National Association for Behavioral Healthcare

Access. Care. Recovery.

9 September 2024

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

Submitted Electronically

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

Medicare and Medicaid Programs: Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies.

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 rules for CY 2025: the outpatient prospective payment system (OPPS) and physician fee schedule (PFS) rules. In addition to other issues, our letter provides recommendations on how to improve the intensive outpatient programs (IOP) benefit that was added to the OPPS in January 2024. This letter also expresses our concern about the insufficient proposed annual updates, our appreciation of proposals to improve opioid treatment programs (OTPs), and the multiple provisions that would extend access to behavioral healthcare services through telehealth.

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

The need for greater SUD treatment in Medicare continues to grow. The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health identified that more than 4.6 million adults ages 65 and older had an SUD in 2023, compared

with 3.9 million in 2022.[1] While CMS has made great progress in recent years to expand coverage, only about one in four older adults received any SUD treatment in 2023, a decrease from the previous year.[2] The U.S. Department of Health & Human Services (HHS) Office of Inspector General found that at least 52,000 people enrolled in Medicare experienced an opioid overdose in 2022, and only about 18% of Medicare beneficiaries with an opioid use disorder received medication to treat their disorder, with notable disparities based on race, age, geographic location, and receipt of the low-income subsidy.[3] Accordingly, we urge CMS to continue to expand coverage of person-centered and comprehensive MH and SUD treatment and remove unnecessary barriers to care.

Behavioral Healthcare Providers Need Modern Information Technology

Many of the initiatives in these proposed rules face outdated health information technology (HIT) that is used across the behavioral healthcare sector. Unfortunately, many psychiatric hospitals and their outpatient departments lack the capacity for interoperable exchange of patient health information. The prevalence of obsolete technology reduces the timeliness and effectiveness of care for more intensive behavioral healthcare patients, joint case management across settings, cross-setting patient transfers, and efforts to achieve parity in integrating physical and mental health.[4][5]

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. The majority of 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.

CMS leadership and Members of Congress have recognized this obstacle to integrated care. In 2023, CMS hosted a webinar with behavioral healthcare stakeholders and acknowledged the importance of building the capacity to exchange patient-level data interoperably. Also, Congress has introduced legislation (H.R. 5116 and S. 2688) to earmark funding to purchase and implement modern HIT resources for our field.

---

[1] SAMHSA, "2023 National Survey on Drug Use and Health," Table 5.3A (2024) https://www.samhsa.gov/data/report/2023-nsduh-detailed-tables.

[2] *Id.* at Tables 5.3A and 5.14A.

[3] U.S. Dep't of Health & Human Services Office of Inspector General, "The Consistently Low Percentage of Medicare Enrollees Receiving Medication to Treat Their Opioid Use Disorder Remains a Concern" (Dec. 2023), https://oig.hhs.gov/oei/reports/OEI-02-23-00250.pdf.

[4] "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.

[5] 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.

More recently, HHS launched two initiatives in 2024 to build the key infrastructure needed to connect behavioral healthcare providers electronically among themselves and other healthcare service providers. First, the SAMHSA and the Office of the National Coordinator for Health Information Technology (ONC) launched the $20 million Behavioral Health Information Technology Initiative to develop a common set of behavioral healthcare-specific data metrics for the field to incorporate in future HIT systems. In addition, CMS launched the Innovation in Behavioral Health Model, in which eight states will partner to develop integrated payment approaches to support behavioral healthcare integration with physical health providers. This initiative clearly will require interoperable behavioral healthcare partners.

CY 2025 OPPS Proposed Rule

Proposed CY 2025 Payment Update Does Not Reflect Actual Cost Pressures

For CY 2025, CMS has proposed an OPPS net update of 2.3 percentage points, which includes a 3.0 percentage point market basket update, a 0.2 percentage-point productivity cut, and other offsets. The proposed net increase is substantially smaller than the CY 2024 net increase of 3.1 percentage points and falls short of addressing the current cost pressures that outpatient behavioral healthcare providers face. The significant cost pressures, which peaked during the COVID-19 pandemic and still persist, 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 even greater limitations addressing these elevated cost pressures.

We also encourage CMS to use the most recent data available to determine the appropriate payment for MH and SUD services, account for current workforce shortages, and related compensation levels. CMS also should continue to monitor access to MH and SUD treatment and ensure that the Medicare reimbursement rates are sufficient to cover the cost of care and appropriately incentivize providers to treat Medicare beneficiaries.[6]

We support CMS expanding payment for IOP services to additional settings, including freestanding SUD treatment programs and facilities, and recommend that all levels of care in the continuum of SUD treatment and recovery be included. We recommend creating an "incident to" billing model for these levels of care with reimbursement no less than outpatient hospital rates. We suggest developing an add-on code to compensate the practitioner for the services (especially if external to the facility) such that the rate for freestanding facilities are not diluted. We also recommend permitting telemedicine in these levels of care to improve much needed access to care. We encourage CMS to develop policies to incentivize all states to offer IOP, as some states have no existing capacity.

[6] *See* Department of Health & Human Services Office of Inspector General, "A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care" (Mar. 2024), https://oig.hhs.gov/documents/evaluation/9844/OEI-02-22-00050.pdf

Individuals Currently or Formerly in Custody of Penal Authorities; Special Enrollment
NABH supports the revision of Medicare's definition of custody and the special enrollment period for formerly incarcerated individuals. However, for the sake of clarity, we recommend that CMS state in the regulatory text that individuals on bail, parole, probation, or home confinement are not considered to be in custody. We also suggest removing the exclusion of individuals under arrest so that it does not include individuals on bail or pre-trial release and whose services are not covered or provided by a carceral setting. In addition, we ask CMS to align with Medicaid's approach to individuals in halfway houses by allowing Medicare to pay for their care.

New Health and Safety Standards for Obstetrical Services for Hospitals
NABH appreciates CMS' leadership in proposing specific actions to improve the quality and safety of care for obstetrical (OB) patients with substance use-related, maternal health needs, recognizing that overdose is now a leading cause of maternal mortality.[7] This crisis can be concretely addressed through targeted training requirements and quality reporting initiatives for hospitals, including inpatient psychiatric hospitals and units. Rather than revising the Medicare conditions of participation, we support the material proposals discussed below: requiring evidence-based trainings for staff at hospitals with OB services, developing standards for facilitating post-hospital referrals, and expanding hospital quality reporting programs (QRP) to include MH and SUD quality metrics. In addition, with regard to parity in medical service delivery, we thank CMS for recognizing that OB services must be provided in accordance with nationally recognized acceptable standards for physical and behavioral health.

Overdose mortality more than tripled among pregnant and postpartum women from 2018 to 2021,[8] and birthing individuals with opioid use disorder are 4.6 times more likely to die during hospitalization.[9] SAMHSA has acknowledged that pregnant women with SUD face stigma from the healthcare community and other significant barriers in seeking and receiving treatment for their SUD during pregnancy, and even more so for women of color.[10] Targeted drug testing disproportionately impacts low-income individuals of racial or ethnic minorities, and many states have adopted punitive measures to prosecute pregnant women who use substances that have no clinical benefit for the parent, child, or family, and dozens of national organizations have opposed such measures.[11] As the National Institutes of Health (NIH) noted, pregnant women are "less likely to receive an appointment to an addiction treatment center" and often "face punitive policies for their substance use, including fines, loss of custody of their children,

[7] American Medical Association, "AMA Report on Overdose Crisis in Pregnant and Postpartum People" (Feb. 29, 2024), https://www.ama-assn.org/press-center/press-releases/ama-report-overdose-crisis-pregnant-and-postpartum-people.
[8] Beth Han et al., "Pregnancy and Postpartum Drug Overdose Deaths in the US Before and During the COVID-19 Pandemic," JAMA Psychiatry, 81(3), 270-283 (Nov. 22, 2023), https://doi.org/10.1001/jamapsychiatry.2023.4523.
[9] SAMHSA, "Evidence-Based, Whole-Person Care for Pregnant People Who Have Opioid Use Disorder" (Mar. 2024), https://store.samhsa.gov/sites/default/files/whole-person-care-pregnant-people-oud-pep23-02-01-002.pdf.
[10] *Id*.
[11] Stephen W. Patrick, David M. Schiff, Committee on Substance Use and Prevention, "Policy Statement: A Public Health Response to Opioid Use in Pregnancy," American Academy of Pediatrics, 139(3), (Mar. 2017), https://doi.org/10.1542/peds.2016-4070.

involuntary commitment, and incarceration," which in turn has adverse outcomes for families and children as well, particularly for Black and American Indian/Alaska Native children.[12]

Today, hospitals often fail to identify, treat, and provide appropriate follow-up care for SUD for pregnant and postpartum women. Even though substance use during pregnancy is common, many individuals do not disclose information about their substance use or seek SUD treatment out of fear of losing their child or other punitive consequences.[13] National SUD leaders and experts in the field agree that universal screening for OB patients for substance use is necessary to improve access to care and both maternal and child health outcomes, and also that medication for opioid use disorder (MOUD) is the standard of care for treatment of opioid use disorder in pregnancy.[14] To help ensure readiness to effectively treat these issues, it is vital that hospitals implement targeted preparation and process improvement related to the screening and treatment of this highly vulnerable population.

Standards for Facilitating Post-hospital Referrals

We encourage CMS to partner with the hospital field to develop standards for facilitating patient referrals for follow-up care, with a focus on improving maternal health outcomes, because pregnant and postpartum women are less likely to get an appointment for the addiction treatment they need.[15] Such standards should identify and require evidence-based policies, including provisions to protect patient privacy. The resulting guidelines would then be implemented in hospital policies and procedures.

Annual Staff Trainings

CMS should require hospitals to implement annual staff trainings about SUD response, including best practices for working with pregnant and postpartum women with SUD, including those using MOUDs. We encourage CMS to incorporate SUD into the proposed staff training requirement for OB services, and to develop standalone trainings for other hospital staff – such as emergency, orthopedic, pharmacy, and outpatient department staff – who are likely to interact with patients with SUD. Policymakers have recommended training as one critical way to improve access to evidence-based SUD treatment among pregnant and postpartum women.[16]

---

[12] National Institutes of Health, "Overdose Deaths Increased in Pregnant and Postpartum Women from Early 2018 to Late 2021" (Nov. 22, 2023), https://www.nih.gov/news-events/news-releases/overdose-deaths-increased-pregnant-postpartum-women-early-2018-late-2021; Office of National Drug Control Policy, "Substance Use Disorder in Pregnancy: Improving Outcomes for Families" 2 (Oct. 2021), https://www.whitehouse.gov/wp-content/uploads/2021/10/ONDCP_Report-Substance-Use-Disorder-and-Pregnancy.pdf.

[13] American Society of Addiction Medicine, "The ASAM Criteria," Chapter 21: Supporting Patients who are Pregnant and Parenting (4th Ed. 2023).

[14] American Medical Association, *supra* note 11; The American College of Obstetricians and Gynecologists, "Opioid Use and Opioid Use Disorder in Pregnancy" (Aug. 2017), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy; American Society of Addiction Medicine, *supra* note 18; Stephen W. Patrick et al., *supra* note 15; SAMHSA, *supra* note 13; Office of National Drug Control Policy, *supra* note 16.

[15] American Society of Addiction Medicine, *supra* note 18; Office of National Drug Control Policy, *supra* note 16.

[16] Office of National Drug Control Policy, *supra* note 16; *see also* Public Health on Call, "Treating Substance Use Disorder in Pregnancy," Johns Hopkins Bloomberg School of Public Health (Nov. 30, 2022), https://johnshopkinssph.libsyn.com/549-treating-substance-use-disorder-in-pregnancy; Alliance for Innovation on

Furthermore, research has shown that patients who initiate MOUD within seven days of an opioid use disorder-related hospital visit had lower odds of a fatal or nonfatal overdose at 6 months.[17] However, among Medicare beneficiaries who presented to the hospital after a nonfatal overdose in 2020, only 4% of patients received any MOUD and only 6% filled a naloxone prescription, and the average number of days until the MOUD initiation was 72 (more than 10 weeks).[18] One systematic review (81.2% of articles) found that the institutional environment was the most common reason for physician reluctance to address substance use in their practice, suggesting that "effort should be directed at creating institutional environments that facilitate delivery of evidence-based addiction care while improving access to both education and training opportunities for physicians to practice necessary skills."[19] Therefore, annual trainings and continuing education opportunities, coupled with standards on access to SUD care, are important ways CMS can help to increase high quality care, particularly for pregnant and postpartum individuals.

Expand QRPs to Include MH and SUD Metrics

In addition, CMS should expand the existing hospital QRPs to include MH and SUD quality metrics, with resulting data made publicly available. Doing so will help address the root causes of the maternal health crisis. To fulfill this requirement, facilities can collect data on maternal MH - and SUD-specific metrics that provide feedback on the effectiveness of evidence-based practices, such as postpartum depression screening, follow-up, and initiation and engagement of SUD treatment.[20] In addition, new measures on identifying social needs that can worsen mental health outcomes will help identify root causes and related pattern for this population.[21] Given the racial/ethnic disparities among maternal health outcomes, facilities should be required

---

Maternal Health, "Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle" (2022), https://saferbirth.org/wp-content/uploads/U2-FINAL_AIM_Bundle_CPPPSUD.pdf.

[17] Scott G. Weiner, et al., "Opioid Overdose After Medication for Opioid Use Disorder Initiation Following Hospitalization or ED Visit," JAMA Network Open, 7(7), (July 22, 2024), https://doi.org/10.1001/jamanetworkopen.2024.23954.

[18] Christopher M. Jones et al., "Overdose, Behavioral Health Services, and Medications for Opioid Use Disorder After a Nonfatal Overdose," JAMA Internal Medicine, 184(8), 954-962 (June 17, 2024), https://doi.org/10.1001/jamainternmed.2024.1733.

[19] Melinda Campopiano von Klimo et al., "Physician Reluctance to Intervene in Addiction," JAMA Network Open, 7(7), (July 17, 2024), https://doi.org/10.1001/jamanetworkopen.2024.20837.

[20] The National Committee for Quality Assurance. "Postpartum Depression Screening and Follow-up (PDS-E)," https://www.ncqa.org/hedis/measures/postpartum-depression-screening-and-follow-up/; The National Committee for Quality Assurance. "Initiation and Engagement of Substance Use Disorder Treatment (IET)," https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-substance-use-disorder-treatment/. See also The American College of Obstetricians and Gynecologists. "Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum," https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline/articles/2023/06/screening-and-diagnosis-of-mental-health-conditions-during-pregnancy-and-postpartum; Policy Center for Maternal Mental Health. "Universal Screening for Maternal Mental Health Disorders," https://www.issuelab.org/resources/40013/40013.pdf.

[21] The National Committee for Quality Assurance. "Proposed New Measure for HEDIS®1 Measurement Year (MY) 2023: Social Need Screening and Intervention (SNS-E)," https://www.ncqa.org/wp-content/uploads/2022/02/04.-SNS-E.pdf.

to stratify these data by race and ethnicity.[22] Data from Maternal Mortality Review Committees are another source of valuable guidance.

Medicare Advantage Plans Require Greater Oversight
One of the immediate, material steps CMS can take to significantly expand Medicare beneficiary access to OTPs is to prohibit Medicare Advantage (MA) plans' continued egregious use of prior authorization, primary care referral, and co-pay requirements to access OUD treatment in an OTP. These practices are becoming more widespread and are needlessly restricting access to lifesaving care. CMS should instruct MA plans to cover OTP services without prior authorization, primary care referral requirements, or copayments/coinsurance, just like the traditional Part B benefit, and ensure fair reimbursement for Medicaid services. Additionally, CMS should enforce network adequacy requirements for OTPs in MA provider networks or allow for any willing OTP provider to participate in-network to ensure convenient and timely access to care.

CY 205 Physician Fee Schedule Proposed Rule

Proposed Payment Update
NABH shares the concerns of practitioners across the care continuum about the proposed net decrease of 2.8% to the PFS conversion factor. This material cut would impose a heavy strain on the overall delivery system that results in a negative impact on overall quality of and access to outpatient care for behavioral healthcare and other types of patients.

With specific regard to behavioral healthcare practitioners, we appreciate the proposed increases for these providers of outpatient behavioral healthcare services:

- +3.0% for clinical psychologists,
- +1.0% for psychiatrists, and
- +4.0% for clinical social workers.

That said, salaries and wages are the most effective tool for growing the behavioral healthcare workforce in the near term, and still fall short in many communities. Additional increases in compensation are needed to attract those psychologists and psychiatrists who only provide cash-based services to avoid low payment from Medicare and other payers, as well as to avoid administrative burden, as an April 2024 study from RTI concluded. We also appreciate and support longer-term strategies to increase the behavioral healthcare workforce, including these actions from Congress and CMS in recent years: creating new physician training slots allocated for psychiatrists, offering loan repayment, and expanding nursing and medical schools. Also helpful is the CY 2024 change allowing health behavior assessments and intervention services to be billed by clinical social workers, marriage and family therapists, and mental health counselors, as well as clinical psychologists.

Increase the Cap on CPT® Code 99494
Currently, CPT® code 99494, used for prolonged services, is capped at a maximum of two units per patient per calendar month. We propose increasing this limit to a maximum of **four units**

[22] *See* Alliance for Innovation on Maternal Health, *supra* note 25.

per patient per calendar month. This adjustment is crucial to reflect accurately the complexity and intensity of care required, particularly for patients with chronic conditions who necessitate extended engagement and benefit most from such engagement. By raising this limit, CMS would acknowledge the additional resources and time necessary to manage complex cases, thereby enhancing support for comprehensive patient care.

RVU Increases

We support the proposal to increase the RVU of annual alcohol misuse screening, brief face-to face behavioral health counseling for alcohol misuse, and annual depression screening codes (G0442, GO443, Go444).

Increases for Safety Planning and Post-discharge Follow-up

We support new codes and reimbursement for safety planning interventions (SPI) and post-discharge telephonic contacts related to suicide and overdose risk. We bring your attention to the fact that the proposed elements of SPI are limited to suicide and we recommend that substance use-related crises, risky substance use, and substance use disorder be applied throughout the GSPI1 definition, as relevant. We also recommend developing add-on codes to allow for additional time for safety planning, as individuals with complex needs often require additional time.

Establish HRSN Services as Stand-alone Services

We recommend CMS enable the services addressing health-related social needs to be delivered and billed as standalone services. Currently, the initiation of these services is limited to circumstances in which the billing practitioner delivers one of a subset of codes, such as evaluation and management visits, certain behavioral healthcare office visits, and the annual wellness visit. However, individuals with MH and SUD do not always enter the healthcare delivery system through one of these visits. Community health workers, peer support specialists, and patient navigators may be the first point of contact for individuals with these conditions, especially because part of their role is making connections and referrals; recognizing that, as of 2023, almost 50% of people with MH conditions and more than 75% of people with SUD did not receive treatment.[23] When individuals with MH and SUD face housing instability, financial insecurity, transportation needs, and utility difficulty, they prioritize and address those needs over their healthcare needs. They also may not be able to get a timely appointment, particularly with a psychiatrist or psychologist who could initiate these services addressing health-related social needs due to the low rate of provider participation in Medicare.[24] To ensure

[23] SAMHSA, "Highlights for the 2023 National Survey on Drug Use and Health" (2024), https://www.samhsa.gov/data/sites/default/files/NSDUH%202023%20Annual%20Release/2023-nsduh-main-highlights.pdf.

[24] *See* Department of Health & Human Services Office of Inspector General, "A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care" (Mar. 2024), https://oig.hhs.gov/documents/evaluation/9844/OEI-02-22-00050.pdf; Senate Committee on Finance, "Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks" (May 3, 2023), https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf; Meredith Freed, Juliette Cubanski & Tricia Neuman, "FAQs on Mental Health and Substance Use Disorder Coverage in Medicare," KFF (Jan. 18, 2023),

these needs are met in a timely and efficient manner, consistent with CMS' priority of patient-centered care, we encourage CMS to authorize these services to be delivered and billed as standalone services.

Integration of Behavioral and Physical Healthcare Requires Additional Resources
Our members report that *cross-organization* integration of medical and behavioral healthcare services occurs only on a relatively rare basis. Given the long history of clear separation of these service lines, it is not surprising that material challenges must be addressed to create meaningful integration. These challenges include cross-organization training of key personnel, coordinated workflows, and bi-directional communication and health information exchange protocols. Underlying these challenges is the recognized lack of modern HIT systems in most behavioral healthcare settings, as we noted above. The Medicare program's current investments in integration fall short of the amount needed to fill these gaps. In fact, the modest movement toward cross-organization integration is primarily limited to at-risk physical healthcare providers seeking to achieve overall cost savings per episode of care that invest in this area to reduce costs and improve care for the covered episode, which requires including coordinated behavioral healthcare services. Overcoming these substantial barriers will require greater investment from Medicare.

Looking forward, successful integration of physical and mental healthcare services will require:

- Electronic Health Record (EHR) Integration: EHR interoperability is needed to achieve bi-directional information flow between the physical and mental healthcare providers, including diagnosis, treatment plan, and response of shared patients.

- Dedicated Support Staff: Dedicated staff and technology are necessary to facilitate warm hand-offs between the physical and mental healthcare providers.

- Specialized Benefits Verification and Intake: Specialized benefit verification and intake personnel are needed to verify coverage for core services and supplemental services that may be required, especially for higher-acuity patients.

- Outcomes Tracking Tools: Outcome tracking and reporting capabilities customized for the shared patient population are needed.

- On-site Costs: One or both partners could face costs to prepare for and deploy integration, including IT one-time and ongoing purchases, employee training, and physical space preparation. This includes either or both partners implementing a new set of clinical protocols to treat both the primary and secondary comorbidities of patients receiving integrated care.

https://www.kff.org/medicare/issue-brief/faqs-on-mental-health-and-substance-use-disorder-coverage-in-medicare/ (highlighting the low rate of psychiatrist participation in Medicare).

While the costs of integration largely fall on providers today, the benefits of these investments flow back to patients, Medicare, and other payers in the form of better outcomes and lower costs for overall care. However, the potential clinical and cost gains of effective integration across healthcare providers mostly remain unrealized. **Unfortunately, the rule's proposed cuts would greatly reduce efforts to advance integration. As such, we urge CMS to change course and take the following actions,** rather than reducing reimbursement for Collaborative Care Model (CoCM) codes:

- Maintain or Enhance Current Levels of Reimbursement for Practice Expense RVUs for Collaborative Care Services: The proposed rule reflects a divergence in the practice expense relative value units (PE RVUs) for collaborative care services compared to those for psychiatric evaluation, psychotherapy, and office visit evaluation and management services. Specifically, CMS would reduce the average CoCM and Behavioral Health Integration code by 4.1% in its non-facility PE RVU, while in contrast, the average psychotherapy CPT® code is increasing by 3.8%, office visits by 1.4%, and psychiatric evaluation CPT® codes by 0.3%. **It is clear that these proposed decreases will disincentivize the adoption of integration**. **As such, we call on CMS to increase the PE RVUs for CoCM services by 3.8% to align with the average psychotherapy increase and to consider an additional increase to offset the substantial costs of implementing and conducting integrated care.**

- Maintain 100% Reimbursement for Mid-Level Providers in CoCM: We strongly advocate for maintaining the reimbursement rate for mid-level providers at 100% of the Medicare rate, as currently established. The staffing requirements, upfront and ongoing system investments, and intensity of care under the CoCM framework are consistent, regardless of the provider's level of licensure or certification. Reducing reimbursement for mid-level providers would not accurately reflect the resources and time needed to deliver high-quality care within this model and given shortages within many license professionals, would significantly reduce adoption of the integrated care model.

OTPs

Methadone Induction

NABH supports the proposal to allow the initiation of methadone via audio-video telecommunications technology. Methadone is an evidence-based treatment when combined with psychosocial services and improves access to care, promotes positive health outcomes, and advances health equity among Medicare beneficiaries—particularly for the roughly 13% of residents who do not live near an OTP. Further, this change would align CMS' telehealth rules with those that SAMHSA recently promulgated.

Periodic Assessments

CMS should finalize its proposal to permanently allow OTPs to furnish periodic assessments for Medicare beneficiaries using audio-only communications, when video is not available, beginning Jan. 1, 2025. This flexibility would expand access to those who lack video technology. Importantly, if OTP physicians and clinicians are concerned about something that arises during a telephone-based assessment, that patient could receive follow-up care on an in-person basis.

Payment for OUD Patient Intakes

NABH supports payment for Intake (HCPCS code G2076) and social determinants of health risk assessments (HCPCS code G0136) to identify unmet health-related social needs (HRSN) or the need for OUD-related, harm-reduction interventions and recovery support services. These payments align with recent reforms to advance HHS' patient-centered and evidence-based paradigms of care for OUD treatments. We also encourage CMS to permit SDOH assessments during periodic assessments, as the patient population often requires reassessments: lack of stable housing and other social supports, as well as the trajectory of their recovery necessitates this flexibility. We encourage additional focus on harm reduction services throughout the payment system.

Existing accreditation (The Joint Commission) requires HRSN assessments and OTPs routinely perform coordination of care, referral and linkage services, including related to HIV, viral hepatitis, sexually transmitted diseases, as well as housing, education legal services. While grant funds or opioid settlement money may be used to supplement the breadth of services provided, the current situation is not ideal. Direct reimbursement from CMS for such services would expand the capacity and continuity for such services by hiring full-time staff. Due to the broad interdisciplinary teams that staff OTPs, we request that the range of credentialed providers be permitted to be reimbursed for the periodic assessments. We recommend either expanding the non-drug component of the bundle to cover these services, or to establish a monthly add-on code for the additional coordination services AND direct provision of the services, such as harm reduction and peer services.

Opioid Agonist and Antagonist Medications

We support the multiple proposals that aim to help prevent additional opioid overdoses and deaths, including payment for the new opioid agonist and antagonist medications that the U.S. Food and Drug Administration approved recently, and their non-drug components. Specifically, a new add-on payment to the bundled payment to account for take-home supplies for nalmefene hydrochloride (nalmefene) nasal spray (Opvee®). We also support paying for a new extended-release injectable buprenorphine product (Brixadi®), indicated to treat moderate to severe OUD using a new weekly bundled payment code to reflect the weekly formulation of Brixadi®. In addition, the proposed payment update for the existing bundled payment for monthly injectable buprenorphine (HCPCS G2069) would be positive, as it accounts for the monthly formulation of Brixadi®. We appreciate CMS continuing to expand treatment options in OTPs.

Opioid Diagnosis for Claims

NABH supports including an opioid use disorder diagnosis on claims, consistent with Medicare coverage and payment provisions.

Cost-sharing

We recommend CMS forgo beneficiary copays for all services that OTPs provide. Background research prior to the passage of the *Affordable Care Act* demonstrated that even very small co-pays posed an outsized disincentive for treatment for many economically disadvantaged

individuals. The population that would be well-served by an OTP does not seek treatment, in part, because of the financial roadblock of frequent co-pays. Such a policy should be applied to the MA program and *Affordable Care Act* marketplace plans.

Bundled Payment
We reiterate previous requests that OTP payment rates should not use the Medicare Economic Index (MEI) that reflects costs for physician practices. OTP care and delivery services require a level of oversight, infrastructure, and safety policies that result in their functioning more like hospital outpatient clinics. As such we again recommend that CMS use the IPPS market basket. This would be more equitable, as well as consistent with TRICARE.

Rural Care
We also reiterate our request to create a rural add-on code for the non-drug components for rural OTP services. A 17% add-on is consistent with Medicare incentives for inpatient psychiatric facilities, an acknowledgment of the cost pressures related to rural healthcare. The government has not made rapid-enough inroads to serving the rural population that has been disproportionately impacted by the opioid epidemic.

Contingency Management
We reiterate our previous request that CMS develop an add-on service code for the use of CM in OTPs for individuals with stimulant use disorder (StimUD). Almost half of the nation's opioid overdoses have co-involved stimulants. 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.

Telehealth Expansion Proposals
Permanent Expansion of Audio-only Telehealth

- NABH supports the proposal to permanently expand the allowable forms of telehealth "interactive telecommunications systems" to include audio-only communication technology if the patient is not capable of, or does not consent to, the use of video technology; and

- We support the proposal to allow *after* December 2025 and beyond, practitioner oversight of the patient via audio-visual telehealth, but only for services that are "low risk by their nature, do not often demand in-person supervision, and are typically furnished entirely by the supervised personnel."

Temporary Telehealth Expansions
NABH supports the following proposals to temporarily expand access to behavioral healthcare services through the use of telehealth:

- For CY 2025 only, allow the use of audio-visual (not audio-only) telehealth for the purpose of physician/practitioner supervision, including three-way telehealth visit involving the patient, teaching physician and medical resident;

National Association for Behavioral Healthcare

Access. Care. Recovery.

- For CY 2025 only, continue to permit physicians to use their currently enrolled practice location instead of their home address when providing telehealth services from home; and

- Extend through CY 2025 the pandemic-originating coverage of telehealth services provided by federally qualified health centers and rural health clinics.

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