



11 September 2023

Chiquita Brooks-LaSure, Administrator
The Centers for Medicare & Medicaid Services
7500 Security Blvd., Baltimore, MD 21244

Submitted Electronically

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; and

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; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program. CMS-1784-P.

Dear Administrator Brooks-LaSure:

The National Association for Behavioral Healthcare (NABH) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) two proposed regulations: the CY 2024 [outpatient prospective payment system](#) (PPS) and [physician fee schedule](#) (PFS) proposed rules. NABH is pleased with and supports CMS' proposal to implement a new intensive outpatient program (IOP) benefit, along with recommendations about its implementation.

NABH members provide the full continuum of behavioral healthcare services to children, adolescents, adults, and older adults with mental health and substance use disorders (SUD) in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs (IOP), medication-assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C.

CY 2024 Outpatient PPS Proposed Rule

Proposed CY 2024 Payment Update Does Not Reflect Actual Cost Pressures

For CY 2024, CMS has proposed an outpatient PPS net update of 2.8%, which includes a 3.0% market basket update and a 0.2 percentage-point productivity cut. The proposed increase of 2.8 percentage point, relative to CY 2023 payment levels, falls short of addressing the current cost pressures that outpatient behavioral healthcare providers face. These significant costs, which peaked during the COVID-19 pandemic and are expected to continue for years, have been well-documented and relate to higher levels of clinical and non-clinical salaries and wages, new recruitment and retention methods, safety training for patient-facing personnel, and resources to partner with external providers' seeking physical and health integration. In general, small and/or rural providers face greater limitations addressing these elevated cost pressures.



Implementation of a Statutorily Mandated IOP Benefit Under Medicare

NABH is pleased that, as Congress mandated in the *Consolidated Appropriations Act (CAA), 2023*, CMS is proposing to implement a Medicare IOP benefit for acute mental illness and substance use disorder treatments, which would take effect Jan. 1, 2024. For hospitals, this benefit would fall under Medicare Part B. We agree that IOPs fill an essential gap in the overall behavioral healthcare continuum and that Medicare should cover this service. We also appreciate the rule's clarification that IOP services are not required to be provided in lieu of inpatient hospitalization and prefer that treating physicians should make clinical determinations.

IOPs treat patients with acute mental illness such as depression, schizophrenia, and substance use disorders for whom their physicians prescribed nine or more hours of outpatient therapy per week. Under the proposed new benefit, IOP services may be furnished in hospital outpatient departments, community mental health centers, federally qualified health centers (FQHC), and rural health clinics. The rule also proposes a payment approach for these services when these services are provided in opioid treatment programs, as we describe below.

We agree with CMS' approach of – at the outset – borrowing key policy elements from the existing PHP regulatory framework, such as scope of benefits, physician-certification requirements, coding and billing, and per-diem payment rates under the IOP benefit. PHPs treat a similar mix of patients who require a higher level of intensity, namely, at least 20 hours of therapy per week.

Scope of Benefits

NABH finds CMS' proposed IOP scope of benefits to be reasonable and will monitor patient needs relative to these standards to identify any necessary adjustments in the future

- Individual and group therapy with physicians or psychologists or other mental health professionals;
- Occupational therapist or therapy assistant services by a therapist or under appropriate supervision;
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric and SUD patients;
- Qualifying drugs and biologicals furnished for therapeutic purpose;
- Individualized activity therapies that are not primarily recreational or diversionary;
- Family counseling when related to the individual's condition;
- Patient training and education when closely and clearly related to the individual's care and treatment; and
- Diagnostic services.

However, with regard to the proposed *patient eligibility qualifications* for IOP services, we support most of the proposed PHP-based criteria, including these: patient is likely to benefit from a coordinated plan of care beyond isolated outpatient therapy; does not require 24-hour care; and has the cognitive and emotional ability to engage in IOP care. **However, two proposed criteria would remove many of our members' patient population from eligibility under this benefit. Specifically, we request that the requirement for an "adequate support system while not engaged in the program" be removed because this is not consistent with other Medicare services and populations and it contradicts a common clinical characteristic for patients already treated in PHP and (non-Medicare) IOP programs. Also, we note that many behavioral health patients, including those already receiving these services, lack an effective support system at home, which is often a contributor to their need for these services. In addition, current PHP and IOP patients may be at a mild or moderate risk of danger to self or others, which also contributes to their need for these services. As such,**



CMS should not finalize these two exclusions, which would materially reduce access to care for affected patients.

Also, CMS' clarification that the coverage category of "mental health diagnosis" generally includes SUD and behavioral health diagnoses for both the existing PHP program and the proposed IOP program is helpful for our members.

Exclusions to the Proposed IOP Benefit

For mental healthcare settings, we agree with CMS' proposal to align with PHP guidelines and exclude from the IOP benefit these services that Medicare covers separately: physician and psychologist services; physician assistant, nurse practitioner and clinical nurse specialist services; and skilled nursing facility services. See OTP section for additional comments.

Proposed Requirements for Physician Certification

Under the rule, the amount and type of IOP services would be prescribed by physicians who have determined that the patient is clinically suitable for this level of care. For each patient, the doctor must create an individualized plan of treatment that addresses all of the conditions that are being treated by the IOP, and, at least every 60 days, reevaluate the plan and recertify those patients who require additional IOP treatment. **Regarding the proposed 60-day recertification period, our members agree with the standard because it already works for the IOP patient population covered by most commercial payers.** They report that this frequency generally contributes to effective patient continuity and overall quality of care.

To address the impact of the currently limited mental healthcare workforce, we recommend that CMS consider whether additional provider types could contribute to the patient certification and treatment planning processes for IOP and PHP services. Additional flexibility to augment the existing physician-led process could allow certain non-physician practitioners, such as psychologists, psychiatric mental health nurse practitioners and clinical social workers, to support the physician in these duties. See OTP section for additional comments.

Proposed Coding and Per-Diem Payments for IOP Services

NABH supports CMS' proposal to differentiate between IOP and PHP billing by continuing to use condition code 41 for PHP claims and a new condition code 92 for IOP claims.

Proposed IOP/PHP Codes

Currently, to identify each service provided during each PHP day, providers assign Healthcare Common Procedure Coding System (HCPCS) codes. The rule proposes a consolidated and updated list of codes that cover the full range of services that both PHPs and IOPs provide. We agree with CMS that a consolidated list would be helpful, especially for patients receiving both services during an episode of care. The addition of new codes should result in greater specificity in capturing services provided and ultimately result in more accurate payment. To qualify for payment under these programs, at least one service must match an IOP APC (5851, 5852, 5861 or 5862) or a PHP APC (5853, 5854, 5863, or 5864).



CMS also has raised the possibility of providing codes for support services that “caregivers”¹ and “peer-support workers”² provide to learn about the related clinical conditions and frequency of these services. CMS suggests these codes could yield a more accurate assessment of the total cost of care, with such cost data used in the calculation of PHP and IOP per-diem payment rates but not counted in the daily tally of services, which is a separate factor in setting payments.

Payment accuracy is critically important to sustaining the operations of an IOP, PHP, or any provider setting. Sustainability of existing providers, at a minimum, is needed to avoid lessening the already-strained levels of behavioral healthcare access. Therefore, it is critical that CMS strive to capture all essential costs of care. Further, additional support services such as these might be useful in extending the existing reach of the current behavioral healthcare clinical workforce.

That said, CMS and stakeholders must first carefully evaluate the codes’ effect on care quality and ensure that any such additions exclusively are treated as optional add-ons – not as substitutes for the specialized care provided by physicians, non-physician practitioners, or behavioral healthcare nurses, who are the clinical personnel trained and organized to lead all aspects of care plan development and execution. In addition, further consideration of these add-ons would require additional research and discussion from CMS and other stakeholders to avoid any unintended reduction in the overall quality of care and the possible patient-safety risks.

Proposed Per-diem Payment Approach

CMS is proposing the same per-diem rates for IOP and PHP services for CY 2024 because both programs use the same services but furnish them at different levels of intensity, with different quantities of services furnished per day and per week. As no IOP benefit existed prior to the CAA, CMS is relying on PHP and outpatient PPS data to set proposed CY 2024 payment rates for both programs, because IOP-like services have been provided in both settings. By using PHP and outpatient PPS data for PHP and outpatient service codes and intensity, CMS strives to achieve more precise rates for CY 2024.

In addition, CMS proposes two tiers for calculating IOP and PHP payment rates: days with three services and days with four services. For days with three or fewer services, the three-service payment rate would apply (for PHP APC 5863 for hospitals, and IOP APC 5861 for hospitals). The four-service payment rate (for PHP APC 5864 for hospitals, and IOP APC and 5862 for hospitals) would apply to days with four or more services. This is a departure from the current PHP policy of making no payment for any PHP days with fewer than three services. CMS clarifies in the rule its expectation that days with fewer than three services would be very infrequent, and their plan to monitor the provision of these days among providers and individual patients.

NABH appreciates the expansion of coverage for PHP services with lower volume. Moving forward, we ask the agency to factor in the concern of NABH and other stakeholders that this two-tiered payment approach may discourage the treatment of certain patients because of the reality that patients will not always be able to complete a full day. When physicians and the interdisciplinary team set a patient’s plan of care, they cannot anticipate future disruptions caused by patient illness or other unforeseen factors, and they should not be penalized for this unavoidable limitation.

¹ Caregivers are described in the rule as being engaged in multi-family group behavior management, depression assessments, and contributing to the development and implementation of individualized plans of care.

² Per the proposed rule, peer support workers could be used to help patients become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services could contribute to extending the reach of treatment beyond the clinical setting into the everyday environment of a patient’s recovery process.



While we recognize that lower-volume cases are intended to be rare, low-volume care is still important. Relatedly, payment accuracy for these and all cases will remain important. We note that across Medicare, for episodes that include a series of treatments, per-visit costs generally are higher for earlier visits, therapy, or other treatments. To avoid unintended access limitations for patients who, because of unplanned factors, receive fewer services than initially planned, that CMS evaluate and confirm whether the average cost of the earlier services, relative to later services in the same IOP and PHP episode, is greater and being accurately reimbursed.

We note CMS' anticipation that in the future there may be significant costs differences between IOPs in community mental health centers and hospitals and will later determine whether a site-neutral payment policy may be needed for all providers of IOP to increase access to mental healthcare services. We acknowledge that this concern accounts for the 20% beneficiary co-pay associated with hospital-based IOP and PHP care. That said, the additional costs incurred by hospital-based services are well-documented and essential for providing the overall effective and efficient functioning of the host hospital and its entire operations. NABH will track this issue with our members, and will include CMS' request for feedback on the design and cost of IOP services for both payment tiers.

PHP-SUD Clarification

In addition, we appreciate CMS correcting the misconception that Medicare does not cover PHP treatment of SUDs. Rather, CMS has determined that the statutory scope of services for PHPs includes treating SUD patients. In addition, to address confusion in the field, the agency also clarifies that its definition of "trained psychiatric nurses, and other staff trained to work with psychiatric patients," includes trained SUD nurses and other staff trained to work with SUD patients. In addition, we ask **CMS to clarify that PHP services may be offered to individuals with any SUD**, such as individuals with alcohol and methamphetamine disorders. Looking forward, we encourage CMS to explore additional settings where SUD treatments could be added and how payment for these additional services could be structured.

Modern Information Technology Infrastructure Needed

Given current health information technology (HIT) limitations across the behavioral healthcare sector, many psychiatric hospitals and their outpatient departments lack the capacity for interoperable exchange of patient health information. This limitation affects the timeliness and effectiveness of certain treatments, joint case management across settings, cross-setting patient transfers, and efforts to achieve parity in integrating physical and mental health.^{3 4} In addition, current HIT levels in our field prevent participation with various recent proposals from CMS and other policymakers, including integration with key clinical partners, full functionality with federal and state health exchanges, and electronic prior authorization processes. Also, while some psychiatric hospitals have HIT systems that comply with current HHS standards for data exchange and other functional specifications, that is not true for most. Most psychiatric hospitals' IT systems are limited to billing payers electronically, and some have a form of electronic prescription management; however, most lack the ability to send or receive interoperable data. Most of the behavioral healthcare field still relies on outdated communication methods including faxes, emails, and phone calls.

³ "Electronic Health Information Exchange At Discharge From Inpatient Psychiatric Care In Acute Care Hospitals," Morgan C. Shields, Grant Ritter, and Alisa B. Busch. *Health Affairs*. June 2020.

⁴ Use of Electronic Health Information Technology in a National Sample of Hospitals That Provide Specialty Substance Use Care, Morgan C. Shields, Ph.D., Constance M. Horgan, Sc.D., Grant A. Ritter, Ph.D., Alisa B. Busch, M.D. M.S., *Psychiatry Services in Advance*. 2021.



CMS leadership and Members of Congress have recognized this obstacle to integrated care. In late May, CMS hosted a webinar with behavioral health stakeholders and acknowledged the importance of building the capacity to exchange patient-level data interoperably. In addition, the *SUPPORT Act* of 2018 urged the Centers for Medicare and Medicaid Innovation (CMMI) to test incentive demonstration models for the adoption of electronic health records in behavioral healthcare settings. Meanwhile, legislation was introduced ([H.R. 5116](#) and [S. 2688](#)) this year to earmark funding to support the purchase and implementation of modern HIT for our field.

Issues Related to IOP SUD Treatment in Opioid Treatment Programs (OTPs)

- We recommend that **CMS articulate in regulation the specific providers** permitted to deliver the services (meaning the specific types of mental health and SUD providers) and the **diagnostic eligibility** (e.g., SUD as primary).
- We request that the **requirement for an “adequate support system while not engaged in the program” be removed** because this is not consistent with other Medicare services and populations, and it contradicts the rationale for needing PHP and IOP services; individuals who need these services often do not have adequate support systems. Note that these individuals may also be a **mild or moderate risk of danger to self or others; therefore, this exclusion should also be removed.**
- We recommend that CMS better align certification and treatment planning for IOP and PHP services with programmatic and clinical standards of practice and permit **other non-physician professionals, such as psychologists and clinical social workers, and other practitioners as permitted by state requirements to perform eligibility assessments and develop treatment plans.** American Society of Addiction Medicine (ASAM) level-of-care determinations do not require a physician to complete the assessment; anyone trained to do level of care determinations may complete them. Requiring a physician will be a significant barrier to care and uptake of this benefit. SUD counselors are certified and licensed differently at the state level and this should be explicitly permitted and addressed.
- **We support 60-day intervals for recertification of IOP services.** This interval currently works well with commercial payers and does not inhibit quality of care. Anything additional is unnecessary and burdensome for providers and clients.
- We recommend that CMS review the ASAM Criteria for **all the SUD services relevant to IOP and PHP and include them in the regulations.** SUD services will not be covered unless this review takes place.
- We **recommend community health integration (CHI), social determinants of health (SDOH), and principal illness navigation (PIN) services, as well as case management and care coordination, be included as services,** as noted in the CY2024 PFS proposed rule.
- We recommend that CMS implement a per-diem rate when **an individual is not able to make all the services required for the nine-hour weekly bundled rate.** Individuals with SUD have many symptomatic and other barriers to attending care. Neither they nor their providers should be penalized when they can't attend minimal service requirements.
- We additionally recommend **using rates for FQHCs as the template upon which to build the IOP/PHP rates for SUD.** In pricing, we **discourage the discounting of one group and one individual psychotherapy service from the IOP/PHP rates,** as these are provided for PHP and IOP, whereas less intense counseling services are offered as part of the weekly methadone OTP bundle and would be *additional*, not duplicative, services.
- We encourage CMS to **permit IOP services to individuals with mental health conditions and SUDs beyond opioid use disorder** because those other conditions are prevalent in the Medicare population.



- We support CMS permitting IOP and partial hospitalization to be offered in OTPs and recommend that **CMS clarify that the services may be offered to individuals with *any* SUD in these service settings**, such as individuals with alcohol and methamphetamine disorders.
- We also propose that CMS **allow additional specialty-care settings to offer these services, and encourage CMS to develop bundled rates** for providers in those other community settings where individuals with SUDs other than opioid use disorder may be more prevalent.
- We support the extension of coverage, as required by law, for **audio-only periodic assessments** through 2024. We urge CMS to **make this permanent**, because pandemic data demonstrates that audio encounters are necessary and beneficial for many people who would otherwise not be able to access care.

Contingency Management

- **NABH requests that CMS develop an add-on service code for the use of contingency management (CM) in OTPs for individuals with stimulant use disorder (StimUD)**. There was a 50-fold increase in the methamphetamine mortality rate in 2021. This consisted of 32,353 total methamphetamine-associated deaths, 60% of which included fentanyl and 40% of which did not⁵. This reflects the high level of co-use of opioids and stimulants and reflects a growing crisis of methamphetamine-only deaths.
- There is only one effective treatment for stimulant use disorder: contingency management. CM's efficacy has been well researched by the federal government and is well documented. We request that CMS acknowledge the instrumental role the federal government can play in preventing these needless deaths by using the California CM pilot to develop an evidence-based protocol for the treatment of individuals with StimUD.
- While we understand that the use of CM is controversial, we believe that saving the lives of tens of thousands of individuals is critical.

CY 2024 Physician Fee Schedule Proposed Rule

Payment Update for CY 2024

NABH shares the concerns of providers across the care continuum about the proposed net decrease of 3.3% to the PFS conversion factor (-\$1.14). This overall decrease accounts for the expiration of the 2.5% statutory payment increase for CY 2023; a 1.25% statutory payment increase for 2024; a 0.00% conversion factor update under the *Medicare Access and CHIP Reauthorization Act*, and a -2.17% relative value unit (RVU) budget-neutrality adjustment. These cuts would produce a material drop from the current conversion factor of \$33.89 to \$32.75 in CY 2024. **An average reduction of this magnitude from one year to the next is more than the delivery system can take without a negative impact on overall quality of and access to care for the outpatient patient population.**

In particular for the behavioral healthcare continuum, we appreciate these modest increases in the proposed psychiatric RVUs.

+1.0% Impact of Work RVU Changes: including misvalued code updates

⁵ Hoopsick, R.A., Andrew Yockey, R., 2023. Methamphetamine-related mortality in the United States: co-involvement of heroin and fentanyl, 1999-2021. *Am J Public Health* 113 (4), 416–419. <https://doi.org/10.2105/AJPH.2022.307212>.



+1.0% Impact of Practice Expense RVU Changes

0.0% Impact of Malpractice RVU Changes

+2.0% Combined total, including rounding

That said, the long-standing shortage of behavioral health clinicians and other personnel persists at crisis levels and, despite the end of the COVID-19 pandemic, is expected to persist for years. The multitude of policy and financial interventions designed by Congress and CMS to boost our workforce are thoughtful and appropriate, but the largest scale strategies (such as loan repayment and the expansion of nursing and medical schools) are not fast acting. **Thus, in the meantime, salaries and wages are the most impactful tool for growing the behavioral health workforce and, as such, the field urgently requires more robust increases to the psychiatric RVUs proposed for CY 2024.**

New Behavioral Healthcare Providers

As required by the CAA, CMS proposes Medicare Part B coverage and payment under the Medicare Physician Fee Schedule for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals. Additionally, the rule proposes to allow addiction counselors that meet all applicable requirements to enroll in Medicare as MHCs. We applaud this change and appreciate that newly enrolled MFTs and MHCs would be able to bill Medicare for services starting January 1, 2024. To clarify these new roles and facilitate efficient adoption, we recommend that new guidelines (both regulatory and sub-regulatory) use the phrase “mental health” or “addiction” services, rather than the more global “behavioral health.” This is especially important for states in which addiction counselors and mental health counselors have distinct roles.

Further, to achieve parity in access to care for the important work provided by social workers, marriage and family therapists, and mental health counselors, we call on CMS to align their PFS payments (currently 75% of physician rates) to that of other non-physician medical staff (currently 85% of physician rates). Such an increase would boost efforts to recruit these professionals to work in the behavioral health space to help address our dire workforce shortage. **Further, we urge CMS also to consider adding psychiatric mental health nurse practitioners to the list of clinicians who can certify and assist in treatment planning for IOP services to materially extend the clinical capacity of outpatient services, as this category of nurse practitioners are highly clinically trained and already serving a wide array of other clinical functions for our patient populations.**

NABH also supports the corresponding introduction of behavioral health integration codes to allow MFTs and MHCs to provide integrated behavioral health care as part of primary care settings. These codes pertain to the addition of behavioral health care to the services delivered in the primary care setting. **While we support this form of integration, we encourage CMS to evaluate whether additional clinical training, and the type and quantity, may be needed to boost the existing level of behavioral health training and practice among current primary care practitioners.**

In addition, NABH supports the proposal to allow health behavior assessment and intervention services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168) to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists. The process of diagnosing and directing patients to the right setting of care would be greatly enhanced by allowing a wider range of practitioner types to assess patients’ psychological, behavioral, emotional, cognitive, and social factors. Further, this change would directly expand access to important stages of treatment.



Psychotherapy for Crisis Services

As also mandated by the CAA, the rule proposes new PFS HCPCS codes under for “psychotherapy for crisis” services that are furnished in a setting other than a physician’s office or mobile unit or home. We support this proposed payment rate set by law is 150% of the PFS amount for non-facility sites of service identified by HCPCS codes 90839 (*Psychotherapy for crisis; first 60 minutes*) and 90840 (*Psychotherapy for crisis; each additional 30*). Along with our members, we will monitor the utilization of this service targeted at patients with the highest crisis levels of their mental health and/or substance use disorder condition.

Increasing the Valuation of Timed Services

NABH supports regular updates to the valuation for timed behavioral health services under the PFS and we are pleased that such valuations would increase under this rule. Specifically, the agency proposed an increase to the work RVUs for psychotherapy codes payable under the PFS, to be implemented over a four-year transition. NABH shares CMS’ concerns about undervaluing care management and integration services given the variability of costs involved with these relatively new and evolving treatment patterns. As such, to promote accurate payment for behavioral healthcare services and, in this case, the correction of distortions to these work RVUs, we urge CMS to implement RVU accuracy assessments annually, or at least more frequently, especially with regard to the new IOP benefit.

In addition, while we favor the proposal to increase the CY 2024 work RVU level for general behavioral health integration care management (CPT Code 99484 and HCPCS Code G0323) work RVU from 0.93 from the current 0.61 with an increase in work time to 21 minutes, we ask CMS to continue closely evaluating the implementation of these relatively new services to ensure that payments are set at a level that actually spurs great integration efforts.

Annual Wellness Visits

Annual wellness visits and social determinants of health (SDOH), community health integration (CHI) services, and principal illness navigation (PIN) services. We fully support separate billing codes for social determinants of health (SDOH) risk assessment, community health integration (CHI) services, and principal illness navigation (PIN) services. We recommend that CMS additionally allow these services to be furnished via **telehealth**. We also support the annual wellness visits as the initiating visit for SDOH services; however, we recommend that **SUD services offered in specialty settings (e.g., opioid treatment programs, residential if applicable, and office-based settings) also be permitted to serve as the initiating visit** for these services as well as CHI and PIN services. As has been well-documented, individuals with SUDs often do not have primary care providers. If these SDOH services are to serve their intended populations, addiction specialty care must be able to assess and refer for these services.

Moreover, we recommend that SDOH, CHI, and PIN services be **added as services under the new intensive outpatient program benefit as well as in partial hospitalization programs**. Again, if services are to be used, they need to be offered where individuals receive care. Rates for SDOH, CHI and PIN workers also need to be evaluated and made competitive. We also recommend that **CMS permit initiating visits for these services to take place at other times during the year**, as the living and clinical situation for individuals needing these services can fluctuate over time. Moreover, we recommend that **mid-level providers be able to perform the initiating visit**, as they often address these types of issues as part of the scope of work and may have more expertise than physicians in making the assessments and referrals.



Additional Issues

Dually-eligible Beneficiaries. In response to CMS' interest in better serving dual-eligible individuals, we recommend that CMS **streamline the process by which Medicare must first deny a claim** before a provider can bill Medicaid. Since many services are not covered by Medicare, individuals needing care face barriers, and extended delays while financing for urgently needed care is determined.

Audio-only Periodic Assessments. We support the extension of coverage, as required by law, for **audio-only periodic assessments** through 2024. We urge CMS to **make this permanent**, as pandemic data demonstrates that audio encounters are necessary and beneficial for many people who would otherwise not be able to access care.

Issues Related to PFS Substance Use Disorder Treatments

G-codes for Office-Based Opioid Treatment (OBOT). The frequency of these treatments have decreased since they were first published in 2020 (G2086 -6%, G2087 -4%, and G2088 – 13%). At the same time, E&M counseling codes have increased (99204 +2%, 99203 +3%, 99213 +19%, and 99214 +16%). Counseling codes 90832 and 93837 have also increased. The G code rates have declined when other codes included in the bundle have increased. This differential is inexplicable; it is incongruous with the Biden Administration's concerted efforts to improve the uptake of buprenorphine and other office-based care for individuals with OUD. We request that **CMS undertake a re-evaluation of the RVUs and bring them commensurate with those of other services.**

SUD Payment. We support the increase in payment rates for office-based SUD bundled services. Behavioral health care rates are uniformly undervalued and we recommend that CMS revamp their methodology in determining appropriate reimbursement. The lack of available and participating physicians and other workers in the Medicare program attests to the substandard payment levels.

Remote Therapeutic Monitoring. We support the proposed expansion of remote therapeutic monitoring (RTM) codes to cognitive behavioral therapy with code 989X6. **We urge CMS to revise all existing RTM codes, inclusive of codes 98975, 98980, 98981, 989X6, to include SUD or create an additional condition/system agnostic RTM device code to allow for the provision of critical services to patients with SUD.** Until such clarification is provided, these codes will not benefit individuals with substance use disorder.

As the healthcare industry shifts to value-based care, adherence to medication assisted treatment can serve as a mechanism to improve outcomes and lower downstream costs for SUD. Research has demonstrated enhanced efficiencies in care, increases in patient satisfaction, retention, and improved medication adherence rates, among other benefits, of using (RTM) for SUDs.

A fundamental barrier to adoption of RTM codes is the current condition-specific limitations of RTM billing to respiratory and musculoskeletal conditions. This has prevented the use of RTM for SUD populations who could benefit from medication adherence support. Some MAT providers have fully integrated best practice digital therapeutics that patients are willing and able to use, however a major barrier to adoption by clinical staff has been a lack of incentive.

We recommend that RTM codes be created for OTP and OBOT treatment services and strongly encourage CMS to develop an add-on code for RTM for take-home situations in which a client benefits from asynchronous remote video monitoring but is not yet receiving a full week of take-home medication. The bundle would cover the incurred costs for technology fees; the direct asynchronous



observation by qualified professionals, documentation, treatment planning, etc. would be covered under the existing full bundle. Several RTM products are now in use and others are in the pipeline. We appreciate CMS keeping pace with the evolving technological changes that hold great promise for improving SUD treatment quality and retention.

Contingency Management

As we more fully discuss in the “Contingency Management” section on page 7, NABH requests that CMS develop an add-on service code for the use of CM in OTPs for individuals with stimulant use disorder (StimUD). CM is the only effective treatment for stimulant use disorder, with its efficacy thoroughly documented in the literature. As such, we urge CMS to consider implementing this policy to save the lives of those patients who are suitable for this evidence-based intervention.

Thank you for considering NABH’s recommendations on these important rules. We look forward to supporting and working with you and your staff to address these issues. Please contact me at shawn@nabh.org or 202-393-6700, ext. 100 if you have questions.

Sincerely,

Shawn Coughlin
President and CEO