the data available related to physician services' input expenses, but CMS is not proposing to update the data underlying the MEI cost weights at this time. Given CMS' previously described policy goal to balance PFS payment stability and predictability with incorporating new data through more routine updates to the MEI, CMSI is not proposing to incorporate the 2017-based MEI in PFS rate setting for CY 2025. CMS invites comments on this approach as well as any information on the timing of the AMA's practice cost data collection efforts and other sources of data CMS could consider for updating the MEI.

CBH recognizes and is grateful for CMS' attention to and strides in strengthening access to mental health and substance use services for Medicare beneficiaries, particularly in the face of an ongoing workforce shortage and mental health and substance use crises that confront our nation. Critical to the comprehensive and multi-prong solutions need to address the crises at hand is the importance of provider rates in determining access. 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.[1] And as CMS noted in the finalized CY 2024 PFS, "[CMS] continue[s] to believe that there is a systemic undervaluation of work estimates for behavioral health services." (*88 FR 78910*). We also recognize that as enrollment in Medicare is projected to increase, beneficiaries will continue to require more mental health and substance use services; access that is particularly important as we see trends increase in older adults' substance use or mental health challenges.[2, 3, 4, 5, 6]

With regard to updating the MEI data, absent statutory constraint, CBH recommends a more frequent update given the dramatic increase in costs of physicians in light of the workforce shortages over the past five years. We fear that using older data has a risk of being outdated and not representative of the current cost of care, making rates inadequate.

In looking towards to future of continued, strengthened access to quality mental health and substance use services, we suggest CMS further investigate methodology and data, such as investigating use of a separate MEI for behavioral health, that adequately and appropriately values outpatient mental health and substance use services as a critical component to ameliorate the aforementioned workforce shortages and mental health and substance use crises afflicting our nation.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (section II.D.)

1.D. Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS is proposing to remove the frequency limitations on Medicare Telehealth subsequent care services in inpatient, nursing facility settings, and critical care consultation services for CY 2025.

CBH affirms support for CMS' efforts to enable access to all modalities of mental health and substance use care that fit an individual's specific context and empowers the provider-client decision-making process to ensure that the individual receives the most clinically appropriate, quality care to meet their needs in the modality that is right for them.

[1] https://www.gao.gov/assets/gao-22-104597.pdf
[2]https://www.cbo.gov/publication/60383#:~:text=Enrollment%20in%20Medicare%20Is%20Projected%20to%20Increase&text=Medicare%20enrollment%20rises%20from%2060,in%202034%20in%20CBO's%20projections.
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5439499/
[4] https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10241125/
[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623878/

1.E. Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"

CMS is proposing to revise the regulation at § 410.78(a)(3) to state that an interactive telecommunications system may also include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication, but the patient is not capable of, or does not consent to, the use of video technology.

CBH supports coverage of audio-only care for mental health and substance use disorder services, consistent with any other regulations and requirements, as a part of a collaborative decision between beneficiary and provider where it is determined that use of audio-only services is an appropriate modality that maintains access to high-quality care, where clinically appropriate, and where the beneficiary is unable or unwilling to access two-way, video-audio services. We further support continued evaluation of best practices to ensure the highest quality of care and patient safety in cases where audio-only services are employed.

1.F. Distant Site Requirements

CMS is proposing to continue to permit distant site practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their home through CY 2025.

CBH affirms support of this proposal to allow providers to choose not to use their home address as a part of protecting their privacy as well as help to alleviate administrative for practitioners who would need to change their billing practices or add their home address to the Medicare enrollment file.

2.A. Direct Supervision via Use of Two-way Audio/Video Communications Technology

CMS is proposing to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025. Additionally, CMS is proposing to adopt a permanent definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), but only for the following subset of incident-to services described under § 410.26: (1) services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5';10 and (2) services described by

CPT code 99211 (*Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional*).

CBH supports permanent establishment of virtual presence flexibilities for direct supervision for mental health and substance use disorder providers because such supervision can be done successfully via real time audio and visual interactive telecommunications without impact to patient safety or quality of care. Allowing continued access to this modality for supervision improves access to high quality care for Medicare beneficiaries as it allows supervising providers to be present and accessible in situations that would otherwise not allow them to be present in the same room. Now, more than ever in the face of continued crises, it is critical to leverage all accessible tools and modalities that can help grow and strengthen the workforce and access to quality care for beneficiaries. The ability for virtual supervision is necessary for continued coverage for telehealth behavioral health services as it enables better communication for practitioners rather than using the same device in the same location where there can often be technological challenges if appropriate equipment is not available. Simultaneously, it is still important to recognize possible drawbacks and challenges that can exist in providing care and supervision to beneficiaries who may have acute symports or are high-risk, and that responsive steps and best practices are employed to ameliorate any such challenges.[7] Additionally, to provide equitable, quality virtual services and supervision, broadband access is vital and can pose challenges for underserved areas such as rural and low-income housing residents.[8]

Valuation of Specific Codes (section II.E.)

(18) Telemedicine Evaluation and Management (E/M) Services

CMS is seeking comment from interested parties on our understanding of the applicability of section 1834(m) of the Act to the new telemedicine E/M codes, and how CMS might potentially mitigate negative impact from the expiring telehealth flexibilities, preserve some access, and assess the magnitude of potential reductions in access and utilization. CMS also notes that historically they have not considered changes in the Medicare telehealth policies to result in significant impact on utilization such that a budget neutrality adjustment would be warranted. However, CMS is unsure of the continuing validity of that premise under the current circumstances where patients have grown accustomed over several years to broad access to services via telehealth. CMS is seeking comment on what impact, if any, the expiration of the current flexibilities would be expected to have on overall service utilization for CY 2025.

As discussed in section III.B. of this Proposed Rule, CMS is proposing to continue to delay the in-person visit requirement for mental health services furnished via communication technology by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to beneficiaries in their

[7] https://psycnet.apa.org/fulltext/2021-50267-001.pdf
[8] https://www.pewtrusts.org/en/research-and-analysis/articles/2022/12/08/broadband-access-still-a-challenge-in-rural-affordable-housing

homes until January 1, 2026 (89 FR 62176). CBH generally supports the continued delay of the 6-month in-person visit requirement in order to avoid gaps in care, and if statutory requirements permitted, would suggest further application to additional organizations in order to better evaluate access data and trends. We recognize the benefits telehealth can bring in regard to access and mitigating mobility challenges a beneficiary may experience. Simultaneously, we also recognize the interpersonal communication benefits for Medicare beneficiaries that come with in-person interactions; something that literature shows may be particularly true for older adults.[9, 10] We urge CMS to provide additional support and guidance to providers in making this transition for Medicare beneficiaries ahead of any expiration of telehealth flexibilities.

Relatedly, we commend CMS' attention to strengthening access to social determinants of health (SDOH) benefits for Medicare beneficiaries under this Proposed Rule. We believe that improved access to services that meet beneficiaries' SDOH needs, such as by addressing transportation barriers, may be particularly applicable to this transition in expiring flexibilities as a part of providing responsive care and support for beneficiaries who are identified to face a mobility challenge that could present a barrier to meeting the in-person requirement. Additional guidance and communication efforts that highlight the connection to covered SDOH related supports for provider organizations could be helpful to mitigate barriers to accessing care through in-person requirement transitions.

Section 4113(a)(2) of the CAA, 2023 amends section 1834(m)(4)(C)(iii) of the Act to temporarily expand the telehealth originating sites for any service on the Medicare Telehealth Services List to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home through December 31, 2024. Statutory requirements permitting, CBH supports permanent expansion of this flexibility for mental health and substance use disorder services on the Medicare Telehealth Services List in order to bolster access and options for the beneficiary when telehealth is the right modality for their care, and as aligned with all other regulations and requirements. As discussed in our comments in previous years, CBH urges CMS to continue to maintain its definition of "the patient's home" under §410.78(b)(3) to broadly include homeless shelters, group homes, or other settings that the beneficiary identifies as their home or residence, whether permanent or temporary, as an important consideration in advancing equitable access to care.

(28) Annual Alcohol Screening (HCPCS codes G0442 and G0443)

CMS is proposing the RUC-recommended work RVU of 0.18 for HCPCS code G0442 (Annual alcohol misuse screening, 5 to 15 minutes), and is also proposing the RUC recommended work RVU of 0.60 for HCPCS code G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes). The RUC recommended an increase in the work RVU for HCPCS code G0443 from 0.45 to 0.60 which CMS believes is warranted based on time and intensity of the service in preventing alcohol misuse. In valuing this code, the time and work valuation is for separate and distinct services from same-day

[9] https://journals.sagepub.com/doi/full/10.1177/10748407211031980
[10] https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.13667

E/M services since HCPCS codes G0442 and G0443 are typically billed with an annual wellness visit (AWV) or office visit.

CBH supports improved valuation for annual alcohol screening and notes the importance of improving rates in connection to strengthening access to care; something that is particularly important for the population of Medicare beneficiaries as alcohol use in older adults has been trending upwards.[11, 12, 13] As noted earlier, low reimbursement rates for mental health services are a critical contributing factor to service access challenges across our country.[14] Continuing to improve valuation of behavioral health services will help work to strengthen integrated care. Of particular importance to this service is ensuring appropriate referrals and connection to substance use provider experts for beneficiaries in need of continued or more intensive care, as included in the 5As approach in this service.[15] CBH also urges CMS to include additional settings, such as Certified Community Behavioral Health Clinics (CCBHCs) and Community Mental Health Centers (CMHCs), as we would anticipate this screening would be just as effective in a community setting and there may exist cases where the entity may have an eligible provider on staff who is seeing an individual and recognizes that the annual screening and brief counseling is clinically appropriate for an individual in need.

(29) Annual Depression Screening (HCPCS code G0444)

In 2012, HCPCS code G0444 (Annual depression screening, 5 to 15 minutes) was added to the PFS (77 FR 68955 and 68956) to report annual depression screening for adults in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, treatment and follow up. In April 2022, the Relativity Assessment Workgroup identified this service with Medicare utilization of 10,000 or more that have increased by at least 100 percent from 2015 through 2020. In September 2022, the RUC recommended that this service be surveyed for April 2023 after CMS published the revised code descriptor in the CY 2023 PFS final rule (87 FR 69523). CMS is proposing the RUC-recommended work RVU of 0.18 for HCPCS code G0444 and are proposing to maintain the current 15 minutes of clinical labor time.

CBH agrees with CMS that 5 minutes is likely not typically enough time for clinical staff to administer the questionnaire, clarify questions where needed, and record the answers in the patient's medical record. Moreover, in cases where a person does endorse an item in the depression screening, it is important the provider takes time to express support rather than rapidly move to the next question. Efforts that promote quality integrated care are vital for people with mental health and substance use conditions, and particularly for older adults. Studies have shown

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5439499/
[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5710229/
[13] https://www.nytimes.com/2024/03/30/health/seniors-alcohol-consumption.html
[14] https://www.gao.gov/assets/gao-22-104597.pdf
[15] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf

people living with mental health and substance use conditions have a higher risk of developing chronic physical health conditions such as heart disease, diabetes, and stroke.[16, 17] The Centers for Disease Control and Prevention (CDC) has also noted that depression is more common in people who also have other illnesses or whose function becomes limited and older adults are often misdiagnosed and undertreated with regard to depression.[18] Thus, it is also important that integrated care be bidirectional and in the case of providing annual depression screenings, adequate and meaningful referrals and follow-up are provided to the beneficiary where needed. Moreover, as raised above, we urge CMS to include additional settings such as CCBHCs, CMHCs, and substance use treatment settings, for this code to apply to. As an example, a primary care physician on staff in one of these settings who sees an individual for a matter not initially regarding depression but realizes furnishing such screening would be clinically appropriate for the individual would be important for the beneficiary to have access to.[19]

(39) Payment for Caregiver Training Services c. Proposals and New Coding (B). Individual Behavior Management/ Modification Caregiver Training Services

CMS is proposing to establish new coding and payment for caregiver behavior management and modification training that could be furnished to the caregiver(s) of an individual patient. Current CPT coding (CPT 96202 and 96203) allows for "multiple-family group behavior management/modification training services," meaning that this caregiver training service can only be furnished in a group setting with multiple sets of caregivers of multiple beneficiaries (88 FR 78818).

CBH supports CMS' proposal to include coding and payment for furnishing caregiver(s) training services of an individual patient to allow more client and provider choice for the right service that meets the individual and caregiver(s) needs, particularly if a group setting is not feasible or clinically appropriate.

(40) Request for Information for Services Addressing Health-Related Social Needs (Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136))

For CY 2025 CMS is issuing a broad request for information (RFI) on the newly implemented Community Health Integration (CHI), Principal Illness Navigation (PIN), Principal Illness Navigation-Peer Support (PIN-PS), and Social Determinants of Health Risk Assessment (SDOH RA) services to

[16] https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health#:~:text=People%20who%20have%20depression%20are,due%20to%20symptoms%20like%20fatigue
[17] https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/addiction-health
[18] https://www.cdc.gov/aging/olderadultsandhealthyaging/depression-and-aging.html
[19] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

engage interested parties on additional policy refinements for CMS to consider in future rulemaking. CMS is requesting information if there are other types of auxiliary personnel, other certifications, and/or training requirements that are not adequately captured in current coding and payment for these services. CMS is also interested in hearing more about what types of auxiliary personnel are typically furnishing these services, including the certifications and/or licensure that they have. CMS is interested in whether there are nuances or considerations that CMS should understand related to auxiliary personnel and training, certifications or licensure barriers or requirements that are specifically experienced by practitioners serving underserved communities.

CBH appreciates CMS' efforts and attention to improving access to peer services for Medicare beneficiaries. Access to peer supports is important in both mental health and substance use services.[20],[21] CBH would also like to note appreciation for the clarifications provided in CMS' Frequently Asked Questions on Medicaid and CHIP Coverage of Peer Support Services, released in June 2024.[22] This document is helpful in clarifying the discretion states have for determining the type of mental health professional able to supervise per support specialists, thus offering opportunity to more effectively address the workforce shortage and reduce administrative burden. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Financing Reform and Innovation reported that 30 states do not allow peers to supervise other peers and instead require clinical staff to do so.[23] Again, as noted, clarifying and allowing peers to supervise other peers will help to address the workforce shortage and improve access to peer services. However, it is also important to note that many peer service providers to do not make a living wage and adequate rates must be provided to maintain and strengthen the peer workforce.[24]

CBH also wishes to express our support and appreciation for CMS' efforts on PIN services, enabling specialty providers, inclusive of psychiatrists, to be able to bill for services that primary care providers can bill for under complex management codes. CBH further expresses support for the Community Health Integration codes. With regard to these codes, we ask that staff eligibility and training to provide these codes be consistent with Medicaid requirements for community case management and community support commonly billed under the rehabilitation option as these services are similar and functional in nature.

[20] https://store.samhsa.gov/sites/default/files/financing-peer-recovery-report-pep23-06-07-003.pdf
[21] https://mhanational.org/peer-support-research-and-reports
[22] https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf
[23] https://store.samhsa.gov/sites/default/files/financing-peer-recovery-report-pep23-06-07-003.pdf
[24] https://mhanational.org/sites/default/files/2024-State-of-Mental-Health-in-America-Report.pdf?eType=ActivityDefinitionInstance&eId=18ffe536-c4fd-4ab3-83b8-6b2a34118652

Enhanced Care Management (section II.G.)

3. Request for Information: Advanced Primary Care Hybrid Payment

As noted the above subsection, *d. Duplicative Services and Concurrent Billing Restrictions*, for Behavioral Health Integration (BHI), including CPT codes 99492, 99493, 99494, and 99484 and HCPCS code G0323, CMS is seeking information on payment and coding policy considerations (*89 FR 61721*).

CBH affirms support of the importance of strengthening access to bidirectional healthcare integration, particularly as people living with mental health and substance use conditions have a higher risk of developing chronic physical health conditions.[25, 26, 27, 28] Moreover, advancing integrated care is consistent with and helps further measurement informed care, a vital component of making treatment decisions in behavioral healthcare.[29]

CBH notes that the proposed rule reveals a significant discrepancy in the Practice Expense Relative Value Units (PE RVUs) for Collaborative Care services compared to those for Psychiatric Evaluation, Psychotherapy, and Office Visit Evaluation and Management (E/M) services. Specifically, the average Collaborative Care Model (CoCM) and Behavioral Health Integration (BHI) code is seeing a decrease of 4.1% in its non-facility PE RVU. Given the growing need for integrated behavioral health services, we urge CMS to reassess these proposed reductions to ensure that PE RVUs accurately reflect the resources required to deliver high-quality Collaborative Care services. We also advocate maintaining the reimbursement rate for mid-level providers at 100% of the Medicare rate, as currently established. The staffing requirements and intensity of care under the CoCM framework are consistent, regardless of the provider's level of licensure or certification. Reducing reimbursement for mid-level providers would not accurately reflect the resources and time needed to deliver high-quality care within this model and could discourage the participation of these essential professionals in delivering Collaborative Care services. Additionally, currently, CPT code 99494, used for prolonged services, is capped at a maximum of two units per patient per calendar month. We propose increasing this limit to a maximum of four units per patient per calendar month. This adjustment is crucial to accurately reflect the complexity and intensity of care required, particularly for patients with chronic conditions that necessitate extended engagement. By raising this limit, CMS would acknowledge the additional resources and time necessary to manage complex cases, thereby enhancing support for comprehensive patient care. Finally, we urge CMS to reconsider the ongoing use of HCPCS code G0512 for Collaborative Care management services in

[25] https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/
[26] https://www.thenationalcouncil.org/our-work/focus-areas/integrated-health/
[27] https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health#:~:text=People%20who%20have%20depression%20are,due%20to%20symptoms%20like%20fatigue
[28] https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/addiction-health
[29] https://www.thenationalcouncil.org/resources/advancing-measurement-informed-care-in-community-behavioral-health/

FQHCs and RHCs (*89 FR 61781*). The existing flat-rate reimbursement does not adequately account for the complexity and time required to implement the comprehensive, evidence-based Collaborative Care model. We recommend replacing the current code with the dedicated CPT codes for Collaborative Care (99492, 99493, 99494). This change would align reimbursement more accurately with the care provided, enabling health centers to sustain Collaborative Care services and better serve their communities.

Advancing Access to Behavioral Health Services (section II.I.)

1. Safety Planning Interventions and Post-Discharge Telephonic Follow-up Contacts

In light of the rate of suicide described in the older adult population, CMS is proposing to establish separate coding and payment under the PFS describing safety planning interventions. Specifically, CMS is proposing to create an add-on G code that would be billed along with an E/M visit or psychotherapy when safety planning interventions are personally performed by the billing practitioner in a variety of settings. CMS recognizes that training and expertise are needed to perform these interventions safely and appropriately and are seeking comment regarding whether clinical staff who meet the definition of auxiliary personnel defined at 42 CFR 410.26(a)(1) or who are employed by a hospital could participate in furnishing this service under the supervision of the billing practitioner in certain settings with the relevant training needed to perform the service as well as what sort of training would be needed. The proposed G-code is HCPCS code GSPI1: *Safety planning interventions, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health professionals or agencies; and making the environment safe; (List separately in addition to an E/M visit or psychotherapy)*. CMS is proposing to value HCPCS code GSPI1 based on the valuation for CPT code 90839 (Psychotherapy for crisis), which describes 60 minutes, and which CMS believes describes a similar level of intensity as HCPCS code GSPI1. For HCPCS code GSPI1, CMS is assuming a typical time of 20 minutes, resulting in a proposed work RVU of 1.09 (based on one third of the work value currently assigned to CPT code 90839, which is 3.28).

CMS is also proposing to create a monthly billing code to describe the specific protocols involved in furnishing post-discharge follow-up contacts that are performed in conjunction with a discharge from the emergency department for a crisis encounter, as a bundled service describing four calls in a month, each lasting between 10-20 minutes. The proposed G code is HCPCS code GFCI1: *Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, per calendar month*. CMS is proposing to price this service based on a direct crosswalk to CPT code 99426 (*Principal care*

management; first 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional), which is assigned a work value of 1.00 work RVUs. CMS also proposes that the billing practitioner would need to meet a threshold of at least one real-time telephone interaction with the patient in order to bill HCPCS code GFCI1, and that unsuccessful attempts to reach the patient would not qualify as a real-time telephone interaction.

CBH strongly supports CMS' efforts to further suicide prevention interventions under the Medicare program, specifically the Safety Planning Intervention (SPI) and the Post-Discharge Telephonic Follow-up Contacts Intervention (FCI). Both interventions are evidence-based, safe, and effective methods for reducing risk of suicide behaviors;[30] such that they warrant being part of standard care for individuals with elevated suicide risk. As discussed in our comments last year, such interventions are often only implemented in certain integrated/staff-model health systems, and even then, they are only furnished to a small fraction of the individuals for whom they are indicated. And providers have further reported that the lack of reimbursement has been a barrier to implementation. CBH further supports that this code be applicable to any setting that furnishes crisis services, in addition to emergency departments, this can include urgent care, receiving centers, 23-hour observation units, crisis stabilization units, and crisis residential centers.

Overall, we strongly support efforts to advance these lifesaving interventions through this proposal. Regarding CMS' request for comment on the amount of time to accurately capture the typical amount of time spent on these services, CBH urges adoption additional code for every additional 15 minutes as safety planning can take between 20-45 minutes depending on the individual's needs, complexity, and circumstance.[31]

In response to CMS' request for comment on staff who could participate in furnishing this service, CBH agrees that training and practicing within scope is crucial. Continued training and education for such providers is also important; as one study noted that most providers who furnished suicide safety planning desired further training and research has shown that personal characteristics of the provider can impact care delivered.[32] Additionally, we recommend staff qualifications to be able to bill for the services be similar to the staff qualifications required for mental health community case management and/or mental health community support under the Medicaid Rehabilitation Option as these positions are frequently used to provide the same services under Medicaid. Moreover, with appropriate training, a diverse array of providers could furnish this service and in practice, this work is not always done by licensed staff. There is emerging evidence that peers are effective at furnishing this service.[33]

[30] https://pubmed.ncbi.nlm.nih.gov/29998307/
[31] https://www.sciencedirect.com/science/article/abs/pii/S1077722911000630?via%3Dihub
[32] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7559434/
[33] https://psychiatryonline.org/doi/10.1176/appi.ps.202100561

With regard to follow-up, CBH strongly supports CMS' proposal to establish coding and payment for post-discharge follow-up contacts. Similar to our comments regarding SPI, we suggest that this billing code should be applicable to other settings where an individual is discharged for a crisis encounter. CBH also urges applicability of the code, or partial reimbursement, for earnest attempts to contact the individual even if the contact is unsuccessful in order to recognize the effort and time it takes for the provider to attempt to furnish critical follow up. To this end, the modality of follow-up is important and has implications for successfully reaching an individual. Some individuals may have preferences for phone calls, texts, or app-based messages and the modality that is most effective to reach the individual should be a choice that is available to be made between the provider and individual. Moreover, with regard to timing to furnish this service, follow-up soon after discharge is important. One study found that early follow-up outpatient care was associate with a lower risk of suicide after discharge and suggested that intensive follow-up immediately after discharge can be key.[34]

2. Digital Mental Health Treatment (DMHT)

CMS is proposing Medicare payment to billing practitioners for digital mental health treatment (DMHT) devices furnished incident to or integral to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care. The proposed coding and payment policy only applies to DMHT devices that have been cleared by the FDA and the billing practitioner must diagnose the patient and prescribe or order the DMHT device. The proposal would create three new HCPCS codes for DMHT devices modeled on coding for RTM services. Effective beginning in CY 2025, CMS proposes that physicians and practitioners who are authorized to furnish services for the diagnosis and treatment of mental illness would be able to bill a new HCPCS code: GMBT1 (*Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan*) for furnishing a DMHT device. The two additional proposed codes are GMBT2 (*First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (DMHT) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the DMHT device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month*) and GMBT3 (*Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (DMHT) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the DMHT device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month*). For GMBT2, CMS proposes valuing the first 20 minutes of treatment management services based on a direct crosswalk to CPT code 98980 (*remote therapeutic monitoring first 20*

[34] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2810365

minutes), which is assigned a work RVU of .62. For GMBT3, CMS proposes to value this code based on a crosswalk to CPT code 98981 (*remote therapeutic monitoring each additional 20 minutes*), which is assigned a work RVU of .61.

CBH supports CMS' proposal to cover and pay for digital therapeutics when they are furnished incident to or integral to a provider service as a part of increasing access to mental health services. Studies have shown that employing digital therapeutics can help to ameliorate symptoms of behavioral health conditions such as anxiety, depression, and insomnia.[35, 36] Employing these tools can help further reach individuals in need who may face mobility challenges, offer further choice in care and services that meets an individual's needs, and it can help to alleviate strain on workforce capacity, particularly in workforce shortage areas. Simultaneously, as discussed previously there are also important considerations for continuing to access in-person care, particularly for older adults, as well as equity considerations in areas where broadband might be needed but is less accessible. Additionally, ensuring such technology protects data privacy and does not further perpetuate any existing healthcare biases is key, as well as further communications and training to support provider adoption where appropriate would help to support implementation.[37]

3. Interprofessional Consultation Billed by Practitioners Authorized by Statute to Treat Behavioral Health Conditions

CMS is proposing new codes that would allow clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors to bill for interprofessional consultations with other practitioners whose practice is similarly limited, as well as with physicians and practitioners who can bill Medicare for E/M services and would use the current CPT codes to bill for interpersonal consultations. When the treating/requesting practitioner or consultant practitioner is a physician or practitioner authorized to bill Medicare for E/M services, the practitioner would continue to bill using the current CPT codes that describe interprofessional consultation. Additionally, since these codes describe services that are furnished by the treating/requesting practitioner and the consultant practitioner without the involvement of the patient, CMS is proposing to require the treating practitioner to obtain the patient's consent in advance of these services, which would be documented by the treating practitioner in the medical record, similar to the conditions of payment associated with the CPT interprofessional consultation codes and certain other non-face-to-face services paid under the PFS. Obtaining advance patient consent includes ensuring that the patient is aware that Medicare cost sharing applies to these services, including informing the patient that there may be cost sharing for two services (one for the treating/requesting practitioner's service and another for the consultant practitioner's service).

[35]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10594135/#:~:text=A%20meta%2Danalysis%20of%2066,in%20reducing%20paranoia%20%5B4%5D.
[36] https://www.apaservices.org/practice/ce/expert/digital-therapeutics
[37] https://www.apa.org/practice/digital-therapeutics-mobile-health

CBH supports CMS' proposal to establish new codes that would allow for interprofessional consultations across behavioral health providers as well as physicians and practitioners. Finalizing this proposal would help to advance and value team-based approaches for behavioral health services and healthcare integration. And critical to efforts to strengthen integration, we wish to highlight the importance that such integration be bidirectional.

With regard to obtaining patient consent, it is also vital to ensure that the request for consent is provided in clear and plain language to the individual, particularly for cases in which cost sharing would apply. Efforts and additional guidance that help mitigate any added administrative burden with obtaining consent, alignment with previous guidance,[38] and communications efforts to avoid unexpected cost sharing will all be helpful in implementation. Additionally, we urge that the requirement for consent not apply in any circumstances where the patient already has an existing treatment relationship with the professional providing the consultation or when the consultation is pursuant to an intent to refer the patient to the person providing consultation for treatment. In both circumstances, consultation is already permitted absent patient consent under HIPAA if the professional requesting consultation is a covered entity under 42 CFR part 2 if the consultation involves sharing any private health information (PHI) related substance use disorder treatment. We believe it would only be appropriate to require additional patient consent if the patient is going to be responsible for the co-pay pursuant to the consultation. Moreover, in general, we fear that charging a co-pay for a consultative service as proposed would substantially suppress demand and utilization.

Further, as related to our comments below regarding CCBHCs, CCBHCs are a particular setting where quality integrated care can be realized. CCBHCs play an important role in integrated healthcare and work closely with primary care providers through multiple pathways that results in increased access to primary care across individuals served. As a part of CCBHC Certification Criteria, CCBHCs have a responsibility to screen and monitor key health indicators to ensure clients' whole health needs are met through collaboration and partnerships with primary care providers. The vast majority of CCBHCs directly deliver primary care screening and monitoring while other clinics contract with primary care providers as a part of a Designated Collaborating Organization (DCO). The most recently published 2024 CCBHC Impact Report showed that half of CCBHCs exceed the CCBHC minimum requirements by making comprehensive primary care available on-site.[39] Furthermore, 76% of CCBHCs respondents in the survey reported that referrals to primary care have increased since becoming a CCBHC, including 30% reporting that referrals have increased by 20% or more.[40] In connection to the proposal at hand, ability to furnish interprofessional consultations will help improve beneficiary access to quality that treats the whole person in a setting where infrastructure for care integration is already in place.

[38] https://www.medicaid.gov/federal-policy-guidance/downloads/sho23001.pdf
[39] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[40] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

4. Comment Solicitation on Payment for Services Furnished in Additional Settings, including Freestanding SUD Treatment Facilities, Crisis Stabilization Units, Urgent Care Centers, and Certified Community Behavioral Health Clinics (CCBHCs)

In response to CMS' solicitation of comments under this subsection, CBH has included response below and appreciates CMS' attention to and consideration of CCBHCs. As CMS further considers CCBHCs under Medicare, we strongly urge continued communication and collaboration with SAMHSA as the CCBHC program is operated through a partnership across SAMHSA, CMS, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

CCBHCs were established by Congress in 2014 under section 223 of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) and launched through a demonstration program in 2017. In 2022, section 11001 of the Bipartisan Safer Communities Act (BSCA) expanded the demonstration program to add 10 new states every two years. And most recently, the Consolidated Appropriations Act, 2024 (CAA 2024) provided a definition for CCBHCs in Medicaid statute, permanently establishing CCBHCs as an optional Medicaid benefit.[41] CCBHCs can be implemented and funded through the Section 223 Medicaid Demonstration, CCBHC Expansion Grants administered by SAMHSA, or through independent state programs. And it is important to note that states participating in the Demonstration select one of four Medicaid Prospective Payment System (PPS) rate methodologies to establish payment rates for CCBHCs based on the expected cost of delivering care.[42] Today, there are nearly 500 CCBHCs across 46 states and territories (offering services in 40% of all U.S. counties, covering 62% of the nation's population) serving an estimated 3 million people nationwide.[43] A regularly updated list of CCBHCs across the country can be found on National Council for Mental Wellbeing's website.[44]

PAMA established that CCBHCs must provide services to anyone seeking care for a mental health or substance use condition, regardless of ability to pay, place of residence, or age. PAMA also provided for program requirements and directed HHS to establish criteria for clinics to be certified as CCBHCs; SAMHSA most recently updated the CCBHC criteria in 2023.[45] There are nine core services CCBHCs are required to provide either directly or through formal partnerships. The required CCBHC services include: crisis services, outpatient mental health and substance use services, person- and family-centered treatment planning, community-based mental health care for veterans, peer, family support, and counselor services, targeted case management, outpatient primary care screening and monitoring, psychiatric rehabilitation services, and screening, diagnosis, and risk assessment. Notably, in response to CMS' specific solicitation on CCBHC services, in National Council for Mental

[41] https://crsreports.congress.gov/product/pdf/R/R48075
[42] https://www.medicaid.gov/medicaid/financial-management/downloads/section-223-ccbh-pps-prop-updates-022024.pdf
[43] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[44] https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-locator/
[45] https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

Wellbeing's 2024 Impact Report, CCBHCs reported that the CCBHC model has helped them to address SDOHs in their communities through a wide array of strategies from screening for unmet social needs to proactively assisting clients with finding or maintaining stable housing, and have been able to hire community health workers.[46] Additionally, CCBHCs have shown to improve healthcare integration working closely with primary care providers through multiple pathways that results in increased access to primary care across individuals served.[47]

Since launching in 2017, CCBHCs have overall dramatically improved access to a comprehensive range of mental health and substance use services to individuals in vulnerable situations; inclusive of 24/7 crisis services as a part of the 988 crisis system, hiring hundreds of new substance use-focused clinicians, expanding medication assisted treatment, and reducing patient wait times. CCHBCs are a successful, integrated, and modern way of delivering 21st century mental health and substance use care to individuals and families. And data have continuously shown that CCBHCs are making a difference in communities throughout our nation.[48] In the 2024 Impact Report, Medicaid CCBHCs (CCBHCs that are certified by their states and receive a Medicaid PPS) reported a 33% increase in the number of individuals served.[49] Specifically pertaining to access for substance use care, 60% of CCBHCs report the number of individuals engaged in medication-assisted treatment (MAT) for opioid use disorder has increased since becoming a CCBHC.[50] CCBHCs have also improved timely connection to care as CCBHC criteria require CCBHCs to see clients for routine needs within 10 days of the initial call or referral, in contrast to the national average of 48 days.[51, 52] Finally, CCBHCs play an important role in strengthening the workforce. Medicaid CCBHCs have reported increased hiring, adding a median of 22 new positions per clinic.[53]

Regarding CMS' solicitation on comment addressing ways to reduce capacity of emergency department visits, it's important to note that CCBHCs have shown decreased emergency room visits by 55%, reduced mental health care hospitalization by 55%, and decreased homelessness measured in the past 30 days by 31%.[54] In general, and connected to further discussion below, the availability of crisis stabilization services is an important approach to improving access to higher quality behavioral health care crisis response at a lower cost than emergency rooms. Access to crisis stabilization centers moves the Medicare benefit closer to providing parity in crisis/emergency care for behavioral health for beneficiaries in a crisis/emergency compared to emergency/crisis medical surgical populations.

In response to CMS' request for comment on entities that offer crisis stabilization services, PAMA requires provision of three crisis behavioral health services: emergency crisis intervention services, 24-hour mobile crisis teams, and crisis receiving/stabilization. The required crisis services can be furnished directly by the CCBHC or through a Designated Collaborating Organization (DCO)

[46] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[47] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[48] https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/ccbhc-data-impact/
[49] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[50] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[51] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[52] https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
[53] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[54] https://www.hhs.gov/sites/default/files/fy-2025-budget-in-brief.pdf

agreement. At minimum, CCBHC crisis receiving/stabilization services must include urgent care/walk-in mental health and substance use disorder services for voluntary individuals, available hours identified as needed in the community needs assessment; and such services are available to identify the person's immediate needs, de-escalate a crisis, and connect the individual to appropriate care in the least-restrictive setting as possible, care that can also be provided by the CCBHC.[55] Crisis stabilization services should ideally be available 24-hours a day, 7-days a week and are encouraged to provide these services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care.[56] Additionally, CCBHCs may also consider providing peer-run crisis respite programs. In a recently published peer-reviewed article, analysis shows that CCBHCs, specifically with the Medicaid bundled payment, significantly improve crisis care with a stronger behavioral health workforce and better array of crisis services that is needed for these populations.[57]

With respect to CMS' request for comment on IOP at CCBHCs, CCBHCs are able to provide services that typically comprise an IOP program. Because of the flexibility that CCBHCs have and based off the community needs assessment, this may look different across the country as CCBHCs can respond with the level of intensity of care that is responsive and personalized to an individual's need in the community, and ultimately the care provided could rise to a level of care similar to what an IOP program might consist of at a CMHC. However, we urge CMS' caution in pursuing this benefit at CCBHCs. As noted in our comment on the CY25 OPPS proposed rule, CMHCs appear to face challenges in providing the IOP benefit under Medicare because the Medicare CMHC Conditions of Participation (CoPs) pose challenges and significant administrative burden for provider organizations. **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.[58] Any CoPs that would be established for CCBHCs to furnish such services or program under Medicare should be aligned to Medicaid criteria with careful consideration of any additional administrative burden placed on organizations that could impede access to care.

CBH is grateful for CMS' attention to addressing CCBHCs' ability to bill Medicare under the PFS and CBH strongly affirms that ability for Medicare to cover and pay for the full range of services under CCBHCs would have a significant and meaningful impact in underserved areas. Already, we understand that CCBHCs can bill Medicare if they are registered as a different provider type such as an Office or CMCH. However, we find that Medicare does not cover all required CCBHC services as outlined above. It is also important to note, and related to the discussion above, that CCBHCs are already certified per federal and state Medicaid criteria and to the extent Medicare were to allow CCBHCs as a Medicare provider, CBH would strongly encourage alignment of any potential future Medicare CCBHC CoPs with existing Medicaid and state certification requirements.

[55] https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
[56] https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
[57] https://psychiatryonline.org/doi/10.1176/appi.ps.20240152
[58] https://www.thenationalcouncil.org/wp-content/uploads/2024/07/Proposed-MDI-TP-position-statement_7.22.24-FOR-WEB.pdf

As noted earlier, in light of Medicare's narrow coverage of the full scope of CCBHC required services, there is great opportunity to expand CCBHC service reach for Medicare and dual-eligible beneficiaries. ASPE's most recent annual report to Congress notes that aggregate findings showed 5% of clients served had Medicare and 62% had Medicaid, CHIP, or were Dual enrolled in Demonstration Year 4 (Exhibit B.5.).[59] National Council for Mental Wellbeing's 2024 Impact Report found that Medicare and dual-eligible beneficiaries are among the two least commonly reported groups to have expanded access to CCBHC services.[60] These findings suggest that establishing CCBHCs as a Medicare provider type with access to a Medicare PPS for the full CCBHC scope of services could greatly improve access to care Medicare beneficiaries.

Finally, with regard to CMS' solicitation on workforce and employment of practitioners who can supervise auxiliary personnel and bill Medicare, many CCBHCs have reported that the model has allowed for improved staffing to serve more people, as well as support integrated care delivery with primary care from primary care physicians and physician assistants. Among practitioners that can supervise auxiliary personnel and bill Medicare, CCBHCs employ primary care physicians, psychiatrists, and physicians assistants, nurse practitioners.[61] In Maryland, for example, CCBHCs demonstrate significantly higher rates of 7-day follow-up after hospitalization than non-CCBHC behavioral health providers.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (section III.B.)

3. Telecommunication Services D. In-Person Visit Requirements for Remote Mental Health Services Furnished by RHC and FQHCs

CMS is proposing to continue to delay the in-person visit requirement for mental health services furnished via communication technology by RHCs and FQHCs to beneficiaries in their homes until January 1, 2026 (89 FR 62176).

Statutory requirements permitting, CBH would urge CCBHCs, CMHCs, and other behavioral health clinics licensed in a state that are nationally recognized to be included in the continued delay of in-person visit requirements for mental health and substance use services in compliance with all other applicable rules and requirements. As noted above, CBH recognizes the benefits telehealth has in improving access to care and supports all modalities being available that will best serve the individual in a decision between the provider and patient.

[59] https://aspe.hhs.gov/sites/default/files/documents/6b9cdcb7cb75ec2c59a029b40d6b2e63/ccbhc-report-congress-2023.pdf
[60] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[61] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Conditions for Certification and Conditions for Coverage (CfCs) (section III.C.)

To clarify the requirements and intent of the program regarding the services provided by RHCs and FQHCs, CMS is proposing changes to the *Provision of services* CfCs, and aims to ensure RHCs are provided flexibility in the services they offer, including specialty services (89 FR 61807). To align the requirements and preserve access to primary care services in rural areas, CMS is proposing to add standards to § 491.9(a)(2) explicitly requiring RHCs and FQHCs to provide primary care services (at § 491.9(a)(2)(i)) and explicitly noting that RHCs cannot be a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases (at § 491.9(a)(2)(ii)). And CMS notes that the proposed changes to RHC CfCs should not be construed as prohibiting or discouraging behavioral health services. Under CMS' proposal, RHCs and FQHCs would continue to be required to provide primary care services to their patient populations, but CMS would no longer determine or enforce the standard of RHCs "being primarily engaged in furnishing primary care services" and would no longer consider the total hours of an RHC's operation and whether a majority, that is, more than 50 percent, of those hours involve primary care services through the survey process. This proposal aims to allow RHCs to provide more outpatient-specialty services within the practitioner's scope of practice to meet the needs of the patient population. CMS also discusses the term "mental diseases", perpetuation of stigma, and uses language to be inclusive of mental health and substance use disorders, despite having to employ the term given current statutory requirements.

CBH affirms support of efforts to improve access for Medicare beneficiaries across our country, recognizes the mobility barriers in rural locales, and as noted above urges the advancement of integrated care for people with mental health and substance use conditions that treat the whole person. Notably, 25 percent of CCBHCs operate in rural areas.[62] While not all RHCs can also be a CCBHC,[63] in the 2024 Impact Report, 6 percent of respondents identified as RHCs. Nearly all RHC/CCBHC respondents reported increased screening for unmet social needs that affect health as well as increased outreach to individuals who have been historically underserved or underrepresented thereby improving access and service utilization. It is also worth noting that Medicaid CCBHCs often partner with Federally Qualified Health Centers (FQHCs) as a common primary care partner; half the CCBHCs in the 2024 Impact Report that partner with FQHCs co-locate services on-site at the CCBHC, and among CCBHCs that partner with a DCO for primary care screening and monitoring, the majority of respondents have a FQHC as their DCO.[64] Additionally, CMHCs, OTPs, and other behavioral health clinics licensed in a state that are nationally recognized are also entity types that specialize in providing behavioral healthcare services and can simultaneously be credentialed as or work in partnership with RHCs. Finally, we do appreciate CMS' discussion of the term "mental diseases" and recognition that this term is outdated and can perpetuate stigma. As we noted in last year's comment, updating and using language that explicitly

[62] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/
[63] https://www.oregon.gov/oha/hsd/bhp/pages/ccbhc-faq.aspx
[64] https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/

and clearly includes both mental health and substance use disorders would be consistent with terms used across fields and in practice.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (section III.F.)

2. Telecommunication Flexibilities for Periodic Assessments and Initiation of Treatment with Methadone

2.A. Proposal To Allow Periodic Assessments To Be Furnished Via Audio-Only Telecommunications on a Permanent Basis

CMS is proposing to allow OTPs to furnish periodic assessments using audio-only communications technology when video is not available on a permanent basis beginning January 1, 2025, to the extent that use of audio-only communications technology is permitted under the applicable SAMHSA and DEA requirements at the time the service is furnished, and all other applicable requirements are met.

CBH applauds the work that CMS has done in prior rulemakings to improve access to OUD services furnished by OTPs in Medicare. We support CMS' proposal to permanently allow periodic assessments furnished by OTPs through audio-only technology when video is not available and consistent with all other related requirements. CBH believes having such flexibility enables services to be more accessible to beneficiaries and helps facilitate successful care in which a provider and individual engage in collaborative decision making to ensure access to quality care for that person's needs – and particularly helpful for Medicare beneficiaries as CMS notes their analysis of claims data shows that the proportion of telephonic audio-only visits increases with patient age (89 FR 61820).

3.A. Proposal To Establish Payment for Social Determinants of Health Risk Assessments

CMS is proposing to update the payment rate for intake activities described by HCPCS code G2076 by adding in the value of the non-facility rate for SDOH risk assessments described by HCPCS code (G0136). CMS notes that they understand that OTPs have been involved in collaborative agreements with organizations who address health-related social needs (HRSNs) sand offer various recovery support services (84 FR 62648), and they believe that for OTPs to appropriately identify these types of organizations that target a specific need, identifying these HRSNs as part of SDOH risk assessments is likely needed prior to engaging in activities to coordinate service delivery. However, CMS seeks comment on whether these types of SDOH assessments ordinarily complement the type of community coordination activities that OTPs perform. CMS is proposing to revise the current descriptor for the intake add-on code for consistency with revisions to § 8.12(f)(4)(i) and to reflect

furnishing an SDOH risk assessment. CMS also notes that intake activities (G2076) should only be billed for new patients (that is, patients starting treatment at the OTP), and since SDOH risk assessments would be bundled into the code describing intake activities, this billing requirement would similarly apply. However, CMS seeks comment on the frequency with which these SDOH risk assessments occur, and whether it would be more appropriate if these assessments occur when OTPs furnish periodic assessments described by HCPCS code G2077.

CBH applauds CMS' efforts to attend to, improve valuation, and incorporate SDOHs into care for Medicare beneficiaries receiving care at OTPs. Doing so plays an important role in building protective factors, supporting the whole person in their care, and promoting positive outcomes. For example, people that face food insecurity and housing instability were found to have greater associated risk for mental health and substance use challenges.[65, 66] Integrating SDOH considerations into care can help identify and address these underlying social factors that contribute to health disparities. Interventions designed and funded to provide patients with access to and coordination with social services and community-based resources can lead to improvements in health outcomes and reduced healthcare utilization.[67] Finally, critical to any SDOH assessment furnished is ensuring that the appropriate follow-up care is connected to and related resources are accessible for the beneficiary.

3.B. Request for Information on Payment for Coordinated Care and Referrals to Community Based Organizations that Address Unmet Health-Related Social Needs, Provide Harm Reduction Services, and/or Provide Recovery Support Services

CMS is seeking comment to understand how OTPs are currently coordinating care and making referrals to community based organizations (CBOs) that address unmet HRSNs, provide harm reduction services, and/or provide recovery support services.

In response to CMS' request for information under this subsection, OTP partnerships with local Recovery Community Organizations (RCOs) is important to highlight. One OTP has found that oftentimes clients may be resistant to traditional therapy and have adjusted their own internal procedure to provide connection to their local RCO at admission, upon request, or when the need is identified. That need can be identified in an individual counseling session, case management visit, or medical visit. The local RCO provides services via telehealth as needed and can assist with transportation for those who may not qualify for transportation through their insurance. An OTP in New Mexico developed a memorandum of understanding (MOU) with their local RCO and are in the process of setting up time for them to come to the OTP to meet with and engage clients into services. Depending on the client need, referrals to AHPs' internal care coordination and/or care

[65] https://www.nimhd.nih.gov/resources/understanding-health-disparities/food-accessibility-insecurity-and-health-outcomes.html
[66] https://www.sciencedirect.com/science/article/abs/pii/S0376871619301462
[67] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9501992/

management programs may be provided. It was also strongly suggested that additional rate as well as dosing increases are adopted to help improve care access.

Connections to residential where appropriate and building partnerships with the state are also important to note. One recovery center in Indiana allows OTPs to refer clients to the recovery center, which is a 28-day program for people who are on methadone but in need of a higher level of care due to continued use of substances other than opioids. After the person is approved based on medical necessity, the OTP contacts the Division of Mental Health and Addiction (DMHA) and requests a 14 day take home dose based on the need for residential treatment. Once the request is approved, the center makes arrangements to transport the client to the recovery center for admission. The center later transports the client back to the OTP to dose and get remaining bottles for 28 day stay when the first 14 days are complete. In addition, the OTPs also make referrals to recovery houses. When a client is transitioning back to the community, they are always set up with outpatient services and connection to recovery supports in the community.

Finally, OTPs can exist in partnership with CCBHCs. Of the CCBHC respondents that prescribe methadone in our 2024 Impact Survey, every respondent also facilitates access to a supportive housing program operated by their organization (not specific to the CCBHC). Additionally, starting July 1, 2024, CCBHCs are required to partner with OTPs in their service areas, and we look forward to further data that will become available regarding how those partnerships support long-term health goals for clients and financing needs for providers.

Medicare Part B Payment for Preventive Services (§§ 410.10, 410.57, 410.64, 410.152) (section III.H.)

3. Payment for Drugs Covered as Additional Preventive Services (§410.152) b. Proposed Fee Schedule for Drugs Covered as Additional Preventive Services (DCAPS)

CMS is proposing a fee schedule for DCAPS drugs that uses existing Part B drug pricing mechanisms. No cost sharing would apply for the administration or supplying of DCAPS drugs. The authority at section 1833(a)(1)(W)(ii) of the Act provides for payment for additional preventive services, including drugs.

CBH strongly supports coverage and improved access to preventative medication and services for Medicare beneficiaries. Strengthening access to such tools in service to prevention helps to ameliorate crises later downstream. Moreover, advancing preventative coverage also has a tremendous impact for people living with mental health and substance use conditions; as noted above, people living with mental health and substance use conditions have a higher risk of developing chronic physical health conditions.[68, 69] For example, people with a substance use

[68] https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health#:~:text=People%20who%20have%20depression%20are,due%20to%20symptoms%20like%20fatigue
[69] https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/addiction-health

disorder have a higher risk of HIV, and improving access to preventative measures would have an important impact for beneficiaries.[70, 71]

Updates to the Quality Payment Program (section IV.)

(3) Measures Proposed for Use in the APP Quality Measure Set and APP Plus Quality Measure Sets

CMS is proposing a phased approach to establish the APM Performance Pathway (APP) Plus quality measure set over four years. CMS proposes that beginning with the CY 2026 performance period/MIPS payment year 2028 and continuing for subsequent performance periods: The Initiation and Engagement of Substance Use Disorder Treatment (Quality #: 305) measure in the APP quality measure set. This measure is currently available as an eCQM. If this proposal is finalized, CMS would make the Medicare CQM collection type available for this measure prior to the start of performance year 2026 and only for Shared Savings Program ACOs.

Beginning with the CY 2028 performance period/2030 MIPS payment year and continuing for subsequent performance periods: The Screening for Social Drivers of Health (Quality #: 487) and Adult Immunization Status (Quality #: 493) measures would be added to the APP quality measure set. These measures are currently available as MIPS CQMs, but are not currently available as eCQMs or Medicare CQMs. Because developing eCQM specifications typically takes three years, CMS is proposing to add these measures to the APP Plus quality measure set in the CY 2028 performance period/2030 MIPS payment year. If this proposal is finalized, CMS would make these measures available prior to the start of CY 2028 performance period/2030 MIPS payment year to report as eCQMs and, for Shared Savings Program ACOs only, Medicare CQMs.

CBH appreciates CMS' attendance to substance use care and SDOHs under the APP quality measure set in support of whole person care, and we note the importance of mitigating risk for administrative burden and ensuring providers work within their expertise and scope. As noted above, continued and increased attention to substance use care and SDOHs for the Medicare population is critical, and as CMS acknowledges, with regard to substance use challenges, access to early and regular care is vital in promoting positive outcomes for individuals (*89 FR 62025*). With respect to screening for SDOHs, it is critical providers have the appropriate training to respond to identified SDOH challenges and that ample follow-up and connection to resources is provided where the need is identified.

[70] https://www.cdc.gov/hiv/pdf/risk/cdc-hiv-substanceuse.pdf
[71] https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/co-occurring-disorders

August 28, 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