September 9, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1807-P

Submitted via regulations.gov

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS-1784-P)

Dear Administrator Brooks-LaSure:

On behalf of the undersigned organizations advocating access to mental health and substance use disorder care across our country, thank you for the opportunity to comment on the Centers for Medicare & Medicaid (CMS) proposed rule addressing changes to the calendar year (CY) 2025 Payment Policies under the Physician Fee Schedule (PFS) and other proposed policy changes ("the Proposed Rule"), at 89 *Federal Register* ("FR") 61596 (July 31, 2024). We are grateful for CMS' attention to Certified Community Behavioral Health Clinics (CCBHCs) and appreciate the inclusion of CCBHCs in CMS' solicitation of comment at 89 FR 61746. As CMS further considers CCBHCs under Medicare, we strongly urge continued communication and collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA) as the CCBHC program is operated through a partnership across SAMHSA, CMS, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). We provide the following comment in response to CMS' solicitation of comment on CCBHCs.

CCBHCs were established by Congress in 2014 under section 223 of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) and launched through a demonstration program in 2017. In 2022, section 11001 of the Bipartisan Safer Communities Act (BSCA) expanded the demonstration program to add 10 new states every two years. And most recently, the Consolidated Appropriations Act, 2024 (CAA 2024) provided a definition for CCBHCs in Medicaid statute, permanently establishing CCBHCs as an optional Medicaid benefit.[1] CCBHCs can be implemented and funded through the Section 223 Medicaid Demonstration, CCBHC Expansion Grants administered by SAMHSA, or through independent state programs. And it is important to note that states participating in the Demonstration select one of four Medicaid Prospective Payment System (PPS) rate methodologies to establish payment rates for CCBHCs based on the expected cost of delivering care.[2] Today, there are nearly 500 CCBHCs across 46 states and territories (offering services in 40% of all U.S. counties, covering 62% of the nation's

population) serving an estimated 3 million people nationwide.[3] A regularly updated list of CCBHCs across the country can be found on National Council for Mental Wellbeing's website.[4]

PAMA established that CCBHCs must provide services to anyone seeking care for a mental health or substance use condition, regardless of ability to pay, place of residence, or age. PAMA also provided for program requirements and directed HHS to establish criteria for clinics to be certified as CCBHCs; SAMHSA most recently updated the CCBHC criteria in 2023.[5] There are nine core services CCBHCs are required to provide either directly or through formal partnerships. The required CCBHC services include: crisis services, outpatient mental health and substance use services, person- and family-centered treatment planning, community-based mental health care for veterans, peer, family support, and counselor services, targeted case management, outpatient primary care screening and monitoring, psychiatric rehabilitation services, and screening, diagnosis, and risk assessment. Notably, in response to CMS' specific solicitation on CCBHC services, in National Council for Mental Wellbeing's 2024 Impact Report, CCBHCs reported that the CCBHC model has helped them to address SDOHs in their communities through a wide array of strategies from screening for unmet social needs to proactively assisting clients with finding or maintaining stable housing, and have been able to hire community health workers.[6] Additionally, CCBHCs have shown to improve healthcare integration working closely with primary care providers through multiple pathways that results in increased access to primary care across individuals served.[7]

Since launching in 2017, CCBHCs have overall dramatically improved access to a comprehensive range of mental health and substance use services to individuals in vulnerable situations; inclusive of 24/7 crisis services as a part of the 988 crisis system, hiring hundreds of new substance use-focused clinicians, expanding medication for substance use care, and reducing patient wait times. CCHBCs are a successful, integrated, and modern way of delivering 21st century mental health and substance use care to individuals and families. And data have continuously shown that CCBHCs are making a difference in communities throughout our nation.[8] In the 2024 Impact Report, Medicaid CCBHCs (CCBHCs that are certified by their states and receive a Medicaid PPS) reported a 33% increase in the number of individuals served.[9] Specifically pertaining to access for substance use care, 60% of CCBHCs report the number of individuals engaged in medication for opioid use disorder (MOUD) has increased since becoming a CCBHC.[10] CCBHCs have also improved timely connection to care as CCBHC criteria require CCBHCs to see clients for routine needs within 10 days of the initial call or referral, in contrast to the national average of 48 days.[11, 12] Finally, CCBHCs play an important role in strengthening the workforce. Medicaid CCBHCs have reported increased hiring, adding a median of 22 new positions per clinic.[13]

Regarding CMS' solicitation on comment addressing ways to reduce capacity of emergency department visits, it's important to note that CCBHCs have shown decreased emergency room visits by 55%, reduced mental health care hospitalization by 55%, and decreased

homelessness measured in the past 30 days by 31%.[14] In general, and connected to further discussion below, the availability of crisis stabilization services is an important approach to improving access to higher quality behavioral health care crisis response at a lower cost than emergency rooms. Access to crisis stabilization centers moves the Medicare benefit closer to providing parity in crisis/emergency care for behavioral health for beneficiaries in a crisis/emergency compared to emergency/crisis medical surgical populations.

In response to CMS' request for comment on entities that offer crisis stabilization services, PAMA requires provision of three crisis behavioral health services: emergency crisis intervention services, 24-hour mobile crisis teams, and crisis receiving/stabilization. The required crisis services can be furnished directly by the CCBHC or through a Designated Collaborating Organization (DCO) agreement. At minimum, CCBHC crisis receiving/stabilization services must include urgent care/walk-in mental health and substance use disorder services for voluntary individuals, available hours identified as needed in the community needs assessment; and such services are available to identify the person's immediate needs, de-escalate a crisis, and connect the individual to appropriate care in the least-restrictive setting as possible, care that can also be provided by the CCBHC.[15] Crisis stabilization services should ideally be available 24-hours a day, 7-days a week and are encouraged to provide these services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care.[16] Additionally, CCBHCs may also consider providing peer-run crisis respite programs. In a recently published peer-reviewed article, analysis shows that CCBHCs, specifically with the Medicaid bundled payment, significantly improve crisis care with a stronger behavioral health workforce and better array of crisis services that is needed for these populations.[17]

With respect to CMS' request for comment on IOP at CCBHCs, CCBHCs are able to provide services that typically comprise an IOP program. Because of the flexibility that CCBHCs have and based off the community needs assessment, this may look different across the country as CCBHCs can respond with the level of intensity of care that is responsive and personalized to an individual's need in the community, and ultimately the care provided could rise to a level of care similar to what an IOP program might consist of at a CMHC. However, we urge CMS' caution in pursuing this benefit at CCBHCs. As noted in our comment on the CY25 OPPS proposed rule, CMHCs appear to face challenges in providing the IOP benefit under Medicare because the Medicare CMHC Conditions of Participation (CoPs) pose challenges and significant administrative burden for provider organizations. National Council for Mental Wellbeing's Medical Director Institute issued a brief earlier this year highlighting issues regarding parity and evidence-based practices in the current CoPs and it suggests updates to improve beneficiary access to services.[18] Any CoPs that would be established for CCBHCs to furnish such services or program under Medicare should be aligned to Medicaid criteria with careful consideration of any additional administrative burden placed on organizations that could impede access to care.

Moreover, we are grateful for CMS' attention to addressing CCBHCs' ability to bill Medicare under the PFS and strongly affirm the ability for Medicare to cover and pay for the full range of

services under CCBHCs would have a significant and meaningful impact in underserved areas. Already, we understand that CCBHCs can bill Medicare if they are registered as a different provider type such as an Office or CMHC. However, we find that Medicare does not cover all required CCBHC services as outlined above. It is also important to note, and related to the discussion above, that CCBHCs are already certified per federal and state Medicaid criteria and to the extent Medicare were to allow CCBHCs as a Medicare provider, we would strongly encourage alignment of any potential future Medicare CCBHC CoPs with existing Medicaid and state certification requirements.

As noted earlier, in light of Medicare's narrow coverage of the full scope of CCBHC required services, there is great opportunity to expand CCBHC service reach for Medicare and dual-eligible beneficiaries. ASPE's most recent annual report to Congress notes that aggregate findings showed 5% of clients served had Medicare and 62% had Medicaid, CHIP, or were Dual enrolled in Demonstration Year 4 (Exhibit B.5.).[19] National Council for Mental Wellbeing's 2024 Impact Report found that Medicare and dual-eligible beneficiaries are among the two least commonly reported groups to have expanded access to CCBHC services.[20] These findings suggest that establishing CCBHCs as a Medicare provider type with access to a Medicare PPS for the full CCBHC scope of services could greatly improve access to care Medicare beneficiaries.

Finally, with regard to CMS' solicitation on workforce and employment of practitioners who can supervise auxiliary personnel and bill Medicare, many CCBHCs have reported that the model has allowed for improved staffing to serve more people, as well as support integrated care delivery with primary care from primary care physicians and physician assistants. Among practitioners that can supervise auxiliary personnel and bill Medicare, CCBHCs employ primary care physicians, psychiatrists, physicians assistants, and nurse practitioners.[21]

We are immensely grateful for your consideration and continued work to improve access to lifesaving mental health and substance use services. We welcome any questions or further discussion regarding the comments described here; please contact Reyna Taylor, Sr. Vice President, Public Policy & Advocacy, National Council for Mental Wellbeing at ReynaT@thenationalcouncil.org. Thank you very much for your dedication and efforts on this important issue.

Sincerely,