National Alliance on Mental Illness

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850.

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 (CMS-1809-P) (link)

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to comment on the proposed rule listed above, outlining proposed changes to Medicare and Medicaid payment policy for CY 2025. 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 and Medicaid for mental health treatment. Medicaid is a lifeline for many Americans as the nation's largest payer of mental health and substance use disorder services. Medicare is vital 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 and Medicaid can support people with mental illness and ways in which the programs can be improved. We hope our expertise can be helpful as you consider ways to increase access to mental health treatments and medications. We offer the following detailed comments.

1) **Revise Medicare's custody definition and the Special Enrollment Period (SEP) for formerly incarcerated individuals. 42 C.F.R. §§ 411.4(b)(3), 406.27(d), 407.23(d).**

Medicare currently has a broad payment exclusion for services furnished to individuals in custody of penal authorities, which includes hundreds of thousands of people who are on bail,

parole, probation, and home detention. NAMI is grateful that CMS has proposed to narrow Medicare's custody definition to no longer include individuals on bail, parole, probation, and home detention. The new proposed definition will promote successful reentry and community integration for people in the criminal legal system. Research has shown that health coverage and access to care, including for those with unaddressed substance use and mental health conditions, has a positive impact on rearrest rates and recidivism.[1]

We further support CMS's proposal to revise the eligibility criteria for the special enrollment period (SEP) for formerly incarcerated individuals so that people under community supervision can enroll in Medicare.

In response to CMS's specific requests for comments, we offer the following recommendations:

- Explicit Statement: We encourage CMS to explicitly state in the regulatory text that individuals on bail, parole, probation, or home confinement are not considered to be in custody, as this would provide much needed clarity to individuals, providers, and advocates who are navigating these circumstances.
- Pre-Trial Release: We encourage CMS to remove the proposed exclusion of individuals under arrest ((§ 411.4(b)(3)(i)) as it is overly broad, insofar as it could encompass people who are on bail or pre-trial release and whose services are not covered or provided by a carceral setting. To the extent that the population CMS is trying to exclude are those that are confined to jail, that population is already represented in the § 411.4(b)(3)(ii).
- Halfway Houses: We encourage CMS to adopt Medicaid's interpretation and approach to individuals residing in halfway houses. If individuals have "freedom of movement,"[2] they should be entitled to have Medicare pay for their care.

NAMI believes these modifications will advance health equity and expand access to high quality and affordable coverage and care for hundreds of thousands of older adults and people with disabilities who are living in the community under supervised release following incarceration and will make Medicare more consistent with Medicaid and with commercial health insurance.

2) Publicly Report the Median Time From Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients for Psychiatric/Mental Health Patients on Care Compare

CMS currently makes publicly available a measure of the "Median Time for Discharged ED Patients" which evaluates the time from ED arrival to departure, also known as ED throughput time. CMS notes that their routine monitoring and evaluation of the CY 2024 performance

[1] Simes, J.T. & Jahn, J.L. (2022). The consequences of Medicaid expansion under the Affordable Care Act for police arrests. PLoS One, 17(1). https://doi.org/10.1371/journal.pone.0261512.

[2] CMS, SHO # 16-007 Re: To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities, Q3 (April 28, 2016), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf.

period for this measure has shown a median ED throughput time that is significantly higher for psychiatric/mental health patients compared to non-psychiatric/mental health patients. CMS suggests "this is an area that may benefit from additional quality improvement efforts" and we fully agree.

People experiencing mental health crisis who seek help from hospital EDs are too often kept in those facilities (otherwise known as "boarded,") until they can be admitted into a psychiatric treatment program or transferred to another facility. Unfortunately, EDs are rarely well equipped to handle people needing crisis care and are often unable to provide the specialized mental health treatment people need. Publicly reporting the ER throughput times for Psychiatric/Mental Health Patients will help shine a light on the problem of ER boarding and provide information policymakers can use to address the issue.

Therefore, NAMI strongly supports public reporting of ER throughput times for Psychiatric/ Mental Health Patients and encourages its finalization.

3) **Adopt the exception to the four walls requirement for Medicaid clinic services provided outside the four walls by personnel of behavioral health clinics. 42 C.F.R. §§ 440.90(d)**

Making it easier for people with mental health conditions to access care and treatment is a key goal of NAMI, as data consistently show that only half of adults nationwide with a mental health disorder receive mental health treatment. We agree with CMS's observations that barriers to mental health (MH) and substance use disorder (SUD) treatment include lack of transportation, stigma and mistrust of the mental health care system, and that providing an exception to the four walls requirement could increase access to care. We believe this proposed exception will help to expand access to MH and SUD services by allowing coverage of services provided via telehealth when both the provider and patient are located outside the clinic walls. Additionally, as CMS described in the preamble, some states have asked to cover mobile crisis intervention services via the clinic service benefit category. NAMI notes that the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2) authorizes a state option to provide qualifying community-based mobile crisis intervention services during the period starting April 1, 2022, and ending March 31, 2027. NAMI is hopeful that Congress will extend the authorization for this optional benefit category. However, if they do not, and the optional benefit is not extended beyond 2027, being able to cover mobile crisis intervention services via the clinic services benefit will be even more significant.

Additionally, for the reasons CMS presents in the preamble, we agree with the proposal to allow for coverage for those served by the behavioral health clinic and not limited to those beneficiaries with a documented MH/SUD condition.

Therefore, NAMI strongly supports the proposed addition in 42 C.F.R. §§ 440.90(d) and encourages its finalization.

4) Revise Conditions of Participation to add Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals

NAMI supports CMS's proposals to revise the Conditions of Participation for hospitals and critical access hospitals (CAHs) to (1) include baseline requirements for the organization, staffing, and delivery of obstetrical services (§§ 482.59, 485.649); (2) require evidence-based trainings for staff at hospitals with obstetrical services (§§ 482.59(c), 485.649(c)); (3) revise the quality assessment and performance improvement (QAPI) program standards to assess and improve health outcomes and disparities among obstetrical patients on an ongoing basis (§§ 482.21, 485.641); (4) establish a new standard on emergency services readiness (§§ 482.55, 485.618); and (5) have written policies and procedures for transferring patients under their care (§ 482.43).

According to the CDC data collected from Maternal Mortality Review Committees, "mental health conditions", which broadly include mental health, substance use disorders, and suicide, are the leading cause of pregnancy-related deaths.[3] We commend the Biden-Harris Administration for recognizing and taking concrete action to address the escalating maternal health crisis, and urge the Administration to further address the root causes of the maternal health crisis by expanding the proposal to include the substance use and mental health needs of pregnant and postpartum individuals.

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NAMI is grateful for CMS's commitment 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 do not hesitate to contact me at hwesolowski@nami.org.

Sincerely,

Hannah Wesolowski
Chief Advocacy Officer
National Alliance on Mental Illness

[3] Centers for Disease Control and Prevention. "Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 36 U.S. States, 2017–2019," (May 28, 2024), https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html.