Public Comments Submitted Online to and Accepted by CMS June 7, 2025 in response to CMS Medicare Proposed Rule on Inpatient Whole Person Care with respect to Deregulation, Provider Task Unburdening and Duplication Avoidance:

This public comment is being submitted by the following organizations:
Association of Medicine & Psychiatry (www.assocmedpsych.org)
NHMH – No Health w/o Mental Health (www.nhmh.org)
Medical-Psychiatry Unit Consortium
American Association on Health & Disability
Lakeshore Foundation
International Society for Psychiatric Mental Health Nurses
Policy Center for Maternal Mental Health
Clinical Social Work Association and
National Association of Addiction Treatment Providers.

(CMS questions seeking feedback are in italics).

Topic 1: Streamline Regulatory Requirements

1A. Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

The following comments focus on Medicare rules and regulations that make inpatient integrated physical-behavioral whole-person health care so difficult, unnecessarily and inefficiently burdening providers and harming patients' access to and receipt of quality care, and our recommendations for change.

We live in a 'segregated' medical and behavioral health world. This even though behavioral (mental health + substance use) and physical disorders commonly co-occur in Americans. 40% of patients with a chronic medical condition also have a co-occurring mental health or substance use disorder as

well (Kathol et al, 2015). Of patients with a serious mental illness, 50-80% have one or more concurrent chronic medical conditions (Scott et al, 2016; Druss & Walker, 2011).

Our bifurcated health system is leading to higher deaths and illness. Current Medicare policies and reimbursement structures add to this dangerous divide between medical and behavioral health care impeding the delivery of whole-person care which is a barrier to making Americans healthier.

Currently behavioral health and medicine function completely independently of each other with little communication between the two, and as a result patients are the ones who suffer. Medical and BH have separate, independent systems for services delivery, provider payment, and provider networks. This 'carved out' separation was created 40 years ago for reasons that no longer exist. Today the pressing need is to end the healthcare delivery fragmentation, and integrate medical and behavioral healthcare, treating BH like every other subspecialty in medicine, including in both outpatient and inpatient settings. A wide range of approaches to integrating behavioral and physical healthcare have been documented and evaluated. Research consistently reports positive patient outcomes and, in many cases, reduced total costs of care with integration (AHRQ, SOE Draft Review, 2023).

Behavioral health disorders are common in general hospital inpatients. Current meta-analyses indicate that approximately one-third of inpatients have a behavioral health disorder. Given that data, the delivery of evidence-based integrated care in inpatient hospital settings becomes all the more critical (van Niekerk et al, 2022). Yet, less than half of U.S. hospitals have psychiatrists or other mental health clinicians on staff or available for consultation. Moreover, due to the carve out *status quo*, Medicare's current regulatory and billing structures significantly hinder, rather than incentivize, integrated medical and behavioral health in hospitals, contributing to inefficiency, higher costs, staff burnout and delayed patient discharges.

Medical-Psychiatry Units (MPUs), of which there are over 100 throughout the U.S. according to a recent survey, do provide desperately needed integrated medical and psychiatric care in the inpatient setting (Ellison et al, 2022).

However, Medicare's current regulatory and billing structure significantly hinders the effectiveness and growth of these units, resulting in greater inefficiency, higher costs, staff burnout, and delayed discharges for the hospital system, and more fragmented care for patients.

Dually trained medical/psychiatric physicians can provide whole- person care, namely they can address both mental healthcare and physical healthcare at the same time however current hospital billing structures do not allow dual- trained medical and psychiatric physicians to bill for providing both services.

Barriers to Providing Whole-Person Care in Hospitals:

· Fragmented Billing: Medicare requires separate billing codes and documentation for medical and psychiatric care—even when delivered simultaneously—creating administrative complexity and disincentivizing integration. Reference: Medicare Benefit Policy Manual, Chapter 6; Medicare Claims Processing Manual, Chapter 12, Section 30.6.13 (Behavioral Health Integration applies only to primary care).

· Lack of Support for Interdisciplinary Teams: Medicare does not consistently reimburse integrated hospital-based care by interdisciplinary teams, despite the clear need for coordinated treatment for patients with co-occurring conditions.

· Lack of Recognition of Dual-Trained Physicians: Medicare does not have a category to recognize physicians with Board Certification in multiple specialties (such as Internal Medicine & Psychiatry, Family Medicine & Psychiatry, or Neurology & Psychiatry). This restricts dual-trained physicians from being recognized in provider panels and accreditation documents as having expertise in both fields.

· Limitations on Reimbursable Mental Health Care in Medical Hospital Settings: Medicare has restrictions on which types of clinicians and therapies (e.g. recreational therapy, substance use counseling, behavioral therapists for those with developmental disabilities and dementia) can bill and be reimbursed for services. In most hospital settings psychologists and other mental health clinicians are not able to bill easily, whereas physicians/medical doctors can. This restriction on some mental health providers limits the ability of hospitals to

employ those providers who bring important expertise thereby leading to greater cost, inefficiency and potentially negative health outcomes for patients.

· Inadequate Mental Health Parity: Behavioral health services are often reimbursed at lower rates than medical services and are subject to more restrictive rules. This reinforces the perception of mental health as secondary to physical health. Many critical, potentially life-saving mental health interventions, such as Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS) and medication infusions such as Brexanolone and Ketamine, cannot be billed during an inpatient medical stay.

· Insufficient Medical Care for Patients: Many preventative and critical medical treatments and interventions are not available to people who are hospitalized in specialty behavioral health settings such as psychiatric hospitals.

· Discharge Planning Limitations: Current CMS discharge planning requirements focus primarily on physical health, limiting support for transitions of care that address both medical and psychiatric needs.

Recommendations:

· Enable Integrated Billing: Allow bundled or unified payment for concurrent medical and behavioral health care delivered by interdisciplinary healthcare teams.

· Broaden Access to Mental Health Therapies and Clinicians: Expand Medicare's list of behavioral health clinicians able to bill in medical hospital settings.

· Revise Reimbursement Policies: Expand Medicare's support for integrated inpatient care models, beyond just outpatient behavioral health integration.

· Recognize Multi-Specialty Certification: Identify those dual-trained physicians with both medical and behavioral specialty areas as uniquely qualified and cost-effective for leading integrated care implementation in both medical and behavioral inpatient and outpatient settings.

· Promote Parity: Even though the 2008 Mental Health Parity & Addiction Equity Act (MHPAEA) federal parity law does not explicitly apply to Medicare programs, either Traditional or Medicare Advantage, Medicare should nonetheless ensure, under CMS' own coverage and access standards for mental

health services, that reimbursement and regulatory treatment of behavioral health is on par with medical/physical health care.

· Strengthen Transitional Care Rules: Update discharge planning guidelines to explicitly support integrated care follow-up care for patients with complex medical and behavioral health needs.

KEY POINT: Streamlining these above-mentioned regulations would reduce administrative burden, improve patient outcomes, and better align Medicare policy with the realities of whole-person care in today's hospitals. Below we provide an illustrative case representing a common scenario of a patient with comorbid medical and behavioral health needs who is treated in traditional hospital settings vs. an integrated med-psych unit:

ILLUSTRATIVE CASE: An adult male with type1 diabetes, alcohol and amphetamine use disorder presents after an overdose on insulin in a possible suicide attempt. Patient was recently in a substance use disorder treatment facility. These behavioral health records are unavailable due to privacy restrictions (42 CFR Part 2). Initially in hospital ICU then regular medical floor, with expensive 1:1 monitoring, no behavioral health intervention, a medical team untrained in motivational interviewing or withdrawal management attends. Ultimately stabilized medically, but kept in medical bed until a psychiatric bed is available *even though a behavioral health assessment and supportive BH interventions provided concurrently could have established safety for discharge to an outpatient substance use treatment setting*. Transferred to a psychiatric bed in the same hospital system (which transfer requires a discharge and new admission). After one day in the psychiatric unit, patient's blood sugar is very high and patient is taken to the hospital emergency department (ED) because acute medical care and consultations are not available in the hospital's psychiatric unit. (This is due to fact that hospitals operate on a per diem reimbursement basis not a fee-for-service basis; medical care and consultation services in the psych unit are not sustainable for hospitals on their usual per diem reimbursement). Result is that acute medical services in the hospitals' psych unit are not available for patients who may need them. In the ED, ketones are present in the urine, and the patient is re-admitted to the medical facility. No one has established a relationship with the patient to determine whether a

risk of self-harm is elevated, so patient remains on 1:1 monitoring with the plan to return to the psychiatric unit once stable. After a day of fluids and changes to insulin dosing, the medical facility team tries to transfer the patient back to the psychiatry department's psych unit but the latter does not feel the patient is medically stable enough because they do not have anyone to make adjustments in the insulin. Several days of back and forth occur. The medical team does not feel comfortable developing a treatment plan for discharge because of the possible risk of patient self-harm and insist on the patient going to a psychiatric unit before discharge. The patient is again transferred (discharged and admitted) to psychiatry a week later, once insulin dosing has been stable for several days. The patient is then in the psychiatric unit for several days while the behavioral health team establishes rapport, collects collateral information, and determines the patient is low risk for acute self-harm and tries to discharge to a residential substance abuse treatment program. Because of the patient's insulin use, the SUD programs are reluctant to accept. After further delay, the psychiatric team ultimately discharges the patient to a substance abuse outpatient program. (End of Illustrative Case).

1B. Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

Quality Measurement (QM) and Reporting re Bidirectional Integrated Care:

Approaches to delivering integrated primary and behavioral health care have emerged over the past 20 years with a strong evidence base. It is important to recognize at the outset that some integrative approaches derive directly from the foundational Chronic Care Model (CCM) developed by Wagner, Bodenheimer and Grumbach in the late 1990s. The CCM has since then served as an organizing framework for improving chronic illness care to improve care at both the individual and population levels. It is based on the belief that improvement in care requires incorporation of patient, provider and system-level interventions. Its 4 key components are: patient self-management support; clinical IT systems; delivery system redesign; and decision support. The

collaborative care model, a specific type of integrated behavioral and physical care, derived from the CCM.

Research studies indicate integrated treatment for MH/SUDs across multiple providers and healthcare settings results in increased quality of care, improved population health and can contribute to a high-value healthcare system. Further, such integrative care can in time reduce downstream cost for individuals with behavioral health issues and for the national healthcare system as a whole (Milliman, 2018). The key to widespread implementation of integrated care is the development of meaningful and valid quality measures. What is needed are:

· Data-driven BH and BHI (behavioral health integration) Measurement and Quality Improvement: Currently BH quality measures have limited practical data sources, are siloed and mostly non-interoperable. Further, most are process and claims-based measures, there are few with proven association with outcomes. There is a need to establish national quality measures for BH and BHI (Pincus et al, 2022).

· Investment in BH Quality Development: This lack of investment in developing BH and BHI quality measures is mostly due to the complexity of the process (8 different process steps), lack of leadership (SAMHSA and NIMH have no responsibility), limited direct BH expertise at CMS, the fact that BH quality measures have limited practical data sources and most of all, lack of funding.

· Removal of Other Barriers to Integrated Care Quality Measurement: Other barriers include: adequacy/specificity of evidence base; development of Health IT integration of clinical measures for measurement-based care; adequacy of care data sources; determining benchmarks/risk adjustment, especially relevant for BH populations; clarity on who is stewarding/funding measure development; heterogeneity of providers/training/certification; who is accountable for performance, i.e. establishing shared accountability.

· Build a Quality Measurement Infrastructure: There is a need to build a QM infrastructure with patient/consumer participation as an integral pillar, along with clinical perspectives, integrative processes, and leadership support. Such infrastructure would: standardize practice elements (clinical assessment, interventions, HIT), develop guidelines (MH, SUDs, GH), measure performance

across silos and levels, improve performance (learn, reward) and strengthen the evidence base (document stakeholder value, evaluate/elevate effective strategies, move from bench to bed to community).

· Next Steps re Quality Measurement & Integrated Systems: Establish shared accountability as practices need flexibility (capitation) and accountability to deliver integrated care; build/strengthen the QM infrastructure re stewardship and resources; develop sustainable payment models and incentives; bridge technology gaps between medicine and behavioral health; links with community social services; new workforce training and education models; creation of a so-call 'interstitial' workforce; and new roles in/between/among providers.

1C. Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and other providers? break up some of what is above in 1A to add in here?

Recommendation: Address Medicare administrative burden in integrated care clinician credentialing with respect to: numerous multiple providers/disciplines/degrees; behavioral providers working on the 'medical side'; behavioral health carve-out, i.e built-in system silos re healthcare delivery, provider payment, and provider networks; re-credentialing; multiple data sources, e.g. primary source verification, schools, state data bases.

Topic 2: Opportunities to Reduce Burden of Reporting and Documentation

2A. What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?

2B. Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?

Topic 3: Identification of Duplicative Requirements

3A. Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)?

For the American taxpayer, the consequences of fragmented care are significant. Patients with co-occurring medical and mental health conditions account for a disproportionate share of healthcare spending and hospital days. Their care is often fragmented, requiring multiple providers who may not communicate effectively, leading to redundancy, risk for medical errors, and extended length of stay. The strain on frontline clinical staff intensifies when behavioral health needs go unaddressed, contributing to lower staff retention rates, inflating labor costs.

Integrated care—where medical and behavioral health professionals collaborate to provide care in the same place at the same time—has been shown to improve outcomes, shorten hospital stays, and reduce overall healthcare expenditures. This is not just a matter of better patient care; *it's a matter of fiscal responsibility*. By investing in evidence-based models of integration, such as collaborative care, primary care behavioral health, SBIRT (short brief intervention referral to care) SUD programs, MAT, MAUD, MOUD, hospitals can lower public spending, improve system efficiency, and relieve workforce burnout.

In today's hospitals, much of the avoidable cost, inefficiency, and staff burnout stems from a factor that is too often overlooked: the failure to address mental health and substance use disorders as part of whole patient care. While much of general hospital care is organized around physical illness, behavioral health issues—such as depression, anxiety, or substance use—frequently complicate recovery from medical illness, delay discharge, and increase the likelihood of readmission.

Adding to the problem, psychiatric units and hospitals are increasingly unable to adequately accommodate patients with significant medical needs, even when those patients urgently require psychiatric stabilization. This is because psychiatric units face structural, regulatory, and staffing limitations—challenges that have grown more acute as the population of individuals with co-occurring

mental and physical health conditions has increased. As a result, individuals with complex co-occurring conditions are often "stuck" in general medical units that are not equipped—clinically or structurally—to provide appropriate psychiatric care. These patients remain hospitalized longer, often with minimal therapeutic progress, while occupying high-cost beds needed for others. This gridlock drives up healthcare spending and exacerbates bottlenecks across the continuum of care.

3B. How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?

3C. How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

Policies that separate medical and psychiatric services need modification. Medicare could offer reimbursement for interdisciplinary teams that provide integrated care, making it easier for hospitals to manage both aspects of patient health together. Existing CMS policies (e.g., Medicare Benefit Policy Manual, Chapter 6 on "Hospital Services") still tend to treat medical and psychiatric care as separate.

Medicare's current billing structure separates psychiatric and medical services into distinct reimbursement pathways. This creates barriers to billing for integrated care provided by interdisciplinary teams in the same hospital setting, even when delivered simultaneously to the same patient. Streamlining these regulations would reduce administrative burden and better support whole-person care. Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners Section 30.6.13 – Payment and Billing for Behavioral Health Integration Services This outlines Behavioral Health Integration (BHI) billing, but it applies only to primary care and not hospital-based interdisciplinary models, illustrating a mismatch between billing structures and integrated care delivery in hospitals.

Topic 4: Additional Recommendations

4A. We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program

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Additional Recommendations:

Address Mental Health Parity: Regulations that treat psychiatric care as secondary to medical care should be revised. Medicare should ensure that mental health services are reimbursed at the same rate as physical health services, promoting equal priority in treatment.

Improve Post-Discharge Support: Medicare could streamline requirements for post-discharge follow-up care to ensure that both medical and psychiatric needs are addressed together. Current regulations, including CMS's guidelines on care transitions (e.g., Discharge Planning Requirements), often focus more on physical health, which can limit coordinated care.

MPUs: CMS to recognize Medical Psychiatry Units within the regulatory and payment frameworks ensuring unified integrated standards,

State & Federal Regulatory Alignment: CMS to encourage state-federal regulatory alignment to eliminate conflicting oversight that hampers interdisciplinary integration (e.g. New York State Department of Health and Office of Mental Health).

Payment Reform: CMS to explore payment reforms including interdisciplinary billing codes, team-based bundled payments and

Dual-boarded Clinicians Reimbursement: Dual-boarded clinicians (in internal medicine or family medicine, and psychiatry) should be able to be reimbursed at a higher level or for both medical and psychiatric services

Patient Engagement & Retention in Integrated Care Measurement/Reporting:

Patient Priorities: Patient engagement and participation (along with frontline providers) must be an integral part of integrated care measuring and reporting. Assessing patient priorities at the outset has been shown to be an important way to engage patients in the needs that matter most to them. Patient

priorities assessed at the point of care have been shown to reduce inefficiency and help target care to patient's self-determined needs.
Key measures that matter to patients should be included such as:

- **continuous patient-provider/care team relationships;**
- **person-centered care delivery;**
- **comprehensiveness of care;**
- **trust in providers/care team**

<u>Patient Experience of Care</u>: patient experience should always be a required quality measure with the following constituting high quality patient experience:

- **access to care;**
- **care coordination**
- **communication with clinicians**
- **shared decision-making**
- **getting information, and**
- **self management support.**

Tinetti et al (2019) "Patient Priorities Care" model improves patient-reported outcomes in patients with multi-morbidity; Wittink et al (2018) Patient priorities and the 'doorknob phenomenon' in primary care (at the last moment of the clinical encounter patients say something that usually provides crucial information, and clinicians must decide to pursue or defer to next visit).

<u>Peer Specialists</u>: In the context of integrated physical-behavioral care, a positive new development has been the addition to the care team of certified peer support specialists in clinical settings. Peer specialists are increasingly being integrated into clinical care settings where they have been shown to enhance patient engagement, trust, and recovery by providing emotional support, facilitating groups and promoting more person-centered, trauma-informed care.

Chinman et al (2014): A VA-based RCT found that peer support improved activation and recovery outcomes; Wan et al (2021) Effects of peer support interventions on physical and psychosocial outcomes among stroke survivors: A systematic review meta-analysis. Int J Nurs Stud, 2021; SAMHSA and the National Association of Peer Supporters (N.A.P.S.) provide guidelines and competencies.

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