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September 6, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1786-P

Submitted via regulations.gov

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction (CMS-1786-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 Services (CMS) proposed rule addressing changes to the Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems…. ("the Proposed Rule"), at 88 *Federal Register* ("FR") 49552 (July 31, 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.

CBH's comments on the Proposed Rule focus primarily on the provisions discussing CMS' implementation of the new intensive outpatient services (IOP) benefit, as required under the Consolidated Appropriations Act 2023 (CAA 2023), Pub. L. No. 117-328, Div. FF, Section 4124(b); as well as CMS' proposed modifications and updates to coverage and payment for partial hospitalization programs (PHP) in Medicare. These provisions are located at 88 FR 49697-49709.

PHP and IOP are each defined as a bundle of outpatient behavioral health services, ranging from psychotherapy to activity therapies and family counseling, that are furnished under a physician's certification and written plan of treatment. Despite their differing levels of intensity, both IOP and PHP are intended to be provided several days per week, during service days featuring multiple services. Under the law as amended by CAA 2023, payment to outpatient hospital departments (OPDs) and community mental health centers (CMHCs)—as well as, for IOP only, federally qualified health centers and rural health clinics (FQHCs/RHCs)—is to be made under the OPD prospective payment system (PPS), which uses per diem ambulatory service classifications (APC) to pay for a day of IOP or PHP. The introduction of IOP, in combination with other important Medicare reforms in CAA 2023, significantly expands the range of vital behavioral health services that CMHCs

and other community-based behavioral health providers can furnish under Medicare, effective in 2024. These long-sought reforms will improve the effectiveness of the Medicare program by enhancing its behavioral health benefit, and also, will enhance the ability of community-based behavioral health providers to meet the behavioral health needs of dual eligible (Medicare-Medicaid) beneficiaries, who compose a large portion of community behavioral health providers' Medicare population. Additionally, the new IOP benefit forms a bridge between the existing PHP service and the range of lower-intensity outpatient behavioral health services covered under the program.

In general, CBH believes that CMS' proposed coverage and payment provisions under the Medicare OPD PPS for PHP and IOP further buttress the continuum of care, particularly in hand with the new inclusion of Marriage Family Therapists (MFTs) and Mental Health Counselors (MHCs) in the Medicare program. For example, we support CMS' proposed use of two routine ambulatory payment classification (APC) codes each for PHP and IOP within OPDs and CMHCs. Bifurcating each service into two tiers takes into account the varying levels of need among individuals receiving services. We further support CMS' proposed additions to the HCPCS codes to be included in the PHP and IOP benefits, which take into account a broader array of services (including peer services, discharge support, and crisis services) to allow the provision of PHP or IOP to be tailored to each person's needs.

However, as noted in more detail below, CBH urges CMS to reconsider certain provisions of the proposal, or to select certain alternatives set forth in the Proposed Rule preamble. The most significant of these suggestions are the following:

- **We strongly urge CMS to implement site-neutral payment.** As to payment methodology for IOP and PHP under the OPD PPS, CBH urges CMS to finalize a site-neutral payment rule—i.e., each provider eligible to furnish PHP (i.e., OPD or CMHC) or IOP (i.e., OPD, CMHC, FQHC, or RHC) should receive the same per diem payment rate for a given service, regardless in which setting (facility) the service is provided. We believe doing so would be consistent with previously established law, treatment of other free-standing entities furnishing the same services, and aligned with CMS' described approach in evaluating future data applicable to the payment methodology. As described in our comments below regarding section VIII.D. of the Proposed Rule, we believe that a site-neutral approach is equitable and consistent with fair pricing of services and efficiency in the Medicare program. **We urge CMS to reduce barriers to facilities furnishing and billing Medicare for services under both OPD PPS and Medicare Physician Fee Schedule.** CBH further urges CMS to clarify two issues, each for the purpose of reducing barriers to community-based behavioral health providers enrolling in Medicare as CMHCs and providing as comprehensive as possible an array of outpatient behavioral health services to Medicare beneficiaries:
    - We request that CMS clarify that entities enrolled as CMHCs in Medicare may also be enrolled as Medicare Part B physician practices, and may furnish outpatient behavioral health services under the Medicare Physician Fee Schedule (PFS) under such an enrollment, as well as being enrolled as a CMHC and furnishing PHP or IOP services. While it appears clear to us from the law that this is acceptable, it would be helpful for CMS to dispel any doubt on this issue, so that behavioral health organizations understand that they may enroll as both provider/supplier types to furnish a full continuum of Medicare-covered outpatient behavioral health services. Further, this clarification would help expand the availability of PHP and IOP in community settings by

encouraging community-based organizations that have previously not enrolled as Medicare CMHCs to do so.

- CMS seeks comment on whether the introduction of the IOP benefit will result in challenges for CMHCs in meeting the requirement under the CMHC conditions for participation that at least 40 percent of its services furnished by the CMHC be provided to individuals who are not eligible for Medicare. We urge CMS to help reduce the barriers to community-based providers enrolling in Medicare as CMHCs (and accordingly, expand Medicare beneficiaries' access to vital community-based behavioral health services), by clarifying that the "40 percent requirement" may be met by taking into consideration *all services* furnished by the facility in a given year—not merely the PHP and/or IOP services that the facility furnishes as a CMHC.

- In various provisions of the Proposed Rule, CMS has indicated that references to "mental health" in the PHP/IOP regulations are intended to be inclusive of both mental health and substance use disorders. We encourage CMS to amend the text of the regulations in order to refer specifically to substance use disorders as qualifying diagnoses for PHP/IOP eligibility, and to make other comparable changes. 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, and would mitigate ambiguity.

We have additionally suggested various specific clarification in proposed regulatory text. Below, we have associated our comments with the numbered topic section used in Section VIII of the Proposed Rule. We have placed our comments in the order in which topics appear.

VIII. Payment for Partial Hospitalization and Intensive Outpatient Services

Section VIII.A.2 (Revisions to PHP Physician Certification Requirements)

Addition of 20-hour requirement to physician certification. CMS proposes to codify in regulation the requirement that, as a condition for certifying a person for PHP, a physician determine (among other requirements) that the patient needs a minimum of 20 hours of PHP services per week. CMS would add this requirement to the PHP certification requirements in 42 CFR 424.24(e)(1)(i). (88 FR 49698-49699.)

CBH is supportive of this revision. CAA 2023, Section 4124(a) added to the statutory definition of PHP a provision indicating it is available only to those determined to have a need for PHP services for a minimum of 20 hours per week.

Requirement of first physician recertification within 18 days. CMS states that it intends to maintain in the regulations the requirement that any initial recertification for partial hospitalization services take place by the 18th day of services. (See 42 CFR § 424.24(e)(3)(ii).) CAA 2023, Section 4124(a) modified the statutory definition of PHP to require that the physician recertification for PHP services occur "not less frequently than monthly." (88 FR 49699.)

CBH recommends that CMS reconsider the timing associated with the initial PHP recertification requirement, given that the federal statute now specifies that recertification should occur "not less frequently than monthly," whereas the initial recertification timeline in the existing regulation is significantly shorter. It may be clinically beneficial for the PHP to have more days of furnishing partial hospitalization before determining whether recertification is warranted for the person.

Other CBH comments impacting both PHP and IOP:

Additionally, several issues below discussed with respect to IOP services, also apply to PHP services. Specifically,

1. CBH supports the use of site-neutral payments under the OPD PPS (i.e., the same payments regardless of whether the provider is an OPD, CMHC, FQHC or RHC) to pay for both PHP and IOP.
2. CBH is supportive of CMS' proposals to add various services and service codes to the scope of IOP and PHP to develop a more comprehensive bundle of services and acknowledge the important role in recovery played by services such as peer supports and caregiver-related services. Further, while we do not object to CMS' proposal to use a subregulatory process to consider and adopt new HCPCS codes to add to the scope of IOP and PHP services, we do recommend that CMS amend the text of the regulations at 42 C.F.R. §§ 410.43(a)(4) and 410.44(a)(4) to refer to the new categories of services (e.g., peer services, discharge service, etc.), to increase transparency as to the scope of the covered PHP/IOP benefits.
3. For purposes of the clinicians' services that CMS currently excludes from the OPD PPS payment methodology for covered PHP services (see 42 CFR § 410.43(b)) and for which CMS proposes the same exclusions for IOP services (see proposed 42 CFR § 410.44(b)), as detailed below, CBH requests that CMS clarify that CMHCs may bill Medicare independently under the Medicare Physician Fee Schedule (PFS) for the excluded services. Further, we urge CMS to clarify that nothing in the rules prohibits facilities enrolled in Medicare as CMHCs from being simultaneously enrolled in Medicare as physician group practices. In that capacity, the organizations may furnish (as well as IOP and PHP) a full complement of Part B-covered outpatient behavioral health services, and may receive payment (via reassignment by Part B-enrolled clinicians) through the PFS for these services.
4. CBH welcomes CMS' clarification in the preamble to the Proposed Rule that both PHP and IOP services may be furnished for the treatment of substance use disorders, as well as mental illness. Nonetheless, we request that CMS clarify this issue *in the regulatory text* for both PHP and IOP, as specified below, in order to eliminate any ambiguity about this issue.

VIII.B. Intensive Outpatient Program Services

CBH enthusiastically supports the rollout of the IOP benefit in Medicare. Overall, we consider CMS' proposed regulatory implementation to be consistent with the CAA 2023 statute and to take positive initiative in some areas, such as proposed expansions to the scope of the HCPCS codes that may be furnished under the PHP and IOP benefits.

With respect to payment provisions, definitions, and conditions of participation, CBH recommends below several refinements or different policy directions we would recommend that CMS pursue in the Final Rule in order best to incentivize and reduce barriers to the provision of a full continuum of PHP, IOP and other outpatient behavioral health services for Medicare beneficiaries in community settings.

Proposed definition of "intensive outpatient services" at 42 CFR § 410.2. CMS proposes to define the IOP service, at 42 CFR § 410.2, as "a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in § 410.44. Intensive outpatient services are not required to be provided in lieu of inpatient hospitalization." (88 FR 49700)

CBH is generally supportive of this definition. CBH recommends that at the end of the second sentence, the following phrase be added: "and represents a less intensive service than partial hospitalization on the behavioral health continuum of care." We suggest this additional wording because otherwise, the definitions of IOP and of PHP under 42 C.F.R. § 410.2 would be identical, save for the recognition that IOP is not provided in lieu of hospitalization, and for the different internal regulatory reference regarding the scope of covered services. Therefore, it might not be clear to the reader how the IOP service is substantively different from PHP.

Proposed conditions for provision of IOP at 42 CFR § 410.44(a).CMS proposes to define the conditions for the provision of IOP in a manner that is substantially identical to the PHP requirements—specifically, that the services be (1) "reasonable and necessary for the diagnosis or active treatment of the individual's condition"; (2) "reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization"; and (3) "are furnished in accordance with a physician certification and plan of care" as specified in new regulations at Section 424.24(d). Further, IOP would be required to include any of a list of services specified in Section 410.44(a)(4). (88 FR 49700)

This definition is generally consistent with CMS' policy definition the Proposed Rule to conform the regulatory requirements for IOP as closely as possible to those for partial hospitalization services. CBH is cautiously supportive of this approach, but we do urge CMS to remain open to the potential need to reevaluate some of the aligned provisions once the IOP benefit has been in place for several years.

With respect to 42 C.F.R. § 410.44(a), we suggest that paragraph (a)(2) be modified to read as follows: "reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse *or worsening of the individual's condition."* Since under the statute, persons eligible for IOP are not required to have a hospitalization level of need, and IOP is not (as PHP is) a substitute for hospitalization, we suggest it may be appropriate to use more expansive standard when considering the treatment goals of IOP, rather than referring to the IOP as being intended to avoid hospitalization.

Proposed scope of IOP service benefit at 42 CFR § 410.44(a)(4). At 42 CFR § 410.44(a)(4), CMS provides a list of services proposed to be included as IOP services, based on the list in the statutory IOP definition at Section 1861(ff)(2) of the Social Security Act (SSA). CMS also notes that SSA § 1861(ff)(2) provides that IOP services (like PHP services) may include such other items and services as the Secretary may provide (but in no event to include meals and transportation). The list of IOP services in the proposed text of Section 410.44(a)(4) is no broader than the statutory definition in SSA 1861(ff)(2), but in Section VIII.C below, CMS is soliciting comments on potential additions. (88 FR 49700).

As explained in more detail below, CBH is supportive of each addition CMS proposes in Section VIII.C to the scope of the IOP and PHP benefits. CBH nonetheless recommends that when CMS finalize new services to be included in the IOP and PHP benefits (see Table 43 of the Proposed Rule, 88 FR 49704), CMS also include a general description of the added service category (e.g., "peer support services," "discharge-related services") in the regulatory text at 42 § CFR 410.44(a)(4).

Exclusions from IOP services (42 C.F.R. § 410.44(b)). CMS proposes that for IOP, five service types be excluded from payment under the OPPS: physician services, PA services, NP/CNS services, qualified psychologist services, and services furnished to residents of a skilled nursing facility (SNF). These service exclusions would match regulatory exclusions for PHP in 42 C.F.R. § 410.43(b). (88 FR 49700-49701)

Generally, CBH does not object to the exclusions, but wishes to confirm our understanding that, consistent with Medicare Claims Processing Manual, Chapter 4, Section 260.1.1(C), CMHCs are instructed to bill for the PHP services that are excluded from the OPD PPS separately on a Part B (1500) claim, under their Part B physician practice enrollment. Since CMS intends to implement the same exclusion of certain practitioner services from the APCs for IOP (at proposed 42 C.F.R. § 410.44(b)), CBH requests that CMS clarify that the same billing rules would apply for services rendered to IOP participants that would otherwise fall within the IOP benefit, but are furnished by physicians, PAs, NPs/CNSs, or psychologists. This is critical to maintain appropriate care for beneficiaries. For example, beneficiaries with eating disorders receiving IOP services may have a physician, PA, or NP/CNS who may be a part of their care team given acute and ongoing physical health complications that can occur.[1,2]

More generally, CBH requests that CMS clarify and reaffirm that nothing in the Medicare rules prohibits or discourages facilities enrolled in Medicare as CMHCs from maintaining simultaneous enrollment as a Part B practice, enabling clinicians associated with the facility to bill for (and reassign payment to the facility for) the full range of outpatient behavioral health services covered under the Physician Fee Schedule. In light of CMS' stated goal in the regulations of "ensuring the continuum of coverage of outpatient mental health services under the Medicare program," 88 FR

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9324705/
[2] https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf

49846, such a clarification would be immensely helpful to encourage community behavioral health providers to furnish as full a complement of Medicare-covered outpatient services as their clinical capacity allows.

Additionally, CBH wishes to confirm our understanding that while some of the IOP services that are excluded from the OPD PPS per this provision may fall under the Medicare outpatient mental health treatment limitation (see SSA §1833(c)(2), and see further discussion below), such services would not be impacted by the daily mental health cap under the OPD PPS to which CMS refers in the Proposed Rule preamble at 88 FR 49708, given that the excluded services are billed and paid for under the PFS, not the OPPS.

Finally, CBH requests for CMS to clarify whether MHC, MFT, and clinical social worker (CSW) services, when rendered to participants in a PHP or IOP, will (like the professional services of the clinicians presently listed in 42 C.F.R. §410.43(b) and proposed §410.44(b)) be considered to be excluded from the OPD PPS, and paid for via the PFS instead. If this is the case, CBH requests that the regulations be amended to reflect the addition of those professionals to the exclusion effective January 1, 2024.

Clarifications regarding use of PHP and IOP for individuals diagnosed with substance use disorders (SUD), and for purposes of the treatment of SUD (42 CFR §§ 410.43, 410.44). CMS clarifies that, in general, notwithstanding the requirement that PHP services are provided in lieu of inpatient hospitalization, Medicare covers PHP for the treatment of SUD, and CMS considers services that are for the treatment of SUD and behavioral health generally to be consistent with the statutory and regulatory definition of PHP. CMS clarifies the same with respect to IOP, under its newly proposed provisions. For example, while the PHP and proposed IOP patient eligibility criteria refer to individuals with a "mental health diagnosis," CMS is clarifying that "a mental health diagnosis would include SUD and behavioral health diagnoses generally under both the existing [PHP] regulation at Section 410.43(c)(5) and the proposed [IOP] regulation at Section 410.44(c)(5)." Similarly, CMS seeks to clarify that the terms "trained psychiatric nurses, and other staff trained to work with psychiatric patients," as used in Section 410.43(a)(4) and in proposed Section 410.44(a)(4) in the definition of the covered PHP and IOP benefits, would include trained SUD nurses and other staff trained to work with SUD patients. (88 FR 49700-49701)

CBH appreciates CMS' recognition that nothing in the law forecloses the use of PHP or IOP for the treatment of SUD; similarly, nothing prevents SUD diagnoses from being qualifying diagnoses for PHP or IOP eligibility, or prevents nurses trained in the treatment of SUD from being considered "trained psychiatric nurses" for purposes of the PHP/IOP benefits.

We recommend that CMS clarify this issue with full transparency by *amending the relevant regulations* to refer appropriately to SUD, rather than simply noting in the regulatory text that the term "mental health diagnosis" should be interpreted as inclusive of SUD diagnoses, or that the term "psychiatric nurses" should be interpreted to include SUD-trained nurses.

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Accordingly, we recommend that CMS amend 42 CFR §§ 410.43(c) and proposed 410.44(c) to refer to a "mental health or SUD diagnosis," and that CMS amend 42 CFR §§ 410.43(c) and proposed 410.44(c) to refer to "trained psychiatric nurses and trained SUD nurses." It is our understanding that for many years, CMS has sought to dispel a misunderstanding that PHP cannot be used for the treatment of SUD, and CMS seeks to prevent any similar misunderstanding for purposes of IOP. The best means of clarifying the issue is to include mention of SUD in the regulatory text. CBH has submitted similar comment on this issue separately as well on the CY24 Physician Fee Schedule propose rule.

Technical changes to include codify requirements for IOP at CMHCs (42 CFR §§ 410.2 and 489.2). CMS proposes to amend the regulatory provision on CMHC provider agreements at 42 CFR 489.2(c)(2) to specify that CMHCs may enter into provider agreements only to furnish PHP **and IOP** services. Similarly, CMS proposes to amend the Medicare definition of "Participating" for purposes of the CMHC CoPs to list IOP (in addition to the existing PHP) as services CMHCs can provide under the CMHC enrollment. CMS also clarifies in the preamble that an entity would not be required to furnish both PHP and IOP in order to qualify as a CMHC. (88 FR 49701).

CBH does not object to the wording of these changes. We also appreciate CMS' clarification that organizations need not furnish both PHP and IOP in order to qualify as a CMHCs. Nonetheless, we are concerned that there may be a mistaken impression that 42 C.F.R. § 489.2 means that the only clinical activities for which an entity enrolled as a CMHC may bill Medicare are PHP and IOP services. We would like to ask CMS to dispel this potential misconception by stating clearly in the preamble to the Final Rule that *nothing in the CMHC conditions for participation prevents or discourages entities enrolled as CMHCs from also being enrolled in Medicare as Part B suppliers (physician groups) furnishing outpatient behavioral health services covered under the PFS*. Currently, many community behavioral health organizations are not enrolled in Medicare as CMHCs, but instead only as Part B suppliers (physician groups). If CMS clarifies that one entity can operate under both enrollment types, this clarification will motivate more community behavioral health providers to seek to enroll in Medicare as CMHCs, because it will convey that by choosing to provide PHP and IOP, these providers would not be required to relinquish any of the current behavioral health service array that they provide to Medicare beneficiaries.

Technical changes to include codify coverage of IOP at CMHCs (42 CFR § 410.2). CMS proposes to revise the definition of "CMHC" at 42 CFR § 410.2 to state that a CMHC is an entity that provides day treatment or other partial hospitalization services or intensive outpatient services, or psychosocial rehabilitation services. (88 FR 49701).

CBH does not object to the wording of this provision. Nonetheless, we do seek clarification why the regulatory definition of "CMHC" in 42 CFR § 410.2. includes a reference to psychosocial rehabilitation services. It is our understanding that PHP and IOP are the only two discrete Medicare services for which CMHCs may bill the program under the CMHC enrollment, and other regulatory provisions are consistent with that.

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Exclusion of IOP services from the outpatient mental health treatment limitation (42 CFR § 410.155(b)(2)(iii)). Consistent with CAA 2023, Section 2124(b)(3), CMS proposes to amend the regulations to state that IOP services not directly provided by a physician are not subject to the outpatient mental health treatment limitation under Section 1833(c)(1) of the SSA. The SSA currently includes the same provision for PHP services. (88 FR 49702).

CBH is supportive of the CAA 2023 provision, as well as its implementation by CMS. We do request clarification by CMS that due to the application of Section 1833(c)(2) of the SSA, the mental health treatment limitation does not apply to services furnished as part of the PHP or IOP benefits by clinicians other than physicians, which are included in the exceptions from payment under the OPD PPS, per 42 CFR §§ 410.43(b) and 410.44(b) and which, despite their inclusion within the PHP and IOP benefits, would be billed and paid for under the PFS, would not be subject to the mental health treatment limitation.

As background, the law at SSA Section 1833(c)(2) currently excepts from the outpatient mental health treatment limitation "partial hospitalization services that are not directly provided by a physician." Nonetheless, the Medicare Claims Processing Manual, Chapter 4, Section 260.3, provides: "The outpatient mental health treatment limitation applies to services to partial hospitalization patients to treat mental, psychoneurotic, and personality disorders *when furnished by physicians, clinical psychologists, NPs, CAHs, and PAs* [emphasis added]."

We believe the current manual provision (and ostensibly, CMS practice) is inconsistent with the statutory provision. While the services listed in 42 CFR §§ 410.43(b) and 410.44(b) are, by regulation, excepted from payment under the OPD PPS, this does not change the fact they these services by statute, where furnished pursuant to a PHP or IOP care plan and under applicable requirements, *are partial hospitalization or intensive outpatient services*. Since the exclusion of these services from the OPD PPS is regulatory, it does not have the effect of removing the services from the statutorily defined scope of the PHP and IOP benefits. We request that CMS confirm that 42 CFR § 410.155(b)(2)(iii), as amended, means that the mental health treatment limitation does not apply to the professional services furnished to PHP or IOP participants, under the PHP or IOP plan of care, by clinicians other than physicians (for example, clinical psychologists, NPs, and PAs), even though those services are, per CMS guidance, billed under the Part B PFS rather than the OPD PPS.

Additionally, consistent with our comment and request for clarification above concerning the addition of MHCs and MFTs as Medicare Part B clinicians effective in CY2024, if CMS does intend to amend the regulatory exclusions at Sections 410.43(b) and proposed 410.44(b) to encompass the professional services of MFTs and MHCs, then those clinicians' services, additionally, should be exempted from the mental health treatment limitation when furnished as part of a PHP or IOP plan of care.

Certification and plan of care requirements for IOP. For purposes of IOP, CMS proposes to mirror the PHP content of certification and plan of care treatment requirements with the following exceptions: CMS proposes to require the content of the certification to include documentation that the individual requires such services for at least 9 hours per week; and recertification of the IOP services is required to occur no less than every 60 days. CMS is soliciting public comments on whether it would be appropriate to consider finalizing a shorter interval for the first recertification and for subsequent recertification for IOP patients. (88 FR 49702).

Per CAA 2023, Section 4124(a) and (b), recertification of IOP services is required to take place no less frequently than every other month, whereas recertification of PHP services is required to take place at least monthly. In our opinion, these contrasting provisions demonstrate that Congress intended for CMS to designate a longer timeframe for IOP recertification than for PHP recertification.

Generally, CBH supports the 60-day requirement for initial and subsequent recertifications of IOP, as appears in the regulatory text in the Proposed Rule. This provision is consistent with CAA 2023, and we do not feel that a shorter time period would be beneficial for participants.

Section VIII.C. Coding and Billing for PHP and IOP Services under the OPPS

CMS' proposed approach of designing the scope of the PHP and IOP benefits (covered services) identically. CMS asserts that since the statutory definitions of both IOP and PHP generally include the same types of items and services covered, it is appropriate to align the programs using a consistent list of services, so that level of intensity would be the only differentiating factor between partial hospitalization services and intensive outpatient services. (88 FR 49702).

Generally, CBH is cautiously supportive of this approach. Given that Section 1861(ff)(2)(I) gives the Secretary discretion to designate "such other items and services as the Secretary may provide" as additional PHP or IOP services, we do believe CMS has discretion to use different "added" benefits for each service bundle. Nevertheless, in light of IOP being a new Medicare offering, we support CMS' approach of adding the same set of new services under each benefit. We urge CMS to revisit this question after several years have elapsed, to consider whether there are some added services that may be particularly appropriate for either PHP or IOP, but not both.

CMS' proposed billing requirements, codes and procedures for IOP services. Currently, CMHCs are not required to use a condition code on the facility claim forms they submit to Medicare because they are authorized to bill Medicare for only one type of services (partial hospitalization). CMS proposes, with the implementation of IOP services, to require CMHCs to use the same two condition codes (92 for IOP; 41 for PHP) that OPDs will use. CMS believes that this requirement would better allow CMS to identify which claims are for PHP and which are for IOP. Further, CMS currently requires that facility claims submitted by OPDs or CMHCs include specific HCPCS associated with PHP services for a given day. CMS proposes to impose this same requirement for

IOP claims. CMS is soliciting comment on these proposed reporting requirements for PHP and IOP. (88 FR 49702).

CBH supports this approach and agrees that claims should be coded so that PHP and IOP claims are distinguishable. Further, we support the continued requirement of detailed coding for each claim, which enables CMS to determine which combination of covered services was provided. This will enable CMS to collect data to understand how providers are furnishing each service and which service types are most commonly included in PHP and IOP days.

CMS' proposed additions to PHP and IOP benefits various new HCPCS codes. CMS presents, at Table 43, a consolidated list of HCPCS codes that CMS proposes to include within PHP and IOP. Using its discretion in Section 1861(ff) of the SSA, CMS proposes to add 18 new HCPCS codes, ranging from crisis psychotherapy to family and group psychotherapy, to the various Health Behavioral Assessment/Intervention (HBAI) codes. The added codes also include various developmental and behavioral screening and testing codes. CMS also proposes to use a subregulatory process to add new HCPCS codes to PHP/IOP, rather than doing so only through the annual rulemaking process. (Table 43, 88 49704-5)

CBH strongly supports each addition reflected in Table 43. Each added code will enable CMHCs and other providers to address behavioral health disorders using a more comprehensive variety of approaches.

Proposal to use a subregulatory process to add PHP/IOP services. CMS also proposes to use a subregulatory process to add new HCPCS codes to PHP/IOP, rather than doing so only through the annual rulemaking process. CMS explains that it would use the subregulatory process only if a new code is cross walked to a previously included code, or if the descriptor is substantial similar to a code already on the list. CMS notes that for services different from those described at 42 C.F.R. §§ 410.43(a)(4) and 410.44(a)(4), CMS would add the new service through notice-and-comment rulemaking. (88 FR 49706).

CBH is cautiously supportive of this proposal. A subregulatory process allows flexibility in adding new HCPCs to the list of covered services for PHP/IOP, but such a process may not provide enough notice to affected stakeholders of important changes. We agree that for services that are substantially new (i.e., reflective of CMS' discretion under Section 1861(ff)(2)(I) to add services other than those listed in the statute), CMS should add the service via the annual rulemaking process. Consistent with that, we urge CMS to revise the text of 42 C.F.R. § 410.43(a)(4), and revise the proposed 42 C.F.R. § 410.44(a)(4), to mention specifically the categories of new services CMS is proposing to add to the PHP and IOP benefits (e.g., crisis psychotherapy, health behavior assessment and intervention, etc.) via this rulemaking.

Proposal to require that each claim for PHP or IOP include a service from the "primary list." CMS requires that to qualify for payment at the applicable PHP APC for a given day, a CMHC or OPD must document one service from the PHP "Primary List" (see Table 44). CMS is proposing to maintain this

requirement for CY2024, and also to extend the requirement to IOP services. (88 FR 49705-6; Table 44 in the Proposed Rule).

CBH disagrees with this decision. We urge CMS either to eliminate the requirement that IOP (as opposed to PHP) service days feature a service from the "primary list," or to expand, for purposes of IOP, the services included on the list. As CMS notes repeatedly in the Proposed Rule, many of the policy decisions reflected in the rule are intended to promote a continuum of behavioral health services in the Medicare program. The use of the "primary list" undermines that goal, in that the list is composed largely of traditional psychotherapy and testing codes. CMS is therefore imposing a requirement, not present in the statute, that any qualifying day of either PHP or IOP include such a service. While such a requirement may be clinically justified for PHP, given that it serves as a substitute for inpatient psychiatric services, we do not believe it is justified for IOP.

CMS' request for comment on potential new codes to add to the list of PHP and IOP services. CMS invites comment on several new potential categories of services to be added to PHP and IOP, pursuant to CMS' regulatory authority to add new services. The services categories include caregiver-related services, peer services, and discharge-related services. (88 FR 49706-49707).

CBH strongly supports CMS adding to the PHP and IOP benefits each of the categories of services CMS describes on pages 49706-49707.

With respect to family and caregiver services, the addition of the relevant codes (9X015-17) would be useful, as CMS notes, in involving family members in PHP and IOP participants' treatment planning. We urge CMS to reconsider its position that, if added, the provision of a caregiver-related service could not qualify in determining the number of services furnished per day in determining to which APC payment the provider is entitled. Such a policy would not meaningfully encourage the provision of these services. Instead, we suggest that CMS include the caregiver services as a full, qualifying service. CMS may reconsider cost and claims data after several years of experience to determine if the addition of the service resulted in changes warranting adjustments to the rates.

Similarly, CBH strongly supports the addition of peer services in PHP and IOP services. We urge CMS to add codes with adequate reimbursement for activities for peer support specialists and only include the activities that fall within the peer support specialist scope to advance utilization, the positive health outcomes realized, and support peer workforce retention by ensuring services requested of them are fully within their scope of practice.[3,4,5]

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[3] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf

[4] https://store.samhsa.gov/sites/default/files/pep23-10-01-001.pdf

[5] 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

Finally, including discharge support services would be a beneficial addition to the PHP and IOP benefit. As CMS notes, CMHCs are already required in their conditions of participation to address discharge planning for PHP participants. Given that PHP and IOP form a spectrum, the added services should encompass planning of "step down" (from PHP to IOP) or transition from IOP to PHP.

Overall, CBH is strongly supportive of CMS' proposal to use the discretion afforded to it under the Social Security Act to add new services to the PHP and IOP benefits, and we feel CMS has designated service areas whose addition would be helpful for community-based behavioral health providers in providing vital Medicare services. We urge CMS to "count" each new service/service type added to the list for purposes of designating the number of daily services used to obtain the relevant APC rate (rather than creating a category of services CMS determines to be insufficiently resource-intensive to count for that purpose).

Section VIII.D. Proposed Payment Rate Methodology for PHP and IOP

Generally, CBH supports CMS' proposal to create a two-tiered structure for payment under the OPD PPS for PHP/IOP, according to the intensity of the service day. We believe this will advance CMS' goal of promoting a continuum of behavioral health services in Medicare.

However, as explained in more detail below, we disagree with CMS' proposal to continue to use separate PPS rates for (i.e., designate separate APC codes with different values for) services provided by CMHCs, than for the same services provided by OPDs, FQHCs, or RHCs. The stark discrepancy in rates between OPDs and CMHCs for partial hospitalization services may not be representative of these entities' true cost structures, and it creates arbitrary incentives toward the provision of partial hospitalization (and now intensive outpatient) services in settings other than CMHCs. To guard against resulting distortions in costs and availability of services, CMS has in recent years implemented site-neutral payment in other settings and service types.

The addition of IOP to the Medicare service array may encourage additional facilities around the country to elect to enroll in Medicare as CMHCs. Many members of this organization are immediately capable of providing the full spectrum of PHP and IOP services. We encourage CMS to provide for a single site-neutral rate for PHP and IOP, which will help make these services more available in community-based settings and provide for an initial period for IOP cost/claims experience to develop (potentially with a wider array of enrolled CMHC providers). CMS could then consider that cost and claims experience in a future year in designing refinements to the payment methodology.

Proposal to create two categories each for IOP/PHP services (one payment level for three or fewer services per day; a separate payment level four or more services per day). CMS notes that the standard PHP day is typically four services or more per day and that payment for three services a day is made in extenuating circumstances where the client would be unable to attend a full day of

PHP treatment. Under current practice, CMS does not make payment for any PHP days with fewer than three services. CMS is proposing to alter this policy by providing for four APC payment levels: one payment level for CMHCs for 3 or fewer service days (APC 5851 (IOP) or 5853 (PHP)); one payment level for CMHCs for 4 or more service days (APC 5852 (IOP) or 5854 (PHP)); one payment level for OPDs, FQHCs, or RHCs for 3 or fewer service days (APC 5861 (IOP) or 5863 (PHP)); and one for OPDs, FQHCs or RHCs for 4 or more service days (APC 5862 (IOP) or 5864 (PHP)). (88 FR 49708-49710; Table 45).

CBH strongly supports CMS' proposal to establish two rate tiers based on number of services per day. As CMS notes in the preamble, over the course of a period of IOP or PHP levels of service intensity may vary. CMS has therefore included that allowing for two routine levels of service intensity is a more fine-tuned approach than the current one, under which CMS will not pay for any service day with fewer than three services and only in narrow circumstances for days with three services. This approach supports a continuum of care and helps to ensure that providers furnish only those services that are clinically beneficial on a given service day.

As described further below, however, CBH does not support CMS' proposal to continue its policy of paying CMHCs under a different rate-setting framework than other providers of the same services.

Proposal to use same rates for PHP as for IOP. CMS proposes to use the same rates for IOP as for PHP. CMS explains that "setting the IOP payment rates equal to the PHP payments would be appropriate because IOP is a newly established benefit, and we do not have definitive data on utilization." CMS notes it will continue using this approach "unless future data analysis supports calculating rates independently." (88 FR 49708).

CBH is provisionally supportive of this approach. The concern we wish to flag is that because of its choice to set PHP and IOP rates equal, CMS also appears to be favoring the implementation of some policies (for example, requiring a service from the "primary list" each service day for both PHP and IOP; classifying some service codes (e.g., caregiver-related services) as insufficiently resource-intensive to count as a service day) that may undermine the flexibility to provide the full scope of services within IOP.

We urge CMS to revisit this question once a year or more as cost and claims data are available, to analyze the key differences between IOP and PHP, including the prevalence of certain services within the bundle. In the meantime, we urge CMS to finalize the rule including the same rates for IOP as for PHP, but, as argued above, to omit, for IOP, the requirement that each service day include a service from the primary services list.

Proposal to use "site-neutral" payment for OPDs, FQHCs, and RHCs, but to maintain in place the use of lower rates for CMHCs. CMS explains that CAA 2023, Section 4124(c) requires that payment for IOP services furnished in FQHCs and RHCs be equal to the payment amount that would have been paid for the same service furnished by an OPD, whereas "the CAA 2023 is silent with respect to the payment methodology for IOP services provided by CMHCs." CMS proposes to continue calculating CMHC rates based only on CMHC claims, whereas different data, encompassing both

OPD costs and claims and the broader OPPS data set, would be used to set rates for OPDs, FQHCs, and RHCs. To inform public awareness, CMS calculated combined payment rates by using the broader OPPS data from both OPDs and CMHCs to calculate one site-neutral rate for three- and four-service days for each service. (88 FR 49709).

CBH disagrees with CMS' proposed approach of continuing to use lower per diem APC rates for CMHCs for PHP and introducing this policy for IOP furnished in a CMHCs.

First, CMS states that freestanding entities are likely to have lower costs than provider-based entities. However, if that is so, we would like to request clarification on why OTPs, FQHCs, and RHCs, and exempted off-campus OPDs are included in the OPD methodology as they are all freestanding as well. Additionally, currently there are only a small number of facilities across the country that are enrolled in Medicare as CMHCs. It is our view that rather than accurately reflecting reasonable service and associated costs of furnishing PHP, the present CMHC PHP rates may reflect anomalies associated with the small group of providers whose costs were used to compute the rate. OPDs' payment rates, on the other hand, are computed based on rates reflecting averages of a huge, diverse array of outpatient hospital departments around the country.

Furthermore, we have concerns about the justification used for the discrepancy between CMHCs and other provider types. CMS states in the justification for the discrepant methodologies for CMHCs and for other providers that "CAA, 2023 requires that we payment amount for [IOP] furnished in FQHCs and RHCs be equal to the payment amount that would have been paid for the same service furnished by [an OPD] . . . The CAA, 2023 is silent with respect to the payment methodology for IOP services provided by CMHCs." 88 FR 49709. However, under previously established law in section 1832(a)(2)(J), payment is required to be made under Medicare Part B for PHP services provided by CMHCs. Section 1833(a)(2)(B)(iii), in turn, requires that for services provided on/after January 1, 1999, payment for the services described in 1832(a)(2) (i.e., including PHP services furnished by CMHCs be made under the Medicare outpatient hospital PPS. CAA, 2023, in turn, amends Section 1832(a)(J) to add a reference to IOP, as well as PHP. Therefore, CAA, 2023 requires IOP services furnished by CMHCs be paid for under the OPD PPS, just as that provision requires IOP services furnished by FQHCs/RHCs to be paid for as if furnished under the OPD PPS. The difference largely appears that the change is made via legislative text for the FQHCs/RHCs, and via incorporation by reference for the CMHCs.

We further note a discrepancy in the current proposal that may lead to inadequately or unfairly valuing PHP and IOP services furnished in CMHCs. CMS is proposing to take into account, in establishing OPD PPS rates for PHP/IOP in settings other than CMHCs, the broader OPPS data set (not just PHP claims). CMS explains that this decision allows CMS to include the impact of costs of services CMS is proposing to add to the benefit through this rule making, and "to capture data from claims not identified as PHP, but that also include the service codes intensity required for a PHP day." (88 FR 49707.) On the other hand, CMS proposes to continue using solely existing CMHC claims data for PHP services (not taking into account broader OPPS data) in setting the CMHC APCs. We also note that CMS suggests at page 49709 that the differential payment rates are helpful "for

the Medicare beneficiaries that CMHCs serve, who incur a 20 percent copay on all PHP services under Part B." (88 FR 49709.) Given that beneficiaries also incur coinsurance when accessing services in OPDs, we assume that CMS, by highlighting coinsurance burdens for CMHC patients, is referring to the fact that CMHCs and other community-based providers are more likely than OPDs to serve a low-income population. We do not believe it makes sense to use the limitation of coinsurance as a justification for establishing dramatically lower payment rates for a service when furnished by a certain provider type. Additionally, we note that a large percentage of the low-income patients served by community-based behavioral health providers are dual eligible beneficiaries, for whom Medicaid typically covers Medicare coinsurance costs.

We strongly urge CMS to use the site-neutral payment rates displayed in Table 46 for CMHCs and OPDs (for PHP services) and for CMHCs, OPDs, FQHCs, and RHCs (for IOP services). Not only do we believe that doing so is consistent established precedent as described above, but this approach is also the more equitable one—particularly now that a range of four provider types will be furnishing IOP services and CMHCs are a large provider for individuals with Medicaid or are dually enrolled.

Finally, CMS notes that further data analysis will be critical after some initial time period has elapsed to allow CMS to study IOP claims data. In the initial years of implementation of IOP, more community behavioral health providers around the country may enroll in Medicare as CMHCs. Once several years of claims and cost report data are available reflecting the experience of a broader array of providers and experience with both PHP and IOP services, CMS may reevaluate the rates. We also believe that the uniform site-neutral approach would be more consistent with the approach that CMS has chosen to take with respect to the relative pricing of PHP and IOP services: that is, to set the per diem rate for each service category at an equal amount until cost and claims experience are available to allow CMS to consider whether creating different payment rates would be more accurate.The costs and claims experience associated with both PHP and IOP over the coming years will be in flux, as a new benefit is being added, and new provider types are being added. CMS, recognizing that it must use methodologies until data come in, is proposing to use the same rates for IOP as for PHP. It is consistent with this approach to apply the same rates to all providers of PHP or IOP for the next few years.

Proposed CY 2024 PHP and IOP APC Geometric Mean Per Diem Costs. CMS lists in Addendum A to the Proposed Rule, its proposed payment rates for APCs 5851-5864 (proposed payment rates for partial hospitalization and intensive outpatient services). CMS intends to monitor the provision of services in both PHP and IOP programs to better understand utilization patterns, and proposes to set equal payment rates for PHP and IOP services until actual IOP utilization data becomes available for CY 2026 rate setting, at which point CMS anticipates reevaluating its payment rate methodology if necessary. CMS is soliciting comments on the service mix used to develop the per diem amounts for both PHP and IOP. (88 FR 49710).

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The rates set forth in Addendum A reflect the methodology premises that CMS described in Section VIII.C: (1) creating two tiers of per diem payments for PHP/IOP, based on whether the day included four or more services, or three or fewer services; (2) setting the same rates for IOP as for PHP; and (3) using separate cost and claims data to set rates for CMHCs, on the one hand; and for OPDs and (for IOP) FQHCs and RHCs, on the other.

CBH strongly supports CMS' first premise (two-tiered payment for more- and less-intensive service days), which advances CMS' goal of making IOP and PHP available as a continuum of care and adjusting payments to reflect the level of intensity of services on a given service days.

As to the second premise (substantially identical treatment of PHP and IOP services for rate-setting), CBH agrees with CMS' intention to revisit, once two years of claims experience are available, the question of whether PHP and IOP should be paid under the same rates.

As to the third premise, as noted above, CBH disagrees with CMS' reasoning. For the reasons described above, we strongly urge CMS to use the "site-neutral" approach to payment for PHP and IOP, described at 88 FR 49709, and accordingly, to work from the mean per diem costs described in Table 46 to set the rates.

Section VII.E Proposed Outlier Policy for CMHCs

CMS notes in Section VIII.E of the Proposed Rule that it has developed outlier policies for CMHC rate development because it has noted in prior years significantly more outlier payments for CMHCs than for hospitals for PHP services. CMS discusses its proposed outlier policies at 88 FR 49711-49713.

As noted above, CBH is urging CMS to use site-neutral payment rates for all providers of PHP and IOP services. If this approach is used, then CMS would not need to use a distinct methodology to trim CMHC outlier costs and claims. If the overall geometric mean costs displayed in Table 46 were used to set rates for both OPDs and CMHCs, an outlier-trimming procedure would, if used, likely have a negligible effect on payment rates, as CMHCs form a tiny portion of the overall cost and claims experience CMS used in developing the averages set out in Table 46.

We suggest that the dramatic variation in CMHC costs may result in part from the fact that so few facilities are enrolled in Medicare as CMHCs, and the small number of enrolled CMHCs exhibit dissimilar characteristics. Once CMS has two years of cost and claims data to evaluate for purposes of PHP and IOP rate-setting, CMS will be well-equipped to take into account, 2026 and subsequent years, trends in CMHC PHP and IOP claims and costs, and make any corresponding decisions regarding differences in payment rates between CMHCs and OPDs for PHP and IOP services.

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Section VIII.F Rural Health Clinics and Federally Qualified Health Centers

PHP and IOP services in FQHCs and RHCs. CMS proposes to use the same IOP scope of benefits for FQHCs/RHCs as will be used for IOP furnished in other settings. CMS further proposes to use physician certification and plan of care requirements and the same patient eligibility criteria for IOP in FQHCs/RHCs that are identical to the requirements that apply to IOP furnished in OPDs or CMHCs. CMS proposes to require FQHCs/RHCs to use condition code 92 on claims for IOP services (as OPDs and CMHCs will be required to do), and proposes to require for FQHCs/RHCs, like CMHCs/OPDs, that in order to qualify for IOP payment, at least one service must be from the Intensive Outpatient Primary List. (88 FR 49713-49717).

CBH supports CMS' decision to use the same program requirements for IOP furnished in FQHCs/RHCs as in other settings, and we believe this approach is consistent with the provision in CAA 2023 adding FQHCs/RHCs as providers of these services. Further, we support CMS' decision to impose the same requirement to use a condition code for IOP services.

The Proposed Rule does not mention whether FQHCs/RHCs will be required to use specific coding (i.e., to list each HCPS for each discrete service provided in an IOP service day) on IOP claims. We think doing so would be beneficial in that it would improve CMS' access to compete information on the provision of IOP across various provider settings.

As noted above with respect to CMHC payment for IOP, we urge CMS to reconsider its decision to require that at least one service be from the Intensive Outpatient Primary List and look to afford more flexibility for providers of IOP to structure a day of care.

Specific Payment Rules for FQHCs/RHCs. CMS explains that it has interpreted the statute to require IOP services to be included in the provisions for FQHC/RHC supplemental or "wraparound" payments, per Section 1833(a)(3) of the Social Security Act and 42 C.F.R. § believes that the special payment rule, is also included in the FQHC PPS rate as described in section 1834(o) of the Act and therefore, IOP services are included in the wraparound payment. CMS proposes to make revisions under § 405.2469 to reflect these changes. CMS explains that it proposes to allow FQHCs/RHCs to provide a medical visit on the same day as IOP services, but not to allow FQHCs/RHCs to provide a billable mental health visit on the same day as IOP services.

With respect to mental health visits in the same day as IOP services, CBH suggests it may be preferable to allow, at minimum, for an exception so that, under emergency circumstances, an FQHC/RHC mental health visit could be furnished (and billable) on the same day that IOP services are provided. Further, we understand that that payment for IOP in FQHCs/RHCs, like IOP in other settings, will be subject to the clinician exclusions described in proposed 42 C.F.R. § 410.44(b). Under this provision, the clinical services of various professionals, when delivered as part of an IOP care plan, are nonetheless unbundled and not paid for as IOP services under the OPD PPS, but instead, under the relevant Part B methodology. Given that this provision will also apply to IOP furnished in FQHCs/RHCs, a prohibition on same-day payment for mental health visits in those settings may be inappropriate.

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Section VIII.H. Payment Rates Under the Medicare Physician Fee Schedule for Non-Excepted Items and Services Furnished by Non-Excepted Off-Campus Provider-Based Departments of a Hospital

To implement statutory provisions in Bipartisan Budget Act of 2015 (BBA) Section 603, CMS has implemented over years since 2017 a "site-neutral" payment methodology for off-campus provider-based departments of a hospital that were not in existence as of the date of enactment of the BBA (November 2, 2015) (i.e., "non-excepted" off-campus OPDs). These new or relocated off-campus provider-based departments are to be paid under the PFS, rather than the OPD PPS, for services. Since 2017, for those non-excepted off-campus OPDs that provide PHP services, CMS has paid the entities under the CMHC rate, rather than the OPD rate.

Consistent with its proposed change to CMHC payment rates for PHP and IOP (i.e., dividing the payment into two APCs based on service intensity, CMS proposes to apply the same methodology to non-excepted OPDs. Accordingly, CMS would pay the non-excepted off-campus OPD one rate for four or more services per day (APCs 5852 for IOP or 5854 for PHP, both proposed as $151.36 in Addendum A); and one rate for three or fewer services per day (APCs 5851 for IOP, or 5853 for PHP, both proposed as $96.49 per day under Addendum A). (88 FR 49723; Addendum A to the Proposed Rule).

CBH suggests that consideration of CMS policy with respect to non-excepted off-campus OPDs, and Congress goals in enacting BBA 2015 Section 603, demonstrate the policy goals served by site-neutral payment methodologies. CMS' transition, since 2017, to PFS payment rates for new off-campus OPDs, required under BBA 2015, was motivated by a desire to move toward site-neutral payment (i.e., the same payment to provider-based OPDs as to physician practices for the same services). The goal was to ensure that incentives toward the provision of services in off-campus outpatient hospital settings, created by the discrepancy between OPD PPS and PFS payment rates, did not skew patterns in provision of and payment for services.

CMS' proposal with respect to payments to various provider types for PHP and IOP services essentially gives rise to the same concerns that the BBA 2015 "site-neutral" rules were meant to address: the health care system is not well-served when hospital outpatient departments are paid more than other providers for the provision of identical services.

CBH suggests, as argued above, that for CY2024, a neutral set of payment rates under the OPD PPS should apply to all providers of PHP and IOP services (OPDs, CMHCs, OTPs, FQHCs/RHCs, and non-excepted off-campus OPDs). In the future, with the benefit of two years of claims and cost data, CMS can evaluate for purposes of CY2026 whether adjustments among the various providers' rates are warranted. We note that we do not believe such a site-neutral approach would be inconsistent (for off-campus OPDs) with BBA 2015 Section 603, since that legislation required merely that payment to the non-excepted OPD be made under the relevant Part B methodology.

Section XVII. Changes to Community Mental Health Center Conditions of Participation (CoPs)

Effect of IOP services on 40 percent requirement. CMS seeks comment on the potential impact of the addition of IOP services on CMHCs' ability to meet the statutory requirement in Section 1861(ff)(3)(B)(iii) and 42 C.F.R. 485.918(b)(1)(v) that a CMHC provide at least 40 percent of its services to individuals not eligible for Medicare. (88 FR 49847).

CBH requests that CMS clarify its guidance addressing the 40 percent requirement to specify that the percentage of services furnished to non-Medicare-eligible persons is to be determined based on the *whole behavioral health service array furnished by the facility*—not based solely on the provision of services coinciding with the PHP and IOP services that enrolled Medicare CMHCs may provide. The reason for this suggestion is that other payors, such as Medicaid and commercial payors, while they may cover certain comprehensive day treatment programs, are unlikely to cover a benefit package that corresponds precisely to PHP/IOP. Current guidance on the application of the 40 percent requirement (see, for example, 42 CFR 485.918(b)(1)(v) and Medicare State Operations Manual (SOM), Appendix F (CMHC Interpretive Guidance), page 63) do not clearly address this issue.

The regulation states that to meet the CMHC requirements, an entity must demonstrate that it:

> *provides at least 40 percent of its items and services to individuals who are not eligible for benefits under title XVIII of the Act, as measured by the total number of CMHC clients treated by the CMHC for whom services are not paid for by Medicare, divided by the total number of clients treated by the CMHC for each 12-month period of enrollment.* (42 C.F.R. § 485.918(b)(1)(v)).

We request that CMS clarify that the computation described above should be done with respect to all clients served by the CMHC organization, not only those clients who receive PHP/IOP or similar services covered by another payor.

Further, and relatedly, CBH requests that CMS monitor concerns relating to the provision of services by Medicare-enrolled CMHCs to dual eligible beneficiaries. For many community behavioral health providers, dual eligibles (either full benefit dual eligibles (FBDEs) or qualified Medicare beneficiaries (QMBs)) compose a large portion of their Medicare client population. For clients who qualify as QMBs, the State Medicaid agency is responsible for payment of the Medicare coinsurance, subject to potential limits on amount in the Medicaid State plan. (See SSA § 1902(n).) The same is true for FBDEs who also qualify as QMBs (the so-called "QMB Plus" population).

For services rendered to FBDE clients who do not independently qualify as QMBs, the Medicaid agency may nonetheless have a payment obligation as secondary payor, where services furnished and paid for under the Medicare PHP or IOP benefit also correspond to covered Medicaid services (for example, certified community behavioral health clinic (CCBHC) services covered under Medicaid). (See 42 C.F.R. § 433.139(b).)

CMS should monitor (and should require state Medicaid agencies to monitor) challenges faced by CMHCs in obtaining secondary payment from State Medicaid agencies for PHP or IOP services furnished to dual eligibles. Given that dual eligibles represent a large portion of community behavioral health providers' Medicare population, and that this population often has more clinically complex needs than the client population at large, obtaining full payment for services rendered to dual eligible beneficiaries is critical for the providers to be able to serve their clients effectively.

Revisions to 42 C.F.R. 485.900 (basis and scope). CMS proposes to revise the regulation to refer to the statutory provisions that allow CMHCs to receive payments for IOP services under Medicare Part B; establish requirements for the provision of IOP services in CMHCs; and include IOP services in the Medicare provider agreement. (88 FR 49846). CBH is supportive of this provision.

Revisions to 42 C.F.R. 485.904 (personnel qualifications). CMS proposes to add MHCs and MFTs to the list of clinical personnel furnishing services in CMHCs, and to incorporate by reference the definitions of MHC and MFT elsewhere in the Medicare regulations. (88 FR 49846).

CBH supports this provision. We believe MFTs and MHCs will provide vital clinical resources to support PHP and IOP services. As noted above, we also inquire of CMS whether MFTs and MHCs should be added to the list of professionals whose services, when furnished under a PHP or IOP plan of care, are nonetheless excluded from PHP/IOP payment under the OPD PPS (see 42 C.F.R. 410.43(b) and proposed 410.44(b)). Further, we call attention to our position that Section 1833(c)(2) and implementing regulation at 42 C.F.R. § 410.155(b)(2)(iii), mean that the mental health treatment limitation does not apply to professional services furnished to PHP or IOP participants, under the IOP or PHP plan of care, by non-physician clinicians.

Revision to 42 C.F.R. 485.914 (admission, initial evaluation, comprehensive assessment, and discharge or transfer). CMS proposes to add IOP to the requirements for the comprehensive assessment described in subsection (d), so that the assessment would be required to be updated no less frequently than every 30 days. (88 FR 49846).

CBH urges CMS to require assessment updates for IOP less frequently than for PHP. We believe doing so would be more consistent with the requirements for recertification proposed established in the CAA, 2023, as described in our comments above, the contrasting provisions between PHP and IOP demonstrate that Congress intended for CMS to designate a longer timeframe for IOP recertification than for PHP recertification, and we believe the same logic would apply here. CBH suggests CMS consider requiring the comprehensive assessment in IOP to be updated no less frequently than every 60 days. This provision is consistent with CAA 2023, and we do not feel that a shorter time period would be beneficial for participants.

Request for comment from CMHCs on issues relating to rollout of the IOP benefit. CMS requests comments from CMHC stakeholders on the following (88 FR 49847):

1. *Do you expect the total number of clients served in your CMHC to increase with the addition of IOP?*
2. *Do you expect that any of your PHP clients would step down to the IOP program?*

3. *Do you expect any of your outpatient treatment clients, such as office-based therapy, to step up to the IOP program?*

Many of CBH's current members are not enrolled in Medicare as CMHCs, but are in fact capable of furnishing the PHP and IOP benefits. Particularly now that, effective in 2024, Medicare will cover an increasingly comprehensive set of outpatient behavioral health services via PHP and IOP, many new community behavioral health providers may seek to enroll in the program as CMHCs. This, in turn, would help make these important new services more broadly available to the Medicare population.

Many of CBH's members are currently enrolled in Medicare solely as physician practices, and accordingly, for Medicare-only clients, these facilities are able to bill Medicare only for those outpatient behavioral health services covered and paid for under the PFS. Many of these members have identified unmet behavioral health needs among their Medicare patients and a lack of available behavioral supports covered by the program. This gap has become particularly apparent in contrast to State Medicaid programs, many of which have expanded outpatient behavioral health options in recent years to accommodate programs such as the CCBHC demonstration.

For those community behavioral health entities newly enrolling as CMHCs, the option to furnish IOP will be a welcome opportunity to provide more intensive services to Medicare clients who need them and, for dual eligible clients, a welcome step toward alignment of the covered benefits under both programs.

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