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September 8, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P

Submitted via regulations.gov

RE: Medicare and Medicaid Programs: CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Continued Implementation of Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (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) 2024 Payment Policies under the Physician Fee Schedule (PFS) and other proposed policy changes ("the Proposed Rule"), at 88 *Federal Register* ("FR") 52262 (August 7, 2023). 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 publicly-funded behavioral health payers in Maryland.

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>II.D. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (88 FR 52286)</u>

D.1.a.(7) CMS Proposal to Add New Codes to the List (88 FR 52293)

CMS is proposing to add Healthcare Common Procedure Coding System (HCPCS) code GXXX5 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes) to the Medicare Telehealth Services List and to receive a permanent status on the Medicare Telehealth List that is proposed to be required to be furnished on the same date as an evaluation and management (E/M) visit.

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CBH applauds CMS' efforts to attend to and incorporate Social Determinants of Health (SDOHs) into care for Medicare beneficiaries. Addressing behavioral health and SDOHs within a primary care setting has been recognized by the U.S. Preventative Services Task Force as a crucial strategy for achieving comprehensive and effective patient-centered care.[1] Research literature consistently highlights the benefits of integrating behavioral health services into primary care settings. Studies have shown that this integration leads to improved and more equitable patient outcomes, better treatment adherence, and reduced healthcare costs.[2] For example, patients facing challenges related to housing instability, food insecurity, education, and employment are at increased risk for poor health outcomes. Integrating SDOH considerations into primary care and/or hospital settings 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.[3]

However, CBH recommends that CMS consider this service to be bidirectional across primary care providers and behavioral health providers, when it is appropriate (e.g. where a primary care provider can refer a beneficiary to behavioral health services when appropriate given the risk tool assessment and vice versa). SDOH impact mental health and substance use disorder conditions just as much as they impact chronic physical medical illness.[4] SAMHSA validates the importance of behavioral health providers systematically assessing SDOH by making such reporting requirement for states for receiving mental health and substance use disorder funding through their National Outcome Measures (NOMS) reporting requirements.

Given the need for bidirectional communication to occur where appropriate and responsivity to the important impact SDOHs have on mental health and substance use disorder conditions, CBH strongly recommends that CMS reconsider the proposed provision that this service be furnished on the same date as an E/M visit and that such service should not be limited to providers who use E/M codes.

D.1.e.(2) In-person Requirements for Mental Health Telehealth (88 FR 52298)

Consistent with amendments made in CAA, 2023 CMS is proposing revise regulatory text to delay the requirement for an in-person visit with the physician or practitioner within 6 months prior to the initial mental health telehealth service, as well as regulatory change to recognize the delay of the in-person requirements for mental health visits furnished by RHCs and FQHCs through telecommunication technology until January 1, 2025, rather than until the 152nd day after the end of the Public Health Emergency (PHE).

CBH generally supports the continued delay of the 6-month in-person visit requirement in order to avoid gaps in care. We recognize the benefits telehealth can bring in regard to mobility challenges a beneficiary may experience. However, we also recognize the critically important opportunity for

[1] https://pubmed.ncbi.nlm.nih.gov/34468692/
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3810022/
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9501992/
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6696493/; https://nida.nih.gov/about-nida/noras-blog/2023/04/social-determinants-health-cant-be-extricated-addiction-science;
https://fsph.iupui.edu/doc/research-centers/Social-Determinants-of-Health-and-Their-Impact2.pdf

beneficiaries to receive stronger interpersonal communication benefits that come with in-person interactions; something that literature shows is particularly true for older adults who may not receive as impactful benefits of digital communication on their mental health and well-being.[5,6] We urge CMS to provide additional support and guidance to providers in making this transition for Medicare beneficiaries. We also urge CMS' consideration of our comments on SDOH benefits as particularly applicable to this transition in providing responsive care and support for beneficiaries who are identified to face a mobility challenge that could present a barrier to meeting this requirement.

D.1.e.(3) Originating Site Requirements (88 FR 52298)

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, beginning on the first day after the end of the PHE for COVID-19 through December 31, 2024. CMS would not issue any program instructions or proposals to limit or modify telehealth originating sites for CY 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. As recommended in our comment last year, CBH urges CMS to maintain its expansion of the 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.

D.1.e.(4) Telehealth Practitioners (88 FR 52299)

In accordance with CAA, 2023, CMS will recognize marriage family therapists (MFTs) and mental health counselors (MHCs) as telehealth practitioners effective Jan 1, 2024. CBH strongly supports this regulatory change consistent with the new statutory requirements. Inclusion of these essential provider types as telehealth practitioners helps to increase critical service access.

D.1.e.(5) Audio-Only Services (88 FR 52299)

Consistent with CAA, 2023, the Secretary shall continue to provide coverage and payment for audio-only communication systems beginning on the first day of the PHE through December 31, 2024.

CBH supports coverage of audio-only care for mental health and substance use disorder services 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.

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

D.1.e. Place of Service for Medicare Telehealth Services (88 FR 52299)

CMS is proposing that, beginning in CY2024, claims billed with POS 10 (Telehealth Provided in Patient's Home) be paid at the non-facility PFS rate and claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) will continue to be paid at the PFS facility rate.

Similar to the comment provided above, CBH urges CMS to expand the definition of "the patient's home" to broadly include homeless shelters, group homes, or other settings that the beneficiary identifies as their home or residence, whether permanent or temporary. Providing such clarity is especially important in this provision as utilizing the Place of Service (POS) code indicator, POS ''10''—Telehealth Provided in Patient's Home (Descriptor: The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.), as currently written excludes beneficiaries who may be located in a temporary shelter, unhoused, or have to travel outside of their private residence for privacy during their telehealth service though are not located in what would be classified as a facility for application of the facility rate.

D.2.a. Direct Supervision via Use of Two-way Audio/Video Communications Technology (88 FR 52301)

Given change in patterns of practice after the PHE, 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, 2024. Additionally, CMS notes potential for direct supervision to be permanently established with ability for virtual presence flexibility for services.

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. What is more, 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, is not the time to diminish flexibilities that 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 the 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 quality virtual services and supervision, broadband access is vital and, again, poses challenges for underserved areas such as rural and low-income housing residents.[8]

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[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

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II. E. Valuation of Specific Codes (88 FR 52307)

E.4.(20). General Behavioral Health Integration Care Management (CPT Code 99484, and HCPCS Code G0323) (88 FR 52320)

CMS is proposing to refine the work RVU of both CPT code 99484 and HCPCS code G0323 (see section II.J.1.c of this proposed rule) by increasing the work RVU to 0.93 from the current 0.61 and increasing the work time to 21 minutes to match the results of the surveyed work time and are proposing the direct PE inputs as recommended by the RUC without refinement.

CBH supports CMS's proposal to revise the reimbursement rate for behavioral health integration (BHI) services (CPT code 99484 and HCPCS code G0323) to more accurately value the work involved in the delivery of these services. Research demonstrates that the integration of mental health and substance use disorder treatment with medical care improves health outcomes, improves patient and provider experiences, and is cost effective.[9,10] Integrated care also helps to address mental health and substance use disorder treatment barriers that disproportionately affect Black and brown individuals, rural communities, and people with lower incomes.[11] Thus, increasing the reimbursement rate for BHI services will make progress towards CMS's dual goals of improving access to mental health and substance use disorder care and advancing health equity. We urge CMS to ensure the reimbursement rates are adequate for delivering these, accounting for the systemic undervaluation of work for behavioral health services as noted, *88 FR 52320*, and increase where appropriate.

E.4.(27). Services Addressing Health-Related Social Needs (Community Health Integration services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services) (88 FR 52325)

CMS is proposing, and seeking comment on, new coding to describe and separately value three types of services that may be provided by auxiliary personnel incident to the billing physician or practitioner's professional services when reasonable and necessary to diagnose and treat the patient: Community health integration services (CHI), SDOH risk assessment, and principal illness navigation (PIN) services.

CBH strongly supports CMS's proposals to establish separate coding and payment for CHI services, PIN services, and the SDOH risk assessment. We commend CMS for recognizing the valuable role of the various members of the interdisciplinary teams that treat people with mental health and substance use disorder conditions, including community health workers, patient navigators, and peer support specialists. Integration of these trusted members of the community into health care settings has been shown to reduce health care spending and improve health outcomes.[12] These proposals will help address many of the harmful economic and social conditions that affect the

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[9] https://www.bmj.com/content/373/bmj.n784
[10] https://www.aafp.org/pubs/fpm/issues/2021/0500/p3.html
[11] https://www.commonwealthfund.org/publications/explainer/2022/sep/integrating-primary-care-behavioral-health-address-crisis.
[12] https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00981; https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-substance-use-disorders-2017.pdf; https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf.

health of Medicare beneficiaries, which is reasonable and necessary for the diagnosis and treatment of mental health, substance use disorder, and medical conditions given the significant impact of SDOH(s).[13] As CMS notes, these services are currently employed by social workers or other ancillary staff by some practices and facilities to help address a beneficiary's SDOH needs in order to provide medically necessary care but is not consistently appropriately reflected in current coding and payment policies, and again is also very important in the treatment and care for behavioral health conditions – thus the proposal may help to better value this work. *88 FR 52326.* If the rate for these services is set sufficiently high, it will take an impactful step towards supporting and incentivizing team-based care in behavioral health settings. Ensuring that these services are accessible for beneficiaries with mental health and substance use disorder conditions is every bit as appropriate and necessary as it is for medical surgical conditions and would ensure equity and consistency with *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).*

We agree that some of these services will likely be furnished via telehealth, including two-way audio, and thus we urge CMS to add CHI, PIN, and the SDOH risk assessment to the Medicare telehealth services list, as proposed for the SDOH risk assessment. We further support CMS's proposal to allow these services to be furnished under general supervision, and to allow a billing practitioner to arrange to have CHI and PIN services provided by external auxiliary personnel, such as those who work at community-based organizations under contract with the billing practitioner.

In advancing this proposal, we recommend CMS conduct significant outreach and engagement with the provider community and with recovery community organizations to ensure that practitioners and interested community-based organizations are aware of and can take advantage of these new opportunities. We also encourage CMS to develop sufficient incentives and safeguards to encourage authorized Medicare providers to initiate and supervise these services and to ensure adequate reimbursement to the peers and community health workers who deliver them. Doing so will both incentivize service delivery as well as support and set these critical providers up for success by ensuring that the services utilized are in alignment with state scopes of practice for the providers, such as peers.

Furthermore, while we support CMS including the annual wellness visit (AWV) as an initiating visit, we strongly recommend CMS include additional mental health and substance use disorder professional services to serve as the initiating visit for both CHI and PIN services, beyond the proposed E/M visit. We appreciate that CMS has recognized that severe mental illness (SMI) and substance use disorder are two serious, high-risk diseases for which patient navigation services could be reasonable and necessary. However, many of the providers who treat patients with these conditions are not eligible to bill E/M codes; thus, this could exclude beneficiaries who are seeking mental health or substance use disorder services who may face barriers to completing the AWV, as

[13] https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

CMS describes in this Proposed Rule. We recommend CMS include BHI and the bundled office-based mental health and substance use disorder codes, as well as opioid treatment programs services, as the initiating visit for CHI and PIN services.

We appreciate CMS requesting feedback on whether there are gaps in coding for patient navigation services for treatment of serious illness that are not already included in current care management services. We wish to highlight that clinical social workers (CSWs), MFTs, and MHCs are reimbursed at a lower percentage of the physician fee schedule than non-physician medical practitioners (75% compared to 85%). As a result, many of the services that CMS identifies as including care management are reimbursed at a lower rate when delivered to Medicare beneficiaries with mental health and substance use disorder conditions]. We urge CMS, at a minimum, to ensure that these non-physician mental health and substance use disorder providers can initiate visits for services addressing health-related social needs and develop appropriate crosswalk codes to enable equitable payment compared to medical services for the auxiliary staff that deliver these services.

II.J. Advancing Access to Behavioral Health Services (88 FR 52361)

J.1.b. Proposed Changes to Regulations (88 FR 52362)

CBH strongly supports CMS' implementation efforts consistent with the statutory changes provided in CAA, 2023 to increase access to mental health and substance use disorder care by allowing coverage and payment for services provided by qualified MFTs and MHCs under Part B of the Medicare program. With the passage of critically needed legislation in the face of a national behavioral health crisis and workforce shortage, Medicare beneficiaries will gain access to important services provided by these provider types – change that is particularly needed in this population as older Americans have high rates of mental health and substance use conditions yet have lower rates of receiving treatment.[14,15,16,17] We affirm support of the proposed related regulatory amendments to §§420.10, 410.150, and 410.32(a)(2) to add MFTs and MHCs to the list of included medical and other health services, to the list of individuals or entities to whom payment is made, and to the list of practitioners who may order diagnostic tests to the extent that these providers are legally authorized to perform the service under State law.

CBH is grateful for CMS' work and steps being taken to implement the new statutory requirements and appreciates CMS' requirement that an MHC or MFT must have performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience particularly for applicants who obtained this supervised clinical experience in less than two years. However, we are concerned that ambiguity and discrepancies may exist in implementation across states as some states allow supervised clinical experience to count towards licensure requirements prior to completing their degree, and some states

[14] https://www.thenationalcouncil.org/program/older-adults/
[15] https://www.thenationalcouncil.org/substance-use-challenges-in-older-adults/
[16] https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf
[17] https://www.gao.gov/assets/gao-22-104597.pdf

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do not provide for clinical supervised experience requirements for licensure, and finally, licensure requirements can vary between clinicians with a master's or a doctoral degree.

CBH notes that "clinical supervised experience" is not defined and recommends CMS be robust in its consideration of what constitutes such experience. Specifically, CBH urges CMS to clarify and include direct service experience with callers at 988 call centers to count towards clinical supervised experience. 988 crisis counselors provide services in high-intensity and consequential situations that aim to help deescalate an acute crisis and connect the caller to appropriate resources when medically necessary. Yet such experience does not currently count towards hours of supervision for licensure in states despite the overlap across mental health and substance use professions' scopes of work.

In response to CMS' proposal to codify in a new §414.53 the payment amounts authorized under section 1833(a)(1)(FF) for MFT and MHC services as well as codify at §414.53 the payment amount for CSW services at 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for clinical psychologist services under the PFS. CBH affirms support for consistency with statute and recommends continued evaluation along with appropriate steps to ensure that payment rate for these provider types is adequate and conducive to playing a role in ameliorating the mental health workforce crisis that impacts beneficiaries access to critically need mental health and substance use disorder services.

CMS also recognizes variation in the terminology used for licensure across states for MHCs and MFTs and seeks information pertaining to other types of professionals who may meet the applicable requirements for enrollment as mental health counselors. The Williams Jay College offers a compilation of state licensure requirements and designations for mental health counselors and the Association of Marriage and Family Therapist Regulatory Boards provides a state comparison of requirements and designations for MFTs.[18,19]

CBH supports CMS' proposal to allow Addiction Counselors who meet all applicable requirements to enroll in and bill Medicare as an MHC. Doing so recognizes and affirms the value of the lifesaving services that these practitioners provide and helps advance equitable access to substance use disorder services. As CMS has previously noted in its proposed Medicaid Managed Care Access Rule when amending its regulations to specify MH and SUD instead of behavioral health, "It is important to use clear, unambiguous terms in regulatory text," (88 FR 28092, 28110). As such, we believe it is necessary to include "addiction counselor or alcohol and drug counselor" at §§ 410.54(a)(1) and (3); "addiction counseling" at § 410.54(a)(2); and "substance use disorders" at § 410.54(b)(1). We refer CMS to Appendix A of the ASPE Report, Credentialing, Licensing, and Reimbursement of the SUD Workforce: A Review of Policies and Practices Across the Nation, for information on the terminology and training requirements of Addiction Counselors across the country. However, we note that not all states have licensure or certification standards for a type of addiction counselor that would meet the education and clinical requirements of an MHC. To ensure consistent access to substance use

[18] https://www.williamjames.edu/academics/counseling/clinical-mental-health-counseling-ma/lmhc-licensure/LMHC-LPC-by-state.html
[19] https://amftrb.org/resources/state-licensure-comparison/

disorder counseling throughout the country, and to increase access to treatment in the midst of the ongoing opioid public health emergency, we urge CMS to use its authority to develop additional codes for substance use counseling that could be delivered by these practitioners in office-based and community settings, similar to the services developed for community health workers, patient navigators, and peer support specialists in these proposed rules, and the services identified in the opioid treatment program regulations. See § 410.67(b)(iii). We also urge CMS to work with Congress to authorize Medicare to cover addiction counselors who do not have master's degrees but have the appropriate training and supervision to deliver reasonable and necessary substance use disorder counseling services to Medicare beneficiaries. Allowing these additional substance use disorder counselors to serve Medicare beneficiaries – as many already do for Medicaid enrollees – aligns with CMS's objective to expand the workforce capacity to improve access to substance use disorder prevention, treatment, and recovery services, as outlined in its Behavioral Health Strategy.

Finally, we appreciate CMS' interpretation and inclusion of substance use disorders under this proposal and would suggest incorporating and updating language for "mental health and substance use disorders" in current and future regulations. Updating and using language as such explicitly and clearly includes substance use disorders and would be consistent with terms used across fields and in practice. In CMS' proposed Medicaid Managed Care Access Rule (CMS-2439-P), CMS changed "behavioral health" throughout its regulations to clarify when it meant MH and SUD as it was stated that, "[behavioral health] is an imprecise term that does not fully capture the full array of conditions that are intended to be included…It is important to use clear, unambiguous terms in regulatory text," (88 FR 28092, 28110). Accordingly. For consistency across federal programs, and for much needed clarity for Medicare providers and beneficiaries, we urge CMS to make similar changes throughout the Medicare regulations.

J.1.c. Coding Updates to Allow MFT and MHC Billing (88 FR 52363)

CMS is proposing to revise the code descriptor for HCPCS code G0323 in order to allow MFTs and MHCs, as well as clinical psychologists and CSWs, to be able to bill for monthly Behavioral Health Integration services CBH supports this proposal and efforts that advance behavioral health integration. CMS also welcomes comments regarding any other HCPCS codes that may require updating to allow MFTs and MHCs to bill for the services described in the HCPCS code descriptor. CBH urges CMS to incorporate MFTs and MHCs to be paid under the Medicare program for any services paid to clinical psychologists or CSWs that falls within their scope of practice. Commonly used CPT codes for behavioral health service delivery can be found in CMS' *Medicare Mental Health Booklet* in Table 10. Commonly Used Mental Health-Related CPT Codes.[20] Additionally, CPT codes 90845 – Psychoanalysis and 90849 – Multiple-family group psychotherapy are also codes commonly billed by psychologists.[21] CBH supports the inclusion of all the above-referenced CPT codes, as well

[20] https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf
[21] https://www.apaservices.org/practice/reimbursement/health-codes/psychotherapy

as any other codes that CMS allows to be billed by clinical psychologists and CSWs, in the menu of services reimbursable for MFTs and MHCs that fall within their scope of practice and authorized in their state. We further urge CMS to ensure the reimbursement rates are adequate for delivering these services, account for the systemic undervaluation of work for behavioral health services, and increase where appropriate.

J.1.d. Medicare Enrollment of MFTs and MHCs (88 FR 52364)

Under §424.510, a provider or supplier must complete, sign, and submit to its assigned MAC the appropriate Form CMS–855 (OMB Control No. 0938–0685) application in order to enroll in the Medicare program and obtain Medicare billing privileges. MFTs and MHCs that meet the proposed requirements in §§ 410.53 and 410.54 as finalized, would enroll in Medicare via the Form CMS-855I application (Medicare Enrollment Application – Physicians and Non-Physician Practitioners; OMB No. 0938-1355) and could begin submitting their enrollment applications after the publication of the CY24 PFS final rule for services payable after January 1, 2024 consistent with CAA, 2023.

CBH applauds CMS' attention to mental health and substance use crisis services. Such work is particularly important and critically needed as states develop implementation of 988. We generally support the base rate proposed for psychotherapy for crisis services. We also strongly urge CMS to use any existing mechanisms available to apply the same adjustment factor in terms of rural versus urban locales as well as additional payment for milage crisis as is used for EMS/ambulance services. For future development, CBH recommends CMS consider methodology for this service that is designed to account for the availability of 24/7 services and the full cost of resources needed for successful implementation of this critical service across rural and urban locales. Utilizing a Prospective Payment System (PPS) may be a more appropriate model for furnishing mobile crisis services. If pursued, CBH recommends CMS facilitate a group of stakeholders to define the resources needed and related cost or rate setting for various level of intensity for crisis services. In general, in consideration of this methodology, we believe it is vital to ensure that the proposed rate structure for these crisis services would support the standards defined in CMS' 2021 memo, *Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services*.[22] In a similar vein, CBH is concerned that the actual cost to provide crisis services will not be fully covered with this methodology as proposed. For example, ambulance/EMS is paid for across seven different levels of ambulance/EMS care with a base rate for the trip ranging $306-$994.

The current methodology would not cover this cost in addition to providing psychotherapy for a crisis service. In consideration of MHPAEA, we urge consideration of the differences that may exist between EMS/ambulance coverage for MedSurg conditions as compared to crisis services covered for mental health and substance use conditions. CBH further urges CMS' consideration of the cost to deliver mobile crisis services as there can be varying resources required based on the local context (such as travel times and volume). CBH also seeks clarity on if, using the model as currently proposed, a co-pay would be collected for these service codes, as we recognize that collecting a co-

[22] https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf

pay in this context would be difficult unless crisis psychotherapy is provided to a beneficiary with an existing professional relationship with the provider(s) furnishing the service. Similar issues receiving reimbursement could also arise as not all crisis response teams include independently billing licensed clinicians. Further, CBH is concerned that there is a focus on mobile crisis response at the exclusion of crisis receiving center care – both of which are vital to have access to in the crisis continuum. Additionally, we are concerned that the proposal only attends to individual, independently provided services rather than encouraging a two-person response as the Substance Abuse and Mental Health Services Administration (SAMHSA) encourages as best practice in mobile crisis response and another place where access to peer support is important.[23] CMS should also consider if it would be more appropriate to utilize a methodology similar to what it uses for establishing EMS/ambulance base rates which we assume account for multi-person teams.

Any adjustments to these codes to align with best practices should reflect the appropriate cost of care delivery.

Additionally, CBH highlights that providing vital crisis services is something that Certified Community Behavioral Health Centers (CCBHCs) are particularly well positioned to do.[24] Criteria *2.C: 24/7 Access to Crisis Management Services* in SAMHSA's CCBHC Certification Criteria includes access to 24/7 crisis management services through the crisis continuum.[25] Data show positive outcomes, such as reduced hospitalization rates, for people who receive care at CCBCHs.[26] Utilizing PPS through the CCBHC model enables providers to meet individuals with varying needs where they are with high quality care,[27] something that is essential and dynamic in crisis care delivery.

Furthermore, as previously expressed, CBH strongly supports CMS' broad definition of a beneficiary's "home" to include individuals who may be in temporary lodging such as hotels and homeless shelters (*86 FR 65059*). Applying this broad and inclusive definition in this context helps ensure that beneficiaries who may be in vulnerable situations can receive lifesaving services where they are at.

Additionally, section 4123(d) of the CAA, 2023 requires that the Secretary use existing communication mechanisms to provide education and outreach to providers of services, physicians, and practitioners with respect to the ability of auxiliary personnel, including peer support specialists, to participate, consistent with applicable requirements for auxiliary personnel, in the furnishing of psychotherapy for crisis services billed under the PFS under section 1848 of the Act, behavioral health integration services, as well as other services that can be furnished to a Medicare beneficiary experiencing a mental or behavioral crisis.

CBH notes that practitioners seeking full licensure could serve as "auxiliary personnel" for purposes of "incident to" billing, all other "incident to" billing and state requirements being met. Thus, we urge CMS to recognize and engage these providers in training as a part of communication efforts for

[23] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf
[24] https://www.thenationalcouncil.org/resources/2022-ccbhc-impact-report/
[25] https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
[26] https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/ccbhc-data-impact/
[27] https://www.thenationalcouncil.org/resources/ccbhc-pps-cheat-sheet/

implementation of this provision. Doing so could be helpful to draw attention to this to help support, develop expertise, and grow the workforce for this population.

CMS also recognizes varying definitions for peer support specialists as well as SAMHSA's definition for peer support specialists, as well as the definition for auxiliary personnel as defined in §410.26.(a)(1); noting that the agency will not include definitions of any specific type of personnel who could be included under the definition of auxiliary personnel and are not proposing to do so through this Proposed Rule.

CBH strongly supports the inclusion of peer support specialists as vital providers in the mental health and substance use disorder workforce. Inclusion of peer services in crisis care has shown to improve health outcomes for individuals who experienced a mental health or substance use crisis.[28] We appreciate CMS' acknowledgement of the varying definitions of peer support specialists across states and suggest further consideration of defining peer support specialist services in the Medicare program as the peer workforce grows; providing further clarity for eligible provides may help ensure that such services are indeed accessible to beneficiaries. For example, psychotherapy is not within the scope of the peer support specialist role however, peer support does include engagement, education, and support and are specially trained to respond in a crisis and providing clarity with an appropriate code and adequate reimbursement would help to promote positive outcomes and mitigate possible challenges as described above. We also encourage CMS to provide guidance and support that meaningfully encourages incorporation of peer support services, such as by training clinic staff on the value and role of peer services and ensuring that peer services are utilized in alignment with state scopes of practice for peers.

II.J.3. Implementation of Section 4124 of CAA, 2023 (88 FR 52365)

The CAA, 2023 established Medicare coverage and payment for intensive outpatient services for individuals with mental health needs when furnished by hospital outpatient departments, community mental health centers, RHCs, and FQHCs, effective January 1, 2024.

CBH appreciates CMS' efforts on implementation of section 4124 of the CAA, 2023 and will submit separate comment on the CY 2024 Outpatient Prospective Payment System (OPPS) proposed rule (CMS-1786-P).

J.4. Health Behavior Assessment and Intervention (HBAI) Services (88 FR 52365)

CBH appreciates CMS' recognition that CSWs, MFTs, and MHCs have the education and training to address the psychosocial barriers to meet the needs of patients with physical health conditions, in accordance with state laws and scope of practice, and supports CMS' proposal to allow HBAI services to be billed by CSWs, MFTs, and MHCs, in addition to clinical psychologists, to provide for better integration of physical and behavioral health care. As discussed earlier, there is established literature demonstrating the benefits of behavioral health care integration into primary care settings and studies have shown that this integration leads to improved patient outcomes, better treatment adherence, and

[28] https://store.samhsa.gov/sites/default/files/pep22-06-04-001.pdf

reduced healthcare costs.[29] Strengthening access to qualified and eligible practitioners able to provide such integrated services is an important part of realizing these outcomes for Medicare beneficiaries.

J.5. Adjustments to Payment for Timed Behavioral Health Services (88 FR 52366)

Given eminent need for access to mental health and substance use disorder services, CMS proposes to improve valuation for timed psychotherapy services by addressing valuation distortions for psychotherapy codes payable under the PFS that describe one-on-one time with the patient, that would result in an approximate upward adjustment of 19.1% for work RVUs for these services and would be implemented over a 4-year transition.

CBH applauds CMS' discussion of the national behavioral health crisis and workforce shortage and efforts to take timely on this issue. CBH generally supports the increased adjustment for timed psychotherapy services to more appropriately value these services. Doing so is an important part of mitigating the discussed crisis and workforce shortage, and we support the use of the complexity add-on code when it is appropriate. However, we are concerned that there is a lack of consistency across the family of psychotherapy codes, inclusive of psychological assessments, and we urge CMS to consider that psychotherapy is the same service regardless of provider type in which this service falls under their scope. Ensuring that these codes are reimbursed adequately and increasing reimbursement where appropriate to account for the historical undervaluing of the provision of mental health and substance use disorder services, plays a critical role in increasing mental health and substance use disorder providers in the Medicare program.

J.6. Updates to the Payment Rate for the PFS Substance Use Disorder (SUD) bundle (HCPCS codes G2086-G2088) (88 FR 52369)

In CY 2023 PFS, CMS finalized a modification to the payment rate for the non-drug component of the bundled payment for episodes of care under the Opioid Treatment Program (OTP) benefit to base the rate for individual therapy on a crosswalk to CPT code 90834 (Psychotherapy, 45 minutes with patient) instead of the CPT code relating to a 30-minute psychotherapy session as was provided previously. In response to comments received on the CY 2023 PFS proposed rule that these codes be priced consistent with the crosswalk codes used to value the bundled payments made for OUD treatment services furnished at OTPs, as beneficiaries receiving buprenorphine in settings outside of OTPs may have similarly complex care needs as compared to beneficiaries receiving OUD treatment services at OTPs, CMS is proposing to update the valuation and increase the current payment rate for HCPCS codes G2086 (*Office-based treatment for a substance use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month*) and G2087 (*Office-based treatment for a substance use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month*), to reflect two individual psychotherapy sessions per month by adding 1.08 RVUs to the work value assigned to these HCPCS codes, resulting in a new work RVU of 8.14 for HCPCS code G2086 and 7.97 for HCPCS code G2087. CMS is also proposing to update the work RVUs assigned to CPT code 90834 in this proposed rule, which if finalized, would reflect the updated work RVUs for 90834, resulting in a work RVU of 8.36 for HCPCS code G2086 and a work RVU of 8.19 for HCPCS code G2087.

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[29] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3810022/

CBH appreciates CMS' action in response to comments received on this issue. CBH supports efforts to include sufficient payment for OUD treatment services as a critical component to strengthening opportunity to access these important services. By making the proposed adjustment, CMS will help to increase access to office-based SUD treatment and meet beneficiaries where they are. The increased reimbursement rate will also enable more auxiliary personnel to participate in the interdisciplinary team treating the patient, further ensuring that the beneficiaries have the full range of services and supports they need.

J.7. Comment Solicitation on Expanding Access to Behavioral Health Services (88 FR 52369)

In response to CMS' solicitation for comments on expanding access to behavioral health services, CBH urges CMS' consideration of CCBHCs as a part of the Medicare program, considering any mechanisms that currently exist that may advance such inclusion and support any related statutory changes in the future to this end. CCBHCs are community-based clinics, that meet stringent national standards, providing a comprehensive array of mental health and substance use services – inclusive of offering availability of 24/7 crisis services as described above - and span the continuum of care.[30] Already, data have shown that CCBHCs greatly improve access to mental health and substance use care and can help reduce hospitalizations, address the work shortage, and improve patient outcomes.[31,32] Such outcomes could have particular benefit for some groups of Medicare beneficiaries. For example, CCBHCs have been found to serve a higher proportion of veterans as compared to Community Mental Health Centers;[33] and while it is estimated that roughly half of veterans are Medicare eligible,[34] further access to options for needed mental health and substance use services promotes access to quality care that is specific to the individual's needs.

As discussed earlier in this comment, CBH supports defining clinically supervised experience for Medicare mental health and substance use disorder providers to include direct service experience with callers at 988 call centers, where appropriate for the provider's scope. Crisis counselors responding to 988 calls support people experiencing emotional distress, suicidal ideation, substance use, and/or mental health crisis by helping to mitigate the intensity of crises and to connect them to responsive resources in their area where appropriate.[35]

Additionally, CMS notes the lower rate of participation of psychiatrists in the Medicare program relative to other physician specialties (88 FR 52369). We believe that our comments related to establishing adequate and appropriate rates for mobile crisis services (*section II.J.2.*) and for adjustments to payments for timed behavioral health services (*section II.J.5.*) are important considerations to support increased psychiatrist participation in the program.

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[30] https://www.samhsa.gov/certified-community-behavioral-health-clinics
[31] https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/
[32] https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/ccbhc-data-impact/
[33] https://pubmed.ncbi.nlm.nih.gov/36097722/
[34] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/VA-Data
[35] https://www.samhsa.gov/find-help/988/faqs#:~:text=The%20988%20Lifeline%20crisis%20counselors,needed%2C%20to%20support%20their%20wellbeing

Finally, adequate Medicare payment is critical to ensuring that invaluable mental health and substance use disorder practitioners can provide access to lifesaving services for beneficiaries. In a 2022 report, the Government Accountability Office (GAO) cites low reimbursement rates for mental health services as a contributing factor to service access challenges.[36] Literature has also shown that Medicare reimbursement for physicians for common procedural care is three to five times greater than reimbursement for cognitive care,[37] an issue that may be useful in consideration of valuing cognitive work required to deliver mental health and substance use disorder services. As continued efforts develop to ensure adequate and appropriate reimbursement for Medicare mental health and substance use disorder providers, we are encouraged by the steps being taken in this Proposed Rule. CMS projects the CY24 PFS Conversion Factor (CF) will be $32.7476 which reflects the 2.17% budget neutrality adjustment, the 0.0% update adjustment factor, and the 1.25% payment increase for services furnished in CY24, as provided in CAA, 2023. *88 FR 52679.* This would positively impact PFS services furnished by CSWs, clinical psychologists, psychiatrists, and nurse practitioners, practitioners who are all vital in the delivery of mental health and substance use disorder services for beneficiaries.[38] The importance of continuing to take steps to cover all costs of furnishing mental and behavioral health services and incentivize workforce recruitment and retention in the Medicare program cannot be understated. We are grateful for CMS' efforts in attending to the workforce crisis and related proposals that take steps to address this and support continued work on this issue.

III.B. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (88 FR 52395)

B.2.a. Section 4113 of the Consolidated Appropriations Act, 2023 (88 FR 52396)

Consistent with CAA, 2023, CMS is continuing to apply the delay of the in-person requirements under Medicare for mental health services furnished by RHCs and FQHCs and are proposing to make related conforming regulatory text changes.

Aligned with our comments above, CBH supports continuing to delay the 6-month in-person visit requirement as a glide path to avoid gaps in care once the requirement is reinstated and we urge CMS to provide continued guidance and support to providers in making this transition for Medicare beneficiaries that recognizes the value of in-person care and interactions for older adults and their mental health and wellbeing.

B.2.b. Direct Supervision via Use of Two-Way Audio/Video Technology (88 FR 52397)

CMS reports its belief that extending definition of direct supervision for RHCs and FQHCs, to allow the supervising professional to be immediately available through virtual presence using two-way, real time audio-visual technology, instead of requiring their physical presence, through December 31, 2024, would align the timeframe of this policy with many of the previously discussed PHE-related telehealth policies that were extended under provisions of the CAA, 2023. CMS also notes its concern regarding an abrupt transition to the pre-PHE policy of requiring the physical presence of the supervising practitioner

[36] https://www.gao.gov/assets/gao-22-104597.pdf
[37] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1754364
[38] (See Table 104, *88 FR 52680*, of this Proposed Rule).

beginning after December 31, 2023, given that RHCs and FQHCs have established new patterns of practice during the PHE for COVID-19. CMS also reports that there has been an absence of evidence suggesting that patient safety is compromised by virtual direct supervision, thus an immediate reversion to the pre-PHE definition of direct supervision may present a barrier to access services.

In response to CMS' solicitation for comment on this matter and aligned with our comments above regarding provisions in subsection II.D.(2)(a) of this Proposed Rule, 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 for these services, we believe continuing this flexibility supports beneficiaries' increased access to care as well as a continued opportunity for workforce development – particularly important for workforce shortages that exist in rural locales. And again, while this is an important flexibility, we also urge CMS to provide additional guidance and support and work with other stakeholders to advance broadband in underserved areas. [39]

B.2.c. Section 4121 of the CAA, 2023 (88 FR 52397)

Consistent with CAA, 2023, CMS is proposing to codify payment provisions for MFTs and MHCs under 42 CFR part 405, subpart X beginning January 1, 2024, and RHC and FQHCs would be paid under the RHC AIR and FQHC PPS, respectively, when MFTs and MHCs furnished RHC and FQHC services defined in §§ 405.2411 and 405.2446. As eligible RHC and FQHC practitioners, MFTs and MHCs would follow the same policies and supervision requirements as a PA, NP, CNM, CP, and CSW.

CBH appreciates CMS' efforts in making conforming regulatory changes to applicable FQHC and RHC regulations. Inclusion of MFTs and MHCs in services furnished at RHCs and FQHCs is an important step of furthering access to mental health and substance use disorder services for Medicare beneficiaries. As raised in our comments for CMS' consideration above in section II.J.7., inclusion of CCBHCs in the Medicare program would offer incredible value to beneficiaries. While CCBHCs are not a specific provider type in Medicare, CCBHCs are required to establish care coordination with entities such as with FQHCs and RHCs. Given this pre-existing relationship, the overlap for MFT and MHC services that could be furnished in either location, and because behavioral health services are optional at FQHCs, advancing a relationship and partnership through these entities in the Medicare program could be a point for CMS' further exploration as efforts to improve behavioral health care for beneficiaries advance.

B.2.d. Section 4124 of the Consolidated Appropriations Act, 2023 (88 FR 52398)

Section 4124 of Division FF of the CAA, 2023 establishes coverage and payment under Medicare for the Intensive Outpatient Program (IOP) benefit, effective January 1, 2024, which may be furnished by hospitals, Community Mental Health Centers (CMHCs), FQHCs and RHCs. In addition to existing mental health services furnished by RHCs and FQHCs, this new provision establishes coverage for IOP services furnished in RHCs and FQHCs and includes occupational therapy, family counseling, beneficiary education, diagnostic services and individual and group therapy.

[39] https://www.pewtrusts.org/en/research-and-analysis/articles/2022/12/08/broadband-access-still-a-challenge-in-rural-affordable-housing

CBH appreciates CMS' efforts on implementation of section 4124 of the CAA, 2023 and will submit separate comment on the CY 2024 OPPS proposed rule.

B.3. Updates to Supervision Requirements for Behavioral Health Services furnished at RHCs and FQHCs (88 FR 52398)

In order to be more consistent with applicable policies under the PFS, for CY 2024, CMS is proposing to change the required level of supervision for behavioral health services furnished "incident to" a physician or NPP's services at RHCs and FQHCs to allow general supervision, rather than direct supervision, consistent with the policies finalized under the PFS for CY 2023 (87 FR 46062 through 46068). Accordingly, CMS is proposing to revise the regulations at §§ 405.2413 and 405.2415 to reflect that behavioral health services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided by auxiliary personnel incident to the services of a physician (or another practitioner).

CBH applauds CMS for proposing to apply this expansion to allow behavioral health services furnished "incident to" a physician or NPP at RHCs and FQHCs under general, rather than direct supervision, as well as for when such services are provided by auxiliary personnel.

B.3.c.(2) Payment for Community Health Integration (CHI) Services in RHCs and FQHCs (88 FR 52402)

RCHs and FQHCs can help address SDOHs that significantly impact ability to diagnose or treat a patient. Services attending to SDOHs is not explicitly identified in current coding, and as such, CMS believes it is underutilized and undervalued. Accordingly, CMS is proposing to create new coding, GXXX1 and GXXX2 for Community health integration services, to expressly identify and value these services for PFS payment and distinguish them from current care management services, which includes new coding for purposes of payment to RHCs and FQHCs to describe CHI services performed by certified or trained auxiliary personnel, which may include a CHW, incident to the professional services and under the general supervision of the billing practitioner. The requirements stated in II.E.4.(27).b. of this Proposed Rule are similar to the requirements for the general care management services furnished by RHCs and FQHCs but the level of care coordination, services, and resources required in addressing SDOH need(s) that interfere with diagnosis or treatment of the patient addressed in the initiating E/M visit may not be reflected in the RHC AIR or FQHC PPS payment, something that is particularly important for rural and/or low-income beneficiaries served by these entities.

CBH applauds CMS' efforts to address SDOHs in services furnished at RHCs and FQHCs for Medicare beneficiaries and valuing the level of care and resources that go into providing these services. Given the role that RHCs and FQHCs can play in helping to obtain information and address a beneficiary's SDOH and populations that these entities are well positioned to serve, and aligned with our comments regarding II.E.4.(27) of this Proposed Rule, adequately valuing and advancing access to these services will impact positive health outcomes for beneficiaries. However, consistent with our comments above, CBH recommends that CMS consider this service to be bidirectional across primary care providers and behavioral health providers, when it is appropriate, and strongly recommends that CMS consider an initiating visit not be limited only to providers who use E/M codes.

B.3.c.(3). Payment for Principal Illness Navigation (PIN) Services in RHCs and FQHCs (88 FR 52402)

Consistent with CMS' discussion in section II.E.4.(27).e. of this Proposed Rule, there are two new HCPCS codes proposed to describe PIN services (GXXX3 and GXXX4). The requirements for the proposed PIN services are also similar to the requirements for the general care management services furnished by RHCs and FQHCs, and CMS believes the resources required to provide the level of care coordination and resources needed for individualized help to the patient (and caregiver, if applicable) are not captured in the RHC AIR or the FQHC PPS payment, particularly for the rural and/or low- income populations served by RHCs and FQHCs. Consistent with the new services that are being proposed for practitioners billing under the PFS, CMS is proposing to include PIN services in the general care management HCPCS code G0511 when these services are provided by RHCs and FQHCs.

CBH strongly supports the inclusion of PIN services that are provided by RHCs and FQHCs. As CMS describes, doing so has particular benefit for beneficiaries served by providers who work in rural and/or have low-income areas. Consistent with our comments above on PIN services in II.E.4., ability to access these services for diagnosis and treatment of mental health and/or substance use disorders conditions is reasonable, necessary, and inclusion providers such as patient navigators and peer support specialists have shown to reduce health care spending and improve health outcomes.[40] As described in our comments above, if the rate for these services is set sufficiently high, this proposal will take an impactful step towards supporting and incentivizing team-based care for beneficiaries with mental health and/or substance use disorder conditions and would help advance equity and consistency with MHPAEA.

III.C. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Conditions for Certification or Coverage (CfCs) (88 FR 52407)

C.2.b. Staffing and Staff Responsibilities (§491.8) (88 FR 52409)

Consistent with CAA, 2023, CMS proposes to add conforming changes to CfCs to include MFT and MHC services as recognized staff for RHCs and FQHCs.

CBH supports CMS' efforts to conform regulatory text consistent with changes made in the CAA, 2023 to include MFT and MHC services as recognized staff for RHCs and FQHCs and appreciates CMS' discussion of the specific barriers to accessing mental health and substance use disorders services for people living in rural areas.

[40] https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00981; https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-substance-use-disorders-2017.pdf; https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf.

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III.F. Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (88 FR 52413)

F.2. Additional Flexibilities for Periodic Assessments furnished via Audio-only Telecommunications (88 FR 52414)

To better align coverage for periodic assessments furnished by OTPs with the telehealth flexibilities described in section 4113 of the CAA, 2023, CMS is proposing to extend the audio only flexibilities for periodic assessments furnished by OTPs through the end of CY 2024. Under this proposal, CMS would allow periodic assessments to be furnished audio-only when video is not available 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 for Medicare beneficiaries such as the changes made in CY 2023 PFS that allowed for the initiation of treatment with buprenorphine via telecommunications technology and allowing Medicare reimbursement for services furnished by mobile units to beneficiaries. We support CMS' proposal to extend 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. Statutory requirements permitting, CBH supports permanent expansion of this flexibility, with continued monitoring and evaluation of beneficiary outcomes, as an important component of engaging and initiating these services of Medicare beneficiaries and curtailing the existing barriers that can exist to accessing care for this population – particularly for beneficiaries who are older, racial/ethnic minorities, dual-enrollees, living in rural areas, experience low broadband access, low-income, and/or do not speak English as their primary language as CMS notes (*88 FR 52415*).

F.3 Intensive Outpatient Program (IOP) Services Provided by OTPs (88 FR 53416)

In the CY 2024 Outpatient Prospective Payment System (OPPS) proposed rule, CMS provides the full policy discussion and additional details regarding Medicare payment for IOP services provided by OTPs.

CBH appreciates CMS' efforts regarding Medicare payment for IOP services provided by OTPs and will submit separate comment on the CY 2024 OPPS proposed rule (CMS-1786-P).

III.O. Hospice: Changes to the Hospice Conditions of Participation

O.2.a. Updates to the Hospice CoPs To Permit Mental Health Counselors or Marriage and Family Therapists To Serve as Members of the Hospice Interdisciplinary Group (§§418.56 and 418.114) (88 FR 52540)

In accordance with CAA, 2023, CMS is proposing to revise §418.56(a)(1)(iii) to specify that the interdisciplinary group (IDG) must include a social worker, an MFT, or an MHC. CMS emphasizes that it is important for the hospice to assess and determine, along with the input from the patient and family, care and services best align with the preferences and needs of the patient.

CBH strongly supports this statutorily required change and appreciates CMS' acknowledgement of the importance of collaborative decision making between provider, client, and family in providing the best care aligned to that patient's needs and preferences. Beneficiaries' access to robust care provider options to meet their needs is pivotal in providing quality care, during what can be a particularly difficult time, and help to decrease distress.[41]

III.S. A Social Determinants of Health Risk Assessment in the Annual Wellness Visit (88 FR 52548)

S.3. Proposal (88 FR 52550)

CMS is proposing to exercise its authority in section 1861(hhh)(2)(I) of the Act to add elements to the Annual Wellness Visit (AWV) by adding a new Social Determinants of Health (SDOH) Risk Assessment as an optional, additional element with an additional payment proposed to be paid at 100 percent of the fee schedule amount and that the new SDOH Risk Assessment be separately payable with no beneficiary cost sharing when furnished as part of the same visit with the same date of service as the AWV. CMS proposes that the SDOH Risk Assessment service include the administration of a standardized, evidence based SDOH risk assessment tool, furnished in a manner that all communication with the patient be appropriate for the patient's educational, developmental, and health literacy level, as well as be culturally and linguistically appropriate.

As noted earlier in our comments, attending to SDOHs is critical to providing high-quality, responsive mental health and substance use disorder services for an individual and addressing SDOHs within primary care can lead to more equitable healthcare outcomes. We are grateful for CMS' efforts and attendance to valuing and promoting access to services that attend to beneficiaries SDOHs to promote positive and equitable health outcomes. However, CBH strongly recommends that CMS consider an initiating visit not be limited only to providers who furnish AWV. As currently written, this proposal does not necessarily mitigate the barriers raised to beneficiaries' AWV completion and it is possible that a beneficiary may seek specialty care for a mental health or substance use disorder concern prior to completing an AWV, where a SDOH assessment would be important to conduct in providing care and a treatment plan. Furthermore, the impact of SDOH on mental health and substance use disorder

[41] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6986450/

conditions is just as important as it is on physical health conditions.[42] In this Proposed Rule, CMS notes that practitioners across specialties have recognized the importance of SDOH on the care provided to their patients and stated their belief that this tool would be most effective when furnished in a setting with staff-assisted supports in place to ensure follow-up; this does not necessarily limit ability to furnish only in an AWV. While it is proposed to be optional, if the assessment is furnished with another service outside the AWV that is subject to beneficiary cost sharing, cost sharing would then apply, which linguistically appropriate notice could be provided to the beneficiary prior to the service being furnished.

IV. Updates to the Quality Payment Program (88 FR 52552)

A.3.d. Request for Feedback (88 FR 52557)

CMS is seeking comment on how their policies under the Quality Payment Program can be modified to foster clinicians' continuous performance improvement and positively impact care outcomes for Medicare beneficiaries. CMS suggests that such modifications for MIPS may include requiring more rigorous performance standards, emphasizing year-to-year improvement in the performance categories, or requiring that MIPS eligible clinicians report on different measures or activities once they have demonstrated consistently high performance on certain measures and activities.

In light of the inclusion of MFTs and MHCs as providers eligible to enroll in the Medicare program, CBH recommends the inclusion of these provider types as being MIPS-eligible.

A.4.a. Development of New MIPS Value Pathways (MVPs) (88 FR 52558)

CMS is proposing "*Focusing on Women's Health*" and "*Quality Care in Mental Health and Substance Use Disorder*" two of the five new MVPs. (See *Appendix 3: MVP Inventory* of this Proposed Rule, *88 FR 53146*).

CBH supports the development of the new MVPs, *A.1 Focusing on Women's Health* and *A.4 Quality Care in Mental Health and Substance Use Disorder*. We applaud any additional MIPs measures or value pathways applicable to behavioral conditions as behavioral health conditions are significantly under dressed overall in the MIPS program.

In *A.1*, we appreciate the inclusion of the quality measure, *Q134: Preventative Care and Screening: Screening for Depression and Follow-Up Plan*. The Centers for Disease Control and Prevention (CDC) estimate that approximately one in eight women who recently delivered experienced symptoms of postpartum depression, which can have negative impacts on both parents and children, but is identifiable and treatable.[43,44] Additionally, we appreciate the inclusion of attending to prevention and

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[42] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6696493/; https://nida.nih.gov/about-nida/noras-blog/2023/04/social-determinants-health-cant-be-extricated-addiction-science; https://fsph.iupui.edu/doc/research-centers/Social-Determinants-of-Health-and-Their-Impact2.pdf

[43] https://www.cdc.gov/reproductivehealth/depression/index.htm

[44] https://publications.aap.org/pediatrics/article/143/1/e20183260/37306/Incorporating-Recognition-and-Management-of?autologincheck=redirected

alcohol use disorder through *Q431: Preventative Care and Screening: Unhealthy Alcohol Use: Screening & Brief Consultation*. The inclusion of these quality measures helps further access to prevention, early intervention, and quality care. However, attending solely to screening and referral of pregnant people may not have a large impact given the small portion of pregnant and postpartum people with Medicare coverage. We believe a greater impact could be made to do the same screening for persons following accidental injuries.

Regarding *A.4*, CBH is strongly supportive of this new MVP and the included quality measures aiming to promote prevention and quality care for mental health and substance use disorders. Aligned with our comments above, we appreciate CMS' language choice to distinctly include both mental health and substance use disorder in this MVP.

A.4.d.(3)(b). Complex Patient Bonus for Subgroups (88 FR 52560)

As described in the Proposed Rule, CMS has identified issues with using claims data associated with the clinicians in a subgroup that prevents them from calculating the complex patient bonus at the subgroup level. Specifically, they are unable to identify the beneficiaries seen by the clinicians in a subgroup and thus cannot calculate the average Hierarchical Condition Category (HCC) risk score and dual eligible ratio scores. CMS recognizes that they would need to retroactively modify the previously established policy for CY23 performance period. CMS is proposing to add § 414.1365(e)(4)(i) to provide that for subgroups, beginning with the CY 2023 performance period/2025 MIPS payment year, the affiliated group's complex patient bonus will be added to the final score. Additionally, CMS is proposing conforming changes in § 414.1380(c)(3)(v) by removing the term "subgroups" so that beginning with the CY 2022 performance period/2024 MIPS payment year, the complex patient bonus is limited to MIPS eligible clinicians, groups, APM Entities, and virtual groups with a risk indicator at or above the risk indicator calculated median. Similarly, CMS is proposing conforming changes in § 414.1380(c)(3)(vi) by removing the term "subgroups" so that beginning with the CY 2022 performance period/2024 MIPS payment year, for MIPS eligible clinicians and groups, the complex patient bonus components are calculated as described under § 414.1365(c)(3)(vi).

CBH supports this proposal as it would help advance mental health and substance use disorder care equity. Persons with SMI have much higher HCC risk scores and will be in complex subgroups. This proposal would address these factors and likely have a positive impact on providers serving people with SMI.

A.4.f.(2)(a)(iii) New Episode-Based Measures Beginning with the CY24 Performance Period/2026 MIPS Payment Year (88 FR 52571)

CMS is proposing to add five new episode-based measures to the cost performance category, inclusive of a *Depression* measure and *Psychoses and Related Conditions* measure. The *Depression* measure is a chronic condition episode type as CMS asserts that this expresses assessment out outpatient treatment and ongoing care management. The *Psychosis and Related Conditions measure* is an acute inpatient medical condition episode-based measure. CMS describes that Psychosis was selected as a measure because it was identified as one of the most common hospitalizations for inpatient stays and would contribute to filling the gap in the cost performance category of mental health care as currently there are no episode-based or other cost measures assessing this clinical area.

CBH supports the inclusion of the *Depression* and *Psychoses and Related Conditions* measures. We applaud CMS' inclusion of these measures in the Proposed Rule as a part of recognizing and valuing the services provided by the behavioral health workforce. As described in CBH's comment on Request for Information; Episode-Based Payment Model (CMS–5540–NC), about one in four Medicare beneficiaries live with mental illness — conditions such as depression, anxiety, schizophrenia, and bipolar disorder — but only 40 percent to 50 percent receive treatment.[45] In addition, it is estimated that approximately 1.7 million Medicare beneficiaries have a past-year substance use disorder, yet only 11% received treatment. When it comes to episode-based models, behavioral health prevention, screening and engagement can impact patient outcomes positively or negatively, if not accounted for. That evidence has been demonstrated in current episode-based models. Research found that preoperative and postoperative opioid use is associated with poorer outcomes in patients with total knee replacement, including higher rates of complications, longer hospital stays, increased costs, and more frequent need for revision surgery.[46] Research found that there is considerable presence of depression in patients receiving coronary artery bypass graft surgery (CABG) and that systematically detecting depression prior to cardiac surgery could identify patients at potential risk.

A.4.f.(3)(b)(ii) Changes to the Improvement Activities Inventory (88 FR 52577)

CMS proposes two new activities in the Behavioral and Mental Health (BMH) subcategory and notes the importance reflected here of this Federal priority. Specifically, IA_BMH_XX, titled "Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women" would allow MIPS eligible clinicians to receive credit for screening for perinatal mood and anxiety disorders (PMADs) and substance use disorder in pregnant and postpartum women, as well as screening and referring to treatment and/or referring to appropriate social services in patient care plans. The second new activity being proposed in the BMH subcategory is IA_BMH_XX, titled "Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults", which would allow MIPS eligible clinicians to receive credit for the completion of age-appropriate screening for mental health and substance use in older adults, as well as screening and referring to treatment and/or referring to appropriate social services in patient care plans.

CBH applauds CMS' efforts attending to and prioritizing mental health and substance use disorders under this program. As we noted above, allowing credit for screening and referral of pregnant people may not have a large impact given the small portion of pregnant and postpartum people with Medicare coverage. We believe a further impact could be made to include the same screening for persons following accidental injuries.

[45] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771518; https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm
[46] https://orthopedicreviews.openmedicalpublishing.org/article/37496

VII. Regulatory Impact Analysis (88 FR 52674)

C.3.d. Behavioral Health (88 FR 52688)

CMS is considering adding elements to their impact analysis which would detail how policies impact particular patient populations from an equity perspective, this is inclusive of identifying presence of a behavioral health diagnosis code.

CBH strongly endorses persons with serious mental illness being identified as both a health equity and a health care disparities population. Persons with serious mental illness have two to three times the rate of chronic medical disorders as the general population and significantly higher rates of premature mortality. Incorporating this consideration into CMS' impact analysis helps advance health equity.[47]

In sum, CBH appreciates the work CMS has taken to improve access to critical mental health and substance use disorder services for Medicare beneficiaries is encouraged by CMS' proposed CY24 PFS.

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

Sincerely,

Shannon Hall
Executive Director

[47] https://www.nasmhpd.org/sites/default/files/2022-08/Mortality%2520and%2520Morbidity%2520Final%2520Report%25208.18.08_0.pdf