September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
ATTN: CMS-1770-P
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies [CMS-1784-P]

Submitted electronically via Regulations.gov

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the proposed rule, "Medicare Program; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies." NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization, providing education, support and advocacy in communities around the country. We are dedicated to building better lives for people affected by mental illness, including the millions of people with mental illness who rely on Medicare for mental health treatment. Medicare is a lifeline for both older adults who live with mental health conditions as well as younger adults who are eligible because of a disabling mental health condition. We have a unique perspective on how Medicare can support people with mental illness and ways in which the program can be improved. We hope our expertise can be helpful as you consider ways to increase access to mental health treatments and medications through payment policy in the Medicare Physician Fee Schedule (PFS). We offer the following detailed comments.

Marriage and Family Therapists and Mental Health Counselors
The Consolidated Appropriations Act (CAA), 2023 (Pub. L. 117–328), established payment under Medicare Part B for services furnished by Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC), a legislative priority of NAMI's. NAMI applauds CMS' implementation of this important change. We also support CMS's proposal to allow Addiction Counselors who meet all the applicable requirements of a MHC to enroll in Medicare as MHCs and bill Medicare for MHC services. Across the U.S., there is growing demand for mental health care yet an extreme shortage of mental health providers, particularly among rural and marginalized populations. CMS estimates that this change will allow approximately 400,000 MFTs and MHCs to independently treat people with Medicare and be paid directly, which will help address the workforce shortage.

Mobile Crisis Care
The CAA also established payment for psychotherapy for crisis services furnished outside an office setting and required HHS to establish new HCPCS codes for such services beginning January 1, 2024. We applaud CMS for implementation of this important provision as we believe Medicare reimbursement is a critical step in expanding mobile crisis response services across the country. We also strongly support the broad definition of "home" to allow for these services to be delivered in temporary lodging,

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including hotels and homeless shelters, and in settings a short distance away from the exact home location for privacy or other personal reasons.

Additionally, we encourage CMS to create a pathway for peer support specialists to be reimbursed when they work with clinicians on mobile crisis teams. Psychotherapy is not within the scope of practice for peer support specialists. However, peer support specialists do provide engagement services, including education, support, and sharing lived experience to facilitate an individual participating in crisis psychotherapy effectively. Accordingly, we recommend CMS create a code for Crisis Psychotherapy with engagement services to allow for those critical engagement services to be provided in context with mobile psychotherapy.

General Behavioral Health Integration Care Management
NAMI supports CMS's proposal to revise the reimbursement rate for behavioral health integration (BHI) services (CPT code 99484 and HCPCS code G0323) to more accurately value the work involved in the delivery of these services. Research demonstrates that the integration of MH and SUD treatment with medical care improves health outcomes, improves patient and provider experiences, and is cost effective. Integrated care also helps to address MH and SUD treatment barriers that disproportionately affect Black and brown individuals, rural communities, and people with lower incomes. Thus, increasing the reimbursement rate for BHI services will make progress towards CMS's dual goals of improving access to MH and SUD care and advancing health equity.

Principal Illness Navigation Services (PIN)
NAMI supports CMS' work identifying gaps in appropriate coding and payment for care management/coordination and primary care services under the PFS, and the proposal to establish new coding for Principal Illness Navigation (PIN) services. Specifically, for CY 2024, CMS is "proposing to better recognize through coding and payment policies when certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist, are involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease."

NAMI is grateful for the inclusion of certified peer specialists in the PIN definition. Peer support is an evidence-based mental health model of care. Considerable research demonstrates that peer support specialists help improve patient outcomes, including reducing the need for inpatient and emergency services and the frequency of recurrent psychiatric hospitalizations. Peer support specialists can help improve an individual's sense of recovery and hopefulness, and they can help people improve their skills and abilities in desired areas.

However, we are concerned that the definition includes activities that are not within the scope and training of most peer support specialists, and not reflected in SAMHSA's National Model Standards for Peer Certification. Therefore, we urge CMS to work with SAMHSA to revise the language in the activities to reflect peer support principles consistent with the core competencies and only include activities that are within the scope of peer support specialists. Most significantly, that would include changing the focus of this to definition to helping the patient communicate with practitioners, rather than having the peer support specialists communicate with practitioners directly. Suggested red-line changes include the following:

> ++ Assist the patient in *communication with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding*

the patient's psychosocial strengths and needs, , goals, preferences, and desired outcomes, including cultural and linguistic factors.

Alternatively, we urge CMS to consider creating a distinct code for mental health and substance use education and engagement services that better reflects the core competencies and current training for peer support specialists. Just as CMS notes in the preamble that it created the Community Health Integration (CHI) service to reflect the core competencies of community health workers, it should create a code that reflects the core competencies of peer support specialists as defined by SAMHSA.

Telehealth

Telehealth has been shown to improve patient satisfaction and be cost effective for many diagnoses and has become an essential tool to help improve mental health care access. NAMI is pleased to see that CMS has proposed several updates to Medicare telehealth services such expanding the types of practitioners who can bill for telehealth services as well as expanding audio-only services and delaying the in-person visit requirements for telemental health services. Expansion of telehealth services helps eliminate barriers to care especially for individuals in underserved communities. A patient's geographic location should never be a determining factor in whether they receive adequate care. While CMS works to expand more telehealth services, proper guardrails must be put in place to ensure patient wellbeing and avoid potential abuse and fraud. Telehealth should be used as an option of care, not a replacement for in-person care, when determined to be medically necessary or preferred. NAMI commends CMS for its continued efforts in expanding care through telehealth services.

Caregiver Expansions

NAMI applauds CMS for expanding access to services and supports for caregivers. Caregivers play an irrefutably essential role in the health and well-being of people with mental health conditions. An estimated 53 million people provide caregiving for individuals with a chronic condition or disability, which often goes unpaid. The new caregiver training services (CTS) code recognizes the significance of the caregiver role and the importance of having a well-trained caregiver population. In the proposed rule, CMS notes how CTS could be provided by a practitioner in a group setting. When creating specificities surrounding caregiver training, we ask that the definition of training be as broad as possible and does not heighten burden among caregivers. Because this is a new code category, we encourage CMS to undertake broad provider education about the new option and encourage providers to use it to implement new caregiver supports.

Merit-based Incentive Payment System (MIPS)

NAMI supports CMS's proposal to add "Gains in Patient Activation Measure (PAM)" in the Merit-based Incentive Payment System (MIPS) as a reportable Patient Reported Outcome Performance Measure (PRO-PM). Patient activation is a key component of person-centered care and research and practice have shown that increasing patient activation is critical to improving the quality of care. Higher levels of patient activation have been repeatedly shown to be associated with better patient clinical outcomes, mental health outcomes, medication adherence, disease self-management, and treatment satisfaction.

Additionally, inclusion of MIPS metrics for evaluating suicide prevention efforts is important and the assessment of suicidal ideation and brief interventions are essential clinical services that must be provided and monitored. We appreciate the goal of identifying one assessment tool and one intervention however it is preferable to broaden this metric to include any reliable and valid assessment tool for suicidal ideation and behavior and any brief suicide prevention intervention that has been shown to be effective in reducing suicidal ideation and/or behavior. Choice of measure and intervention

depends on population, setting and medical need. The assessment tool and crisis intervention can be standardized within an institution or setting.

Conclusion
NAMI is grateful for the many proposals within this rule to strengthen coverage and care for people with mental health and substance use disorder conditions covered by Medicare. Thank you for the opportunity to comment. For questions or further information, please contact Jennifer Snow, National Director of Government Relations and Policy at jsnow@nami.org.

Sincerely,

Hannah Wesolowski
Chief Advocacy Officer
National Alliance on Mental Illness