Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services

Re: CMS-1807-P; 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 undersigned national mental health and substance use disorder (MH/SUD) organizations are grateful for the many provisions in the CY 2025 Medicare Physician Fee Schedule (MPFS) proposed rule that advance and value MH/SUD care and will provide extensive comments from our individual organizations applauding these efforts. We write together in this brief comment to address the Advanced Primary Care Management proposal and the request for information regarding Advanced Primary Care hybrid payment models to provide recommendations for strengthening the proposal to improve MH/SUD outcomes and promote behavioral health integration in primary care.

We fully support the Centers for Medicare and Medicaid Services (CMS) efforts in the proposed rule to simplify billing and build toward a high-quality and financially sustainable primary care system. However, some of the most pressing public health issues in primary care – MH/SUD conditions – are not addressed in the proposal. We urge CMS to set forth a clear pathway to improving the treatment of these conditions in primary care by achieving broader adoption of evidence-based models of behavioral health integration. High-quality primary care provides critical infrastructure for integrating MH/SUD services, which promotes earlier intervention, more equitable access to care, and better outcomes. Unfortunately, uptake of integrated MH/SUD services in primary care has been limited to date.

As research indicates, movement to integrated care is a progressive process from screening and follow-up to evidence-based models with MH/SUD care specialist staffing. With a few minor changes to the proposed rule and greater attention in future models, the Administration can advance its vision as outlined in the Roadmap for Behavioral Health Integration. Below we comment on both the proposed Advanced Primary Care Management (APCM) codes and the Advanced Primary Care Hybrid Payment RFI.

**The APCM Codes**

The APCM codes offer another critical building block toward a financing system that supports high-quality primary care in the U.S. To ensure that MH/SUD care advances through this new model, we recommend that CMS:

- Clarify that APCM participants can bill separately for behavioral health integration (BHI) codes and allow MH/SUD providers to bill BHI, Health and Behavior Assessment/Intervention (HBAI) services, and the new and existing interprofessional consultation codes for the same patients receiving APCM services billed by the participating primary care provider.
- Require APCM participants to report on the *Preventive Care and Screening: Screening for Depression and Follow-Up Plan* quality measure, either as part of the Quality Payment Program (QPP) or in an Alternative Payment Model (APM). Research has indicated that attention to this process can yield greater screening and most importantly, greater identification of people in need of care.
- Amend and increase the valuation of the APCM code description to require depression screening and follow-up upon positive screen, including referral and care coordination with an in-network provider when needed. Patients with MH/SUD conditions are often frustrated by a referral list of providers that are not taking Medicare payment. A referral list of providers that are not taking

Medicare patients creates an additional barrier to care for patients who may already be reluctant to engage in care or whose symptoms make it very difficult for them to call a long list to find care. Identifying and connecting patients with in-network MH/SUD providers is often more intensive than for other health conditions, where there may be greater availability of providers and less misleading provider directories. Successful connection of patients with in-network providers is critical for effective care. While this activity overlaps with one aspect of Principal Illness Navigation ("Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them"), this would reflect the need for this type of navigation for all patients identified with MH/SUD conditions through screening, many of whom would not otherwise meet the eligibility criteria for Principal Illness Navigation services.

- For APCM participants in APMs, either waive MH/SUD integration spending from counting against shared savings or include the expected spending through administrative benchmarking.

We also request that CMS track APCM participants' spending on BHI, HBAI, and other MH/SUD services to inform revisions to APCM codes in the future and advance the goal of promoting integrated MH/SUD care. HHS also should clearly track and report on how many practices are providing different levels of integrated care and whether practices participating in various models are improving MH/SUD quality measures to assess whether it is making progress on its MH/SUD strategy, enabling HHS to align all parts of CMS toward the goal of moving practices along the continuum to fully integrated care. We have seen no measurement or report of the ultimate success of the Administration's integration strategy and are concerned that several primary care models do not clearly articulate how they are being designed to align with that strategy.

**The Advanced Primary Care Hybrid Payment RFI**

In future MPFSs, we urge CMS to ensure that a comprehensive approach to promoting high-quality primary care also advances the Roadmap for Behavioral Health Integration. In particular, we recommend that CMS:

- Engage in a process of stakeholder input that results in clear articulation of how CMS will include MH/SUD integration going forward with its primary care models and how it will accurately value the services to encourage practices to participate and achieve greater integration. CMS should implement a set of future codes that specifically recognize the importance of delivering integrated and longitudinal MH/SUD care, and require specific evidence-based models of staffing, workflows, and quality measurements. One way to accomplish this may be a system of tiered payments reflecting different levels of integrated MH/SUD care and which align with principles of measurement-based care.
- Require primary care providers to report quality measures for both screening and outcomes focusing on MH/SUD, health-related social needs, and patient experience (such as *Preventive Care and Screening: Screening for Depression and Follow-Up Plan*, *Initiation and Engagement of Substance Use Disorder Treatment*, and *Screening for Social Drivers of Health, Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder* or *Depression Remission at Twelve Months*, and *Consumer Assessment of Healthcare Providers and Systems*). It is critical that CMS establish that these models are improving patient experience and outcomes. Uniform quality measurement is essential to being able to establish the benefit of investments in primary care to policymakers and Medicare beneficiaries. We applauded the inclusion of MH/SUD measures as the first set of adult Medicaid core quality measures for

required reporting and the inclusion of several relevant measures for MH/SUD, patient experience and equity in the universal foundation set of measures. CMS should build on these efforts in future proposals.

- Require completion of relevant quality improvement activities on MH/SUD integration (such as *Completion of Collaborative Care Management Training Program* or *Implementation of Integrated Patient Centered Behavioral Health Model*, among others), in support of consistently billing BHI codes.
- Track spending on BHI, HBAI, and other MH/SUD services across models of advanced primary care, and target QPP and APM incentives to meet goals for integration, including either waiving MH/SUD integration spending from counting against shared savings or including expected spending through administrative benchmarking in APMs. Also, track number of practices providing various levels of MH/SUD integration through claims data and MH/SUD quality measures where they are currently required to report and provide a dashboard on progress to date in advancing MH/SUD integration in primary care.

**Conclusion**

The undersigned appreciates CMS's recognition of the importance of robust and adequately financed primary care and urges the agency to better articulate and measure how its efforts are improving MH/SUD integration in practices and MH/SUD outcomes for patients. We stand ready to support the implementation of these recommendations and please do not hesitate to reach out to Nathaniel Counts at Nathaniel.counts@thekennedyforum.org, Scott Barstow at sbarstow@apa.org, Becky Yowell at byowell@psych.org, or Mary Giliberti at mgiliberti@mhanational.org with any questions.

Sincerely,

American Association of Psychiatric Pharmacists
American Association on Health and Disability
American Psychological Association Services
American Psychiatric Association
Anxiety and Depression Association of America
Clinical Social Work Association
Inseparable
Lakeshore Foundation
Legal Action Center
Maternal Mental Health Leadership Alliance
Mental Health America
National Alliance on Mental Illness
National Council for Mental Wellbeing
The Kennedy Forum