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Memorandum *October 28, 2022*

Senate Finance Releases Discussion Draft of Legislation to Improve Integration, Coordination, and Access to Mental Health Care

Today, staff on the Senate Finance Committee released a discussion draft of the **mental health integration of care provisions** **to be included as a part of the Committee's broader legislative effort to improve mental health care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries**. Policy proposals within the discussion draft pertain to: (1) increasing payments to certain providers for the integration of behavioral health; (2) providing payments for mobile crisis response intervention services in Medicare; (3) providing clarity on the eligibility for participation of peer support specialists in furnishing behavioral health integration services in Medicare; (4) providing payment for crisis stabilization services under the Medicare program; (5) integrating behavioral health care for treatment of mental health and substance use disorder (SUD) services in primary care through the Centers for Medicare and Medicaid Innovation (CMMI); (6) making the Medicaid state option to provide qualifying community-based mobile crisis intervention services permanent; and (7) requiring the Department of Health and Human Services (HHS) to improve integration of behavioral health services under Medicare, Medicaid, and CHIP.

- **Context**. Earlier this year, the Finance Committee identified five areas in which it intends to focus on with regard to mental health care, including: (1) the health care workforce; (2) integration of care; (3) mental health parity; (4) telehealth; and (5) services for youth. President Joe Biden has included addressing mental health and addiction as two of the four pillars of the Unity Agenda he outlined in his 2022 State of the Union address (TRP summary), and mental and behavioral health have been at the forefront of congressional committee priorities with ten hearings dedicated to the subject in 2022 alone (TRP tracker). Today's discussion draft is the fourth legislative discussion draft released by Committee staff after the Senate Finance Committee announced its mental health care initiative in February of 2022. In May and June, the Committee released the discussion draft outlining their tele-mental health provisions (discussion draft; TRP analysis) in addition to their discussion draft pertaining to youth mental health (discussion draft; TRP analysis). In September the Committee released the discussion draft related to addressing the mental health care workforce (discussion draft; TRP analysis).

- **What's Next?** At this time, it is unclear whether the Committee intends to hold a markup on these provisions and introduce them as a single package prior to the end of this Congressional session. Alternatively, some of these provisions could be included in a larger end-of-year package.

Key provisions within the legislation include:

Policies to Incentivize Integration of Certain Behavioral Health Services —

- *Integration of Behavioral Health Care for Treatment of Mental Health and SUD in Primary Care* — Within CMS, CMMI is required to test payment and service delivery models to determine the effect of applying such models on program expenditures and the quality of care received by individuals receiving Medicare or Medicaid benefits. The Secretary of tHHS is tasked with determining certain models which address gaps in care which may lead to poor clinical outcomes or avoidable expenditures. This discussion draft would require CMMI to support the adoption of behavioral health integration — such as through the psychiatric Collaborative Care Model, Primary Care Behavioral Health Model, or other evidence-based models — in primary care settings for the treatment of mental health and SUDs that require regular follow ups.

- *Payment for Mobile Crisis Response Intervention Services* — This provision would require Medicare to cover mobile crisis response team services starting on January 1, 2025, as a single global payment made to a group of providers or a health care system (as opposed to a health care plan) through the physician fee schedule (PFS). To qualify for payment, the care must be furnished by a physician, physician's assistant, nurse practitioner, clinical nurse specialist, clinical social worker, or clinical psychologist.

  The payment would consider work, practice expenses, and malpractice expenses associated with typical care to a person experiencing a mental health or SUD crisis. In determining these payment factors, HHS would be required to account for differences in providing this care in a mobile setting compared to in a traditional physician's office. The draft proposal also includes a clause to ensure that there are no duplicative payments to providers. In order to receive payment, the provider and any supporting personnel must comply with be training in trauma-informed care, be capable of coordinating with crisis and emergency response systems and services, and meet other thresholds as determined by HHS. Other secondary personnel — such as peer support specialists — may also furnish mobile crisis team services under the supervision of the practitioner billing for these services.

  Services would include screening and assessment of mental health and SUD, de-escalation of the crisis, facilitating referrals to other services, and addressing other behavioral health needs, as defined by the Secretary of HHS. These services would have to be provided outside of a hospital or other facility setting to a person experiencing a mental health or SUD crisis.

- *Payment for Crisis Stabilization Services* — The discussion draft includes a provision to include crisis stabilization services as a covered outpatient department service for care furnished on or after January 1, 2025. Crisis stabilization services would include applicable items and services for individuals experiencing a mental health or SUD crisis, subject to certain requirements. These requirements include that a hospital accept referrals for crisis stabilization services and be capable of providing this care — including staffing at all times — as well as an ability to timely coordinate with emergency response systems, crisis intervention hotlines, and mobile crisis teams, among other communications.

  Additionally, applicable items and services under this part would be required to be both reasonable and necessary in order to diagnose and treat a mental health or SUD crisis as well as supportive of the de-escalation of a mental health or SUD crisis. Such services would include: (1) observation and supervised care services for no more than 22 consecutive hours for individuals

in "severe distress"; (2) screening for suicide and violence risk; (3) assessments of immediate physical health needs; and (4) other services as deemed necessary by the Secretary.

Within 18 months of enactment, HHS would be required to submit a report on policy considerations related to Medicare coverage of crisis stabilization services to the Senate Finance Committee and House Energy and Commerce and Ways and Means Committees.

- *Additional Incentives for Behavioral Health Integration* — In order to incentivize behavioral health integration, the discussion draft includes a provision that would alter the payment amount for services under certain HCPCS codes — including 99484, 99492, 99493, 99494, and G2214 — furnished in 2025, 2026, or 2027. The payment amount would be equal to the applicable percent of such payment amount for such year. This applicable percent would be: (1) 175 percent for services furnished during 2025; (2) 150 percent for services furnished during 2026; and (3) 125 percent for services furnished during 2027. These additional payments would be exempt from budget neutrality under the text.

  The draft legislation would additionally establish specified quality measurement reporting requirements for physicians and practitioners related to behavioral health and primary care service integration. Physicians and practitioners — including a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, a clinical social worker, or clinical psychologist — required to abide by this requirement would include those participating in an eligible alternative payment model which involves delivery of primary care services to those who require mental health or SUD services. Such reports would be submitted to the Secretary yearly.

  Under the discussion draft, the Secretary would be required to offer technical assistance, under contract or agreement beginning before January 1, 2024, to primary care practices who wish to adopt behavioral health integration models. Such models include the Collaborative Care Model and the Primary Care Behavioral Health model, as well as any other models identified by the Secretary.

Policies to Increase Integration of Mental Health Services through Guidance —

- *Guidance for Expanding Value-Based Arrangements and Alternative Payment Models (APMs) in Medicare* — The discussion draft would require the Secretary of HHS, within 18 months of enactment, to issue guidance to providers on best practices for integrating behavioral health care within the primary care setting for the treatment of mental health and SUDs such as depression, anxiety, and opioid use disorder. Under this provision, the guidance may include information on how the Collaborate Care Model or the Primary Care Behavioral Health Model could be used to improve health integration. Additionally, HHS is directed to consider, if deemed appropriate by the Secretary, the inclusion of information on: (1) having mental health providers co-located within a physician's practice with same-day visit availability; (2) incorporating peer support specialists or other personnel; and (3) effectively coordinating care for individuals with behavioral health needs.

- *Guidance to States on Supporting Mental Health and SUD Care Integration with Primary Care in Medicaid and CHIP* —

- Required Analysis of Integrated Care Models — Under this provision, the Secretary of HHS, within 18 months of enactment, would be required to conduct an analysis of clinical outcomes among different models of integration of mental health or SUD care in Medicaid and CHIP within the primary care setting. As part of this analysis, HHS must consider different models for how mental health or SUD care is delivered and integrated within the primary care setting, including when: (1) providers operation in an integrated model are physically located in the same building; (2) when at least one provider in an integrated model is available via telehealth; and (3) when primary care, mental health, or SUD providers seek education and consultation from other providers through electronic modalities. In addition, the analysis must evaluate the use of different payment methodologies and the use and quality of enhanced care coordination or case management.
- Required Guidance — Within 12 months after HHS completes the analysis described above, the discussion draft requires the Secretary to issue guidance to States on supporting the integration of mental health or SUD care within the primary care setting in Medicaid and CHIP.

Guidance to States to Support Access to Community Social Supports and Services in Medicaid — The discussion draft would require the Secretary of HHS, within 18 months, to provide guidance to encourage collaboration between States, Medicaid managed care organizations, and community-based organizations in providing beneficiaries with connections to social supports and other non-medical services, when appropriate, that affect or improve health outcomes — particularly mental health or SUD outcomes. In issuing the guidance, the Secretary must include information on: (1) considerations for complying with HIPAA; (2) financing and allowable Medicaid reimbursement and rate setting; (3) measurement of health outcomes; and (4) strategies to incorporate non-clinical professionals and paraprofessionals, among other items. In addition, the discussion draft would require the Secretary of HHS to provide technical assistance to States to support activities identified in the guidance.

- *Guidance and Technical Assistance to States to Support Access to a Continuum of Crisis Response Services under Medicaid and CHIP* —
    - Required Guidance — Within 18 months of enactment, the discussion draft requires the Secretary of HHS, in coordination with CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA), to issue guidance to States regarding Medicaid and CHIP that would:
        - Establish recommendations, in consultation with stakeholders, for an effective continuum of crisis response services that includes crisis call centers and 988 crisis hotlines, promotes access to appropriate and timely mental health and SUD crisis response services, and promotes culturally competent trauma-informed care and de-escalation;
        - Outlines federal authorities under Medicaid through which States can fund and enhance the availability of crisis response services across the continuum;
        - Addresses how States may support the ongoing implementation of crisis call centers, 988 crisis services hotlines, and how to establish regional or statewide crisis call centers under Medicaid and CHIP;
        - Identifies how States may support access to crisis response services that are responsive to the needs of children, youth, and families, including through peer support services;

        - Identifies policies and practices to meet the need for crisis response services with respect to different patient populations and to promote evidence-based suicide risk screenings and assessments; and
        - Describes best practices for coordinating Medicaid and CHIP funding with other payors and sources of Federal funding, among other things.
    - Development of Technical Assistance Center— The discussion draft would also require the Secretary of HHS, in coordination with CMS and SAMHSA, to develop a technical assistance center within 18 months of enactment to assist States to design, implement, or enhance a continuum, of crisis response services for children, youth, and adults under Medicaid and CHIP. In addition, the Secretary of HHS would be required to develop a publicly available compendium of best practices for a successful operation continuum of crisis response services in Medicaid and CHIP.
    - Planning Grants to States — Within a year of issuing the guidance described above, this discussion draft would require the Secretary of HHS to award planning grants to all eligible States for the purpose of establishing or enhancing a continuum of crisis response in Medicaid and CHIP. Under this provision, the Secretary would have the authority to establish the eligibility criteria for States to receive the planning grants, which must then be used by States to:
        - Conduct a needs assessment for crisis response for Medicaid and CHIP-eligible beneficiaries;
        - Identify State legal and regulatory barriers to providing mental health and SUD crisis response services;
        - Identify how States will leverage federal authorities under Medicaid and CHIP to finance mental health and SUD crisis services;
        - Consult with stakeholders support culturally competent care;
        - Identify strategies to support access to follow-on mental health and SUD services; and
        - Identify strategies to measure and monitor crisis response services.

      Within 18 months after a State is awarded a planning grant, this version of the discussion draft would require the State to submit a plan to HHS for implementing a continuum of crisis response services.

Additional Notable Policies—

Clarification on the Eligibility for Participation of Peer Support Specialists in Providing Behavioral Health Services in Medicare — Recently, CMS has proposed to expand access to mental health services by allowing Medicare to directly reimburse certified peer recovery specialists in the calendar year 2023 PFS (proposed rule; TRP analysis). Within a year after enactment, the discussion draft would require that the Secretary clarify that peer support specialists (defined as an individual who is certified as qualified to furnish peer support services under a national certification process) may participate in furnishing behavioral health integration services under the Medicare program. Notably, this provision may be implemented via program instruction.

- *Report on Program Integrating Behavioral Health into Primary Care* — This provision would require the Secretary of HHS to issue a report, within one year after enactment, including an

analysis of the progress made by practices towards integrating behavioral health into primary care under relevant CMMI demonstration programs.

- *Making the Medicaid State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services Permanent* — Section 9813 of the American Rescue Plan, enacted on March 21, 2021, provided states the option to cover qualifying community-based mobile crisis intervention services for a period of up to five years, starting April 1, 2022, and ending March 31, 2027. States who take up this option are provided with an 85 percent match in federal funds for qualifying Medicaid expenditures for community-based mobile crisis intervention services, including the costs of services that are otherwise covered under the state plan that are furnished as part of this new state option. This enhanced federal funding is available during the first 12 fiscal quarters that the state has taken up this new service. The discussion draft released today would remove the 5-year time-limited duration of this service and would create a permanent state option to provide qualifying community-based mobile crisis intervention services.