CMS
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The Intersection of Integrative Medicine, Health Policy, and Advancing Care in Chronic Conditions

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Disclaimer

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This presentation is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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No financial conflicts to disclose

What can you do to help our system optimize health outcomes for the people we serve?

- **Eliminate** patient harm
- **Focus** on healthier people within the population you serve
- **Engage** in accountable care and other alternative payment contracts that move away from fee-for-service to model based on achieving better outcomes at lower cost
- **Invest** in the quality infrastructure necessary to improve
- **Focus** on data and performance transparency
- **Help us** develop and implement effective service delivery models
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes

Objectives

The Intersection of Integrative Medicine, Health Policy, and Advancing Care in Chronic Conditions

- Understand the CMS's statutory authorities, roles and processes.
- Recognize key Medicare and Medicaid covered services and supports.
- Understand the CMS Behavioral Health Strategy, actions, opportunities and challenges.

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CMS

- Administers Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace (the"3Ms")

STRATEGIC PILLARS

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system

EXPAND ACCESS

Build on the Affordable Care Act and expand access to quality, affordable health coverage and care

ENGAGE PARTNERS

Engage our partners and the communities we serve throughout the policymaking and implementation process

DRIVE INNOVATION

Drive Innovation to tackle our health system challenges and promote valuebased, personcentered care

PROTECT PROGRAMS

Protect our programs' sustainability for future generations by serving as a responsible steward of public funds

FOSTER EXCELLENCE

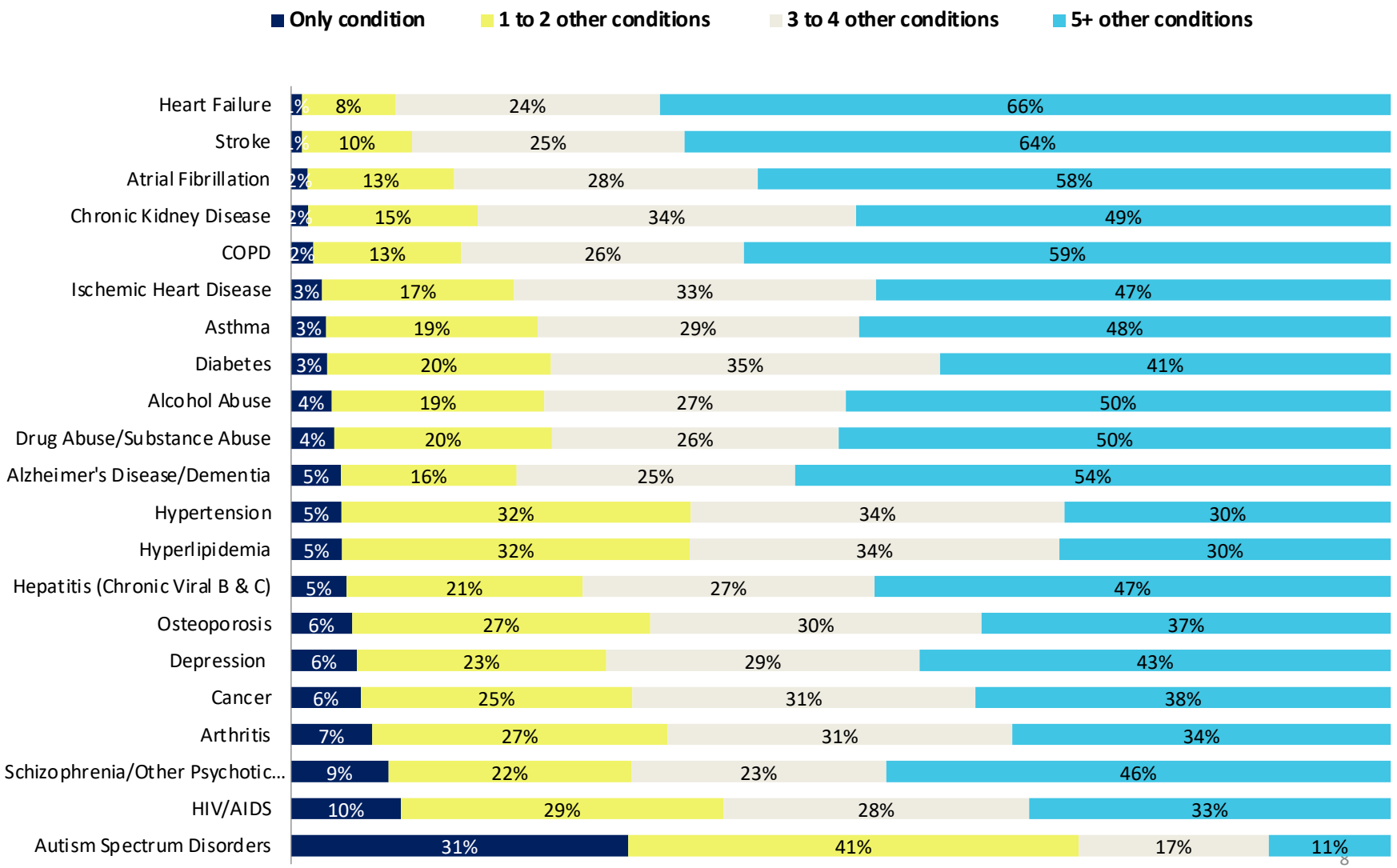
Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS' operations

Centers for Medicare and Medicaid Services

- As the largest single purchaser of health care dollars, Medicare plays a key role in transitioning our health care system away from fee-for-service and towards value-based care.
- CMS is the largest purchaser of health care in the world
- CMS programs provide health care coverage to over 170M people, or 1 of every 3 Americans (Medicare, Medicaid, CHIP, Basic)
- In 2022, more than 66M people are enrolled in Medicare, with more than 88M enrolled in Medicaid and CHIP
- More than 12 million people are enrolled in both programs, and these individuals have very high rates of chronic illness; most with multiple chronic conditions
- Most Medicare beneficiaries - over 80% - are over age 65
- Some people come into Medicare first, typically through age, and others become beneficiaries because of disability or other health status (e.g. renal disease)
- Beneficiaries with Medicaid or no supplemental coverage were more likely to be Black, covered by Medicare based on disability, and have functional limitations

Medicare Beneficiary Enrollment Trends and Demographic Characteristics

Percentage of Medicare FFS Beneficiaries with 21 Selected Chronic Conditions: 2021



Program Facts - Medicare and Medicaid Enrollment

CMS Program Data - Populations[1]

Medicare (avg monthly)	CY 2020	CY 2021	CY 2022[2]
Parts A and/or B	62.8	63.9	65.0
Aged	54.5	55.9	57.3
Disabled	8.3	8.0	7.7
Original Medicare Enrollment	37.8	36.4	35.1
MA & Other Health Plan Enrollment	25.1	27.5	29.8
MA Enrollment	24.4	26.9	29.1
Part D (MAPD+PDP)	47.4	48.8	50.3

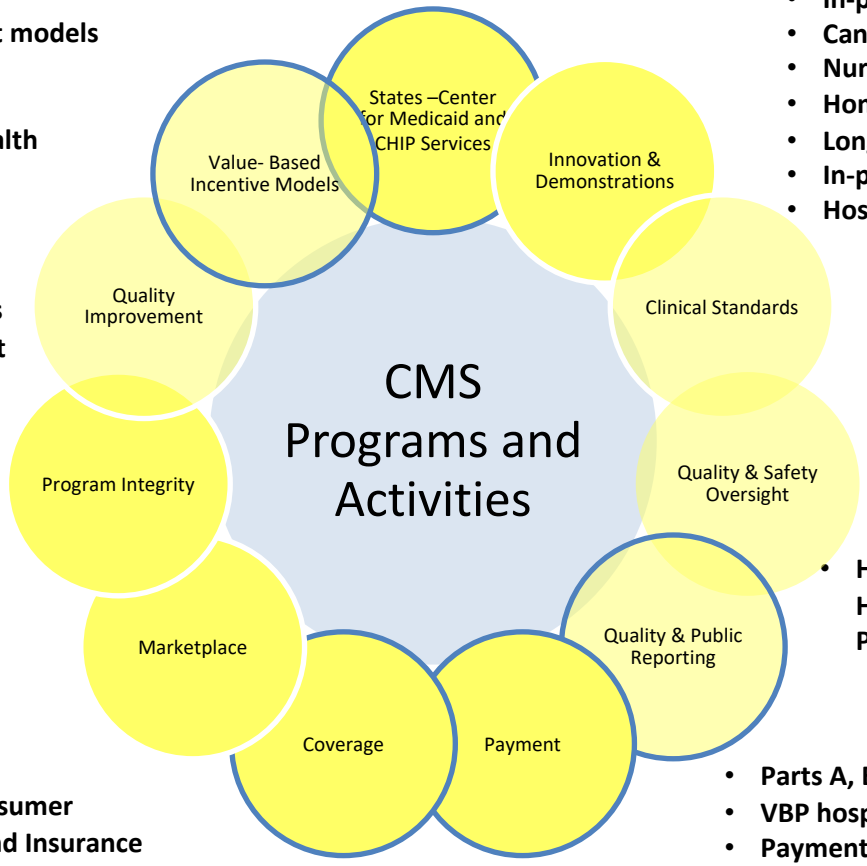
Medicaid & CHIP	2020	2021	2022
Total[3]	72.7	82.3	88.5
Dual Eligible (includes Aged, Disabled & ESRD)	8.0	11.6	--
Children	35.7	38.9	40.6
Medicaid Expansion Adults	18.7	21.8	--

Overall CMS Programs & Activities

- CMCS 1115 Waivers and demonstrations
- CMMI model tests
- Innovation Accelerator Program

- Hospital Inpatient including IRFs
- Hospital Outpatient
- In-patient psychiatric hospitals
- Cancer hospitals
- Nursing homes
- Home Health Agencies
- Long-term Care Acute Hospitals
- In-patient rehabilitation facilities
- Hospices

- Advanced Alternative payment models
- ACOs, PCMH, Bundles
- Multi-payer State agreements
- Prevention and Population Health
- Rapid Cycle Evaluation



- Quality Improvement Organizations
- Hospital Innovation & Improvement Networks

- CLIA
- Target surveys
- Quality Assurance Performance Improvement

- Hospitals, Home Health Agencies, Hospices, ESRD facilities, Marketplace, Plans

- Provider Enrollment
- Fraud, Waste & Abuse Prevention & Detection
- Medical Review
- Audits and Investigations

Center for Consumer Information and Insurance Oversight (CCIIO); Marketplace

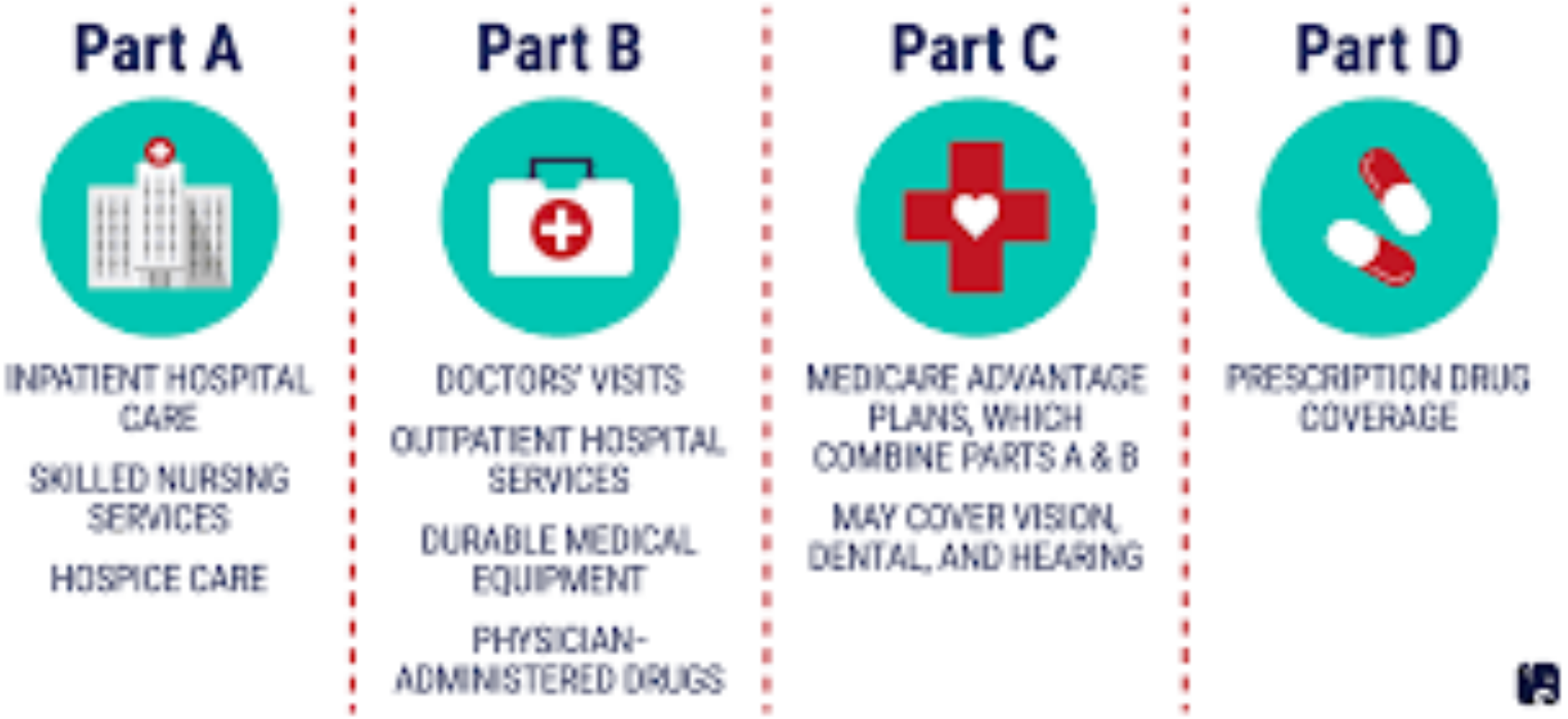
- Parts A, B, C, D
- VBP hospitals, SNF, HHA, ESRD
- Payment adjustments HAC, hospital RRP
- Physician Quality Payment Program (QPP)

- National & Local decisions
- Mechanisms to support innovation (CED, parallel review, other)

Medicare

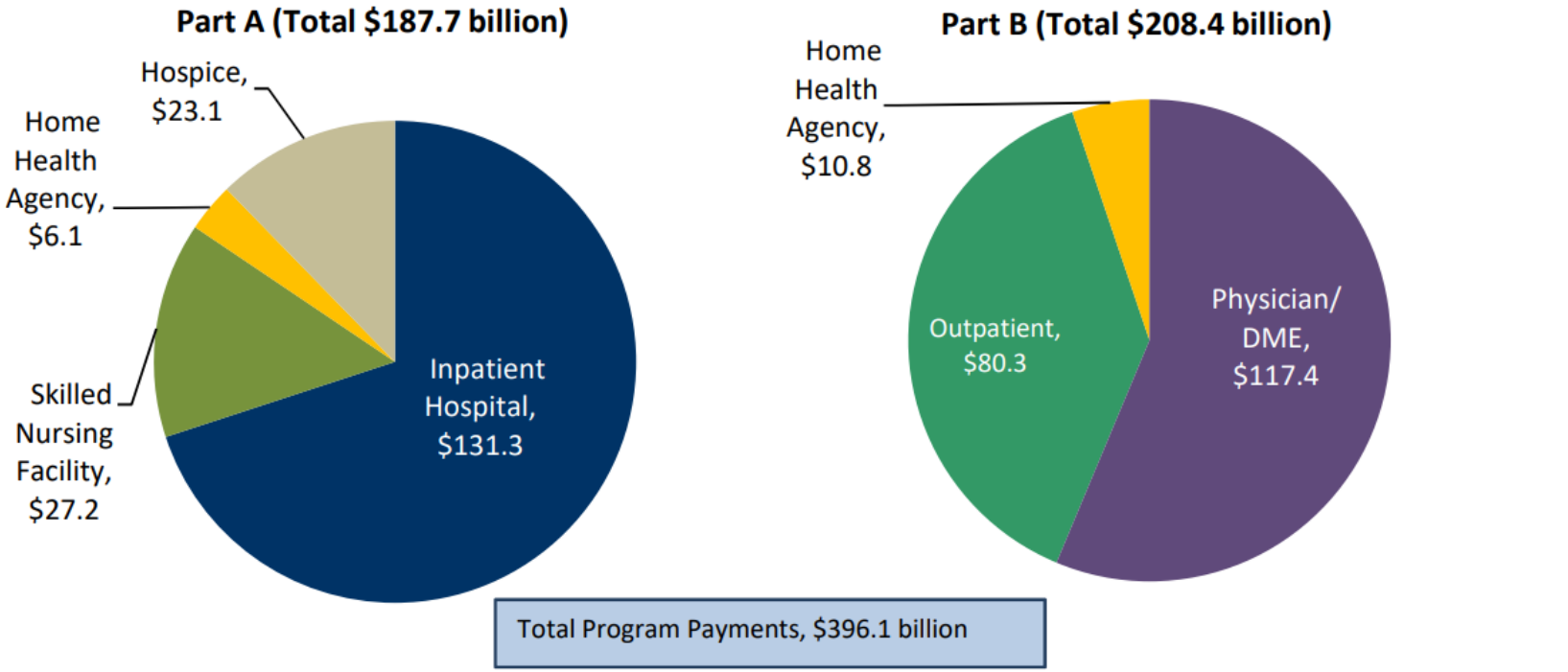
- Established in 1965 at the same time as Medicaid, to provide health insurance mostly to people 65+
- Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) are available to 65+, disabled (including <65 as disabled child), End Stage Rental Disease (ESRD), and Amyotrophic Lateral Sclerosis (ALS)
- Medicare does not include long-term care services, it covers only skilled nursing/rehabilitative care

Parts of Medicare



Medicare Payments 2021

Original Medicare Program Payments (in Billions) by Type of Service
Calendar Year 2021

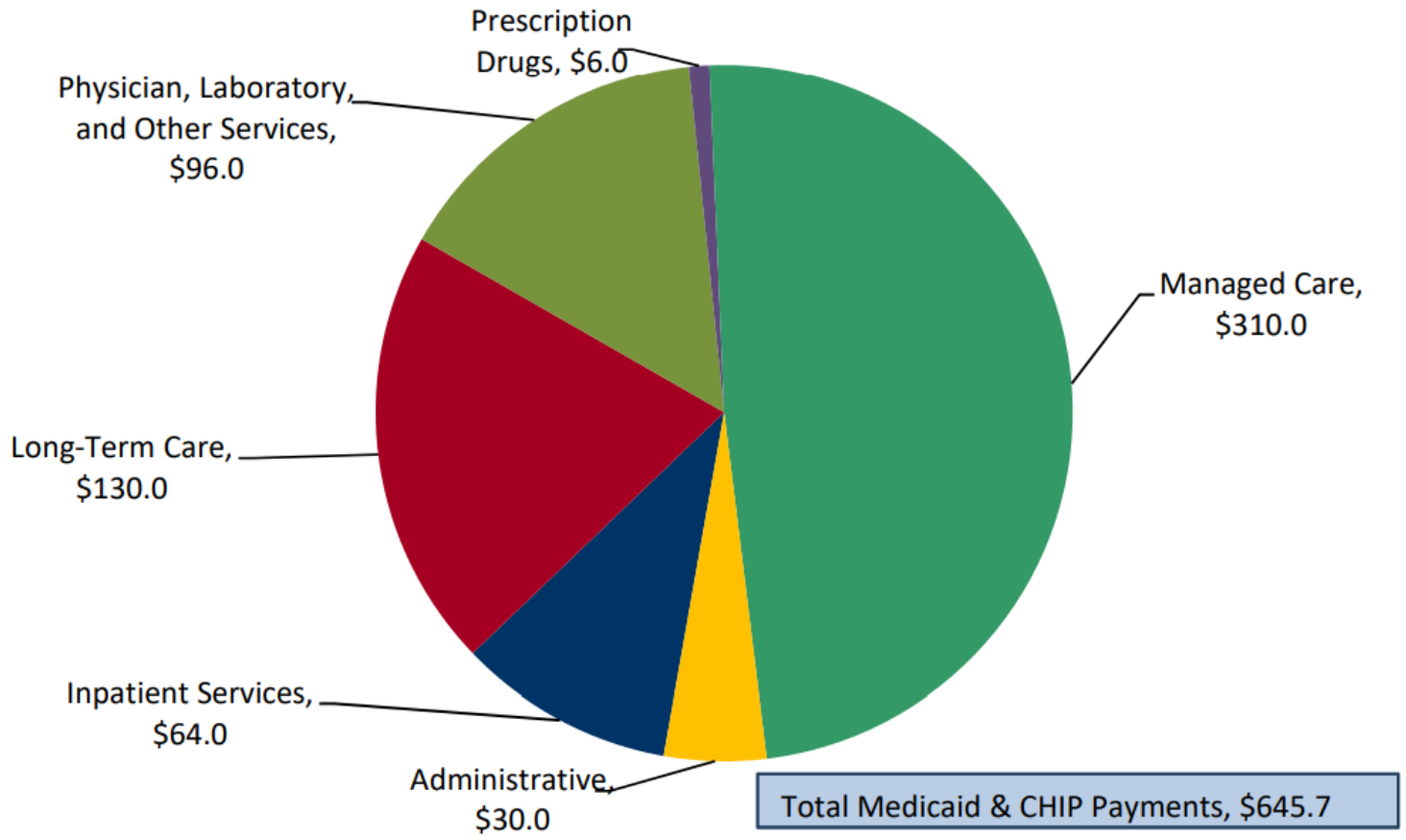


Total = Parts A and/or B

NOTES: Claims for 15.8 million Medicare Advantage beneficiaries who received a COVID-19 vaccination through a special Medicare benefit, accounting for $1.1 billion in Part B program payments, were billed under fee-for-service. These claims were removed and not reported in these charts.

Medicaid Payments 2021

Medicaid & CHIP Payments (in Billions) by Selected Type of Service
Fiscal Year 2019



SOURCE: CMS/Center for Medicaid and CHIP Services

Hospital VBP Program Goals & Structure

The Hospital Value-Based Purchasing (VBP) Program is authorized by Section 1886(o) of the Social Security Act.

- **Program Goals**:
  - Promote better clinical outcomes for hospital patients, improve the patient experience of care during hospital stays, and encourage hospitals to improve the quality and safety of care that all patients receive, including eliminating or reducing the occurrence of adverse events.
- **Program Structure and Scoring**:
  - Value-based incentive payments are made to hospitals that meet the performance standards
  - Hospitals are scored based on achievement and improvement in determining overall hospital performance
  - Important part of CMS' efforts to increase the portion of Medicare fee-for-service payments to hospitals that is linked to the quality of care

Hospital VBP Program Eligibility

- **Eligible hospitals include** subsection(d) hospitals — as defined in Social Security Act 1886(d)(1)(B)
- **Ineligible hospitals include those** excluded from the Inpatient Prospective Payment System (IPPS), such as psychiatric, rehabilitation, long-term care, children's, and 11 Prospective Payment System (PPS)-exempt cancer hospitals and Critical Access Hospitals (CAHs)
- **Excluded hospitals include those:**
  - Subject to payment reductions under the IQR Program
  - Cited for three or more deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients
  - With an approved extraordinary circumstance exception specific to the Hospital VBP Program
  - Without the minimum number of domains calculated for the applicable fiscal year
  - Short-term acute care hospitals in Maryland

Hospitals **excluded** from VBP **will not** have their base operating DRG payments reduced by the withhold percentage.

What is the Hospital Readmissions Reduction Program (HRRP)?

- The **HRRP is a pay-for-performance program** that reduces payments to subsection (d) hospitals with excess readmissions.
  - Supports the national goal of improving healthcare for Americans by **linking payment to the quality of hospital care**.
  - Provides a strong financial incentive for hospitals to **improve communication and care coordination efforts**, and to better engage patients and caregivers, with respect to post-discharge planning.
  - **Includes 6 mandatory claims-based measures of conditions and procedures** that significantly affect the lives of large numbers of Medicare patients. There is no reporting burden associated with these measures.
  - It was established with Section 3025 of the Patient Protection and **Affordable Care Act**.

HAC Reduction Program Background

- HAC Reduction Program was established to incentivize hospitals to reduce the number of HACs.
- HACs include patient safety events and healthcare- associated infections.
- **The program was mandated by section 3008 of the 2010 ACA.** CMS started applying payment adjustments with FY 2015 discharges (beginning
- October 1, 2014).

Medicaid Program Background

- Implementing legislation:
  - ***Title XIX of the Social Security Act, 1965***
- Partnership between Federal and State governments
- State-administered program
- Policies, programs , eligibility varies from state to state

Medicaid in Brief

- States determine their own unique programs – every state is different
- Each State develops and operates a State plan outlining the nature and scope of services; the State Plan and any amendments must be approved by CMS
- Medicaid mandates some services, states elect optional coverage
- States choose eligibility groups, services, payment levels, providers

Medicaid Eligibility

- Individuals must be in a group covered by the State's Medicaid program
- Some groups are mandatory, others are optional
- Examples:
  - Aged, Blind, or Disabled
  - Under 21
  - Pregnant women
  - Parent/Caretaker of a child
  - Childless Adults

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Services in Both Programs to Help People with Chronic Needs

Medicare

- Chronic Care Management
- Complex Chronic Care Management
- Cognitive Assessment & Care Planning
- Caregiver assessment
- Advance Care Planning
- Annual Wellness Visit and Welcome to Medicare
- Group and Individual Counseling
- Psychotherapy
- Psychiatric Collaborative Care and Behavioral Health Integration
- Home Healthhttps://www.healthandagingpolicy.org/
- Hospital
- Short-term Nursing Home Care
- Hospice
- Telehealth service delivery
- Durable Medical Equipment
- Transitional care management
- PT/OT/Speech therapies
- Opioid Treatment Programs
- (Supplemental benefits – MAOs)
- Chronic Pain Management and Treatment
- Principal Illness Navigation
- Caregiver Training Services
- Community Health Integration

Medicaid

- Home and Community-Based Services
- Health Homes
- Targeted Case Management
- Home Health
- Rehabilitative Services
- Program for All-Inclusive Care (PACE)
- Hospital
- Short *and* Long-Term Nursing Home Care
- Hospice
- Telehealth service delivery
- Medical equipment and supplies (DME)
- PT/OT/Speech therapies
- Opioid Treatment Programs
- Health-related social needs supports, reentry services from carceral settings, contingency management, others available through certain waivers

Medicare Coverage Construct: Social Security Act 1862(a)(1)

- **Reasonable and Necessary**

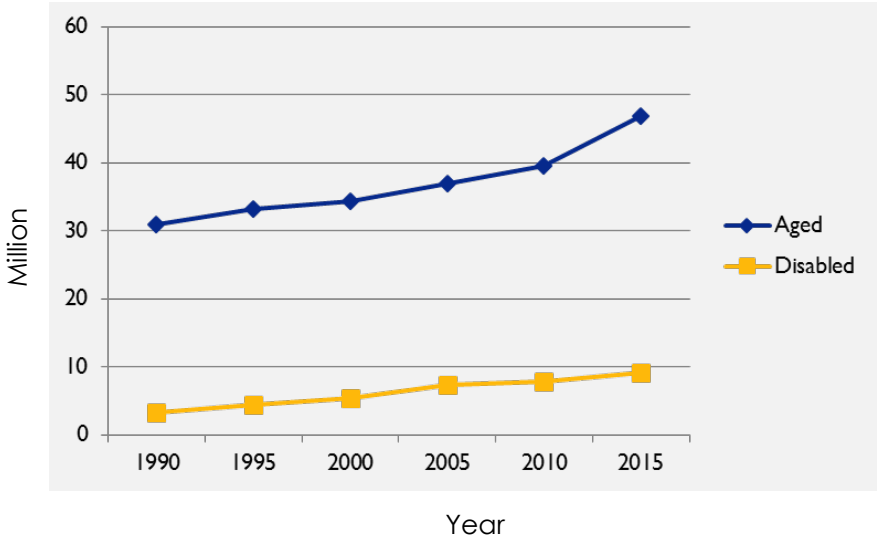
  Notwithstanding any other provision of this title, **no payment may be made** under part A or part B for any expenses incurred for items or services -

  – (A) which, … are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, …

  – (E) in the case of research conducted pursuant to §1142, which is not reasonable and necessary to carry out the purposes of that section, …

- **Defined Benefit Program**

  – Beneficiaries
    - Age ≥ 65 years
    - Disabled individuals
    - End stage renal disease
  – Providers
  – Settings



National and Local Coverage Determinations

The evidence:

- **Sufficient** evidence to conclude that the item or service **improves clinically meaningful health outcomes** for the **Medicare population**
- Based on a comprehensive review of published evidence

National

Definition: Determination by the Secretary with respect to whether or not a particular item or service is covered nationally under § 1862(a)(1)(A) .

CED: § 1862(a)(1)(E) in the case of research conducted pursuant to § 1142, which is not reasonable and necessary. .

Prevention/Screening: Reasonable and necessary for the prevention or early detection of illness or disability under § 1861(ddd).

Local

Definition: Determination by a Medicare Administrative Contractor (MAC) with respect to whether or not a particular item or service is covered in the MAC jurisdictions under §1862(a)(1)(A).

EVIDENCE GAPS REMAIN - OLDER ADULTS ARE NEEDED IN CLINICAL TRIALS

Preferred Road to Coverage

Provide adequate evidence that…

Diagnostics

- ✓ The incremental information obtained by new diagnostic technology compared to alternatives
- ✓ Changes physician/clinician recommendations
- ✓ Resulting in changes in therapy
- ✓ That improve clinically meaningful health outcomes

Therapeutics

- ✓ A treatment strategy using the new therapeutic technology compared to alternatives
- ✓ Leads to improved clinically meaningful health outcomes

In Medicare beneficiaries

Drivers of change

Assessment

Highest-Quality, Best-Value, and Patient-Centered Care within a Resilient System framework

$

Payment Models

Elevator: Quality improvement

Assessment: Quality measures

Minimum for all individuals

Conditions of Participation

Survey and enforcement

CMS
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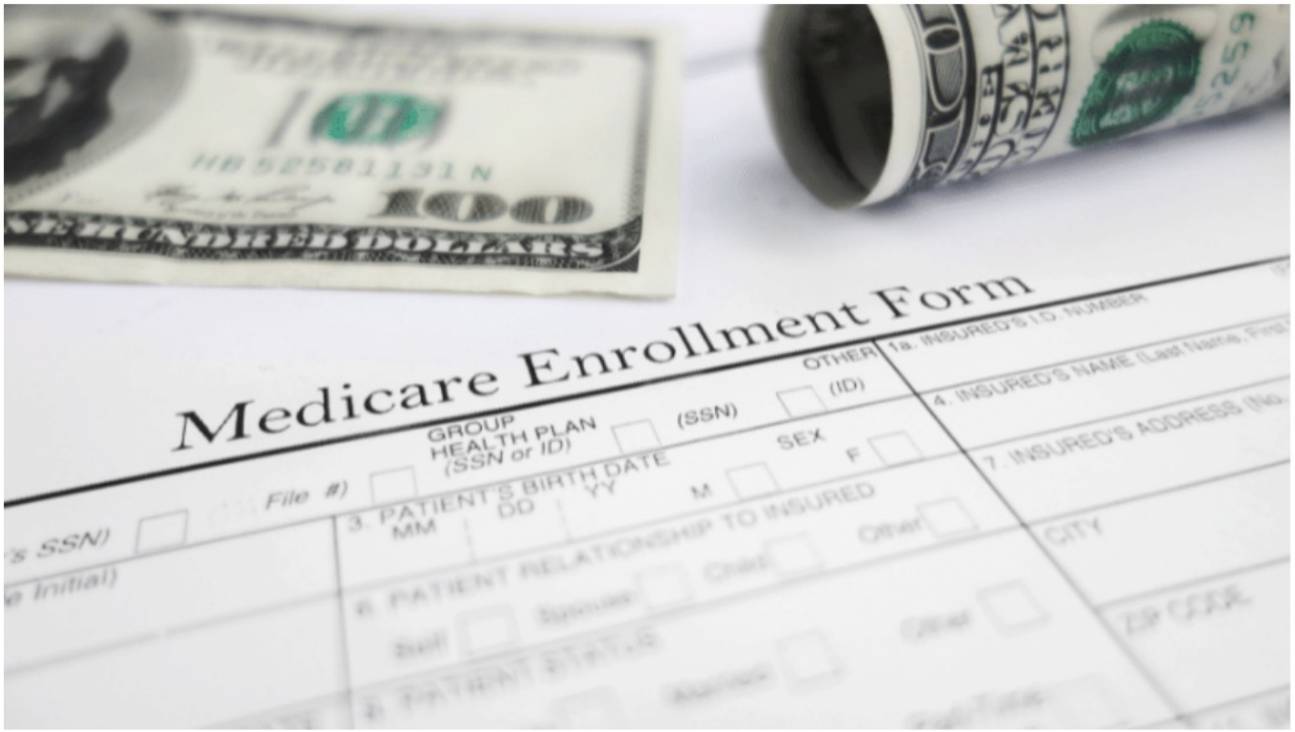
The Medicare Value-Based Care Strategy: Alignment, Growth, And Equity

Douglas Jacobs, Elizabeth Fowler, Lee Fleisher, Meena Seshamani

JULY 21, 2022 10.1377/forefront.20220719.558038



How are we defining value in this Strategy?

- Value **for all people with Medicare.**

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CMS NATIONAL QUALITY STRATEGY

A Framework to Advance Quality and Safety in American Healthcare

https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy

CMS National Quality Strategy Goals

Embed Quality Across the Care Journey

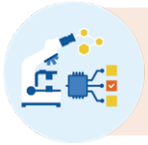
Advance Health Equity & Whole-Person Care

Promote Safety to Achieve Zero Preventable Harm

Foster Engagement to Improve Quality & Build Trust

Embrace the Digital Age

Strengthen Resilience in the Health Care System



Incentivize Scientific Innovation, Advanced Analytics & Technology

Increase Alignment to Promote Seamless, Coordinated Services & Support

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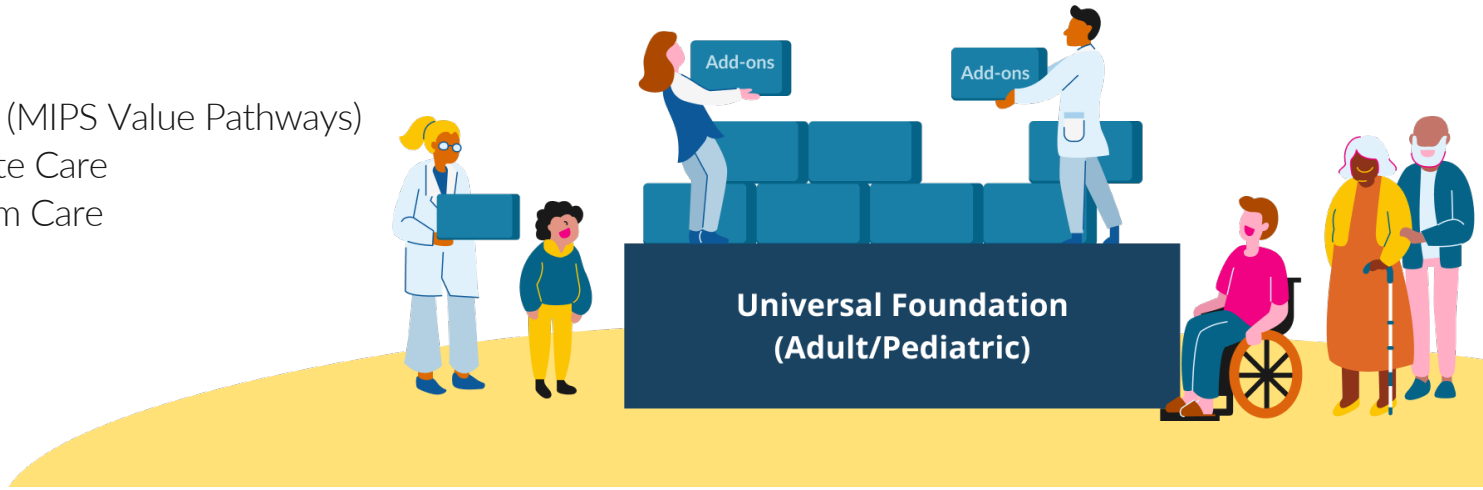
The Universal Foundation
Overview

CMS is introducing a "Universal Foundation" of quality measures to advance the overall vision of the National Quality Strategy and increase alignment across CMS quality programs.

The preliminary adult and pediatric measures were announced in a NEJM article published in February.

- Additional measures for specific settings or populations will be identified as "add-ons" that can be implemented consistently across programs. These add-ons may include:
  - Maternal
  - Hospital
  - Specialty (MIPS Value Pathways)
  - Post-acute Care
  - Long-term Care



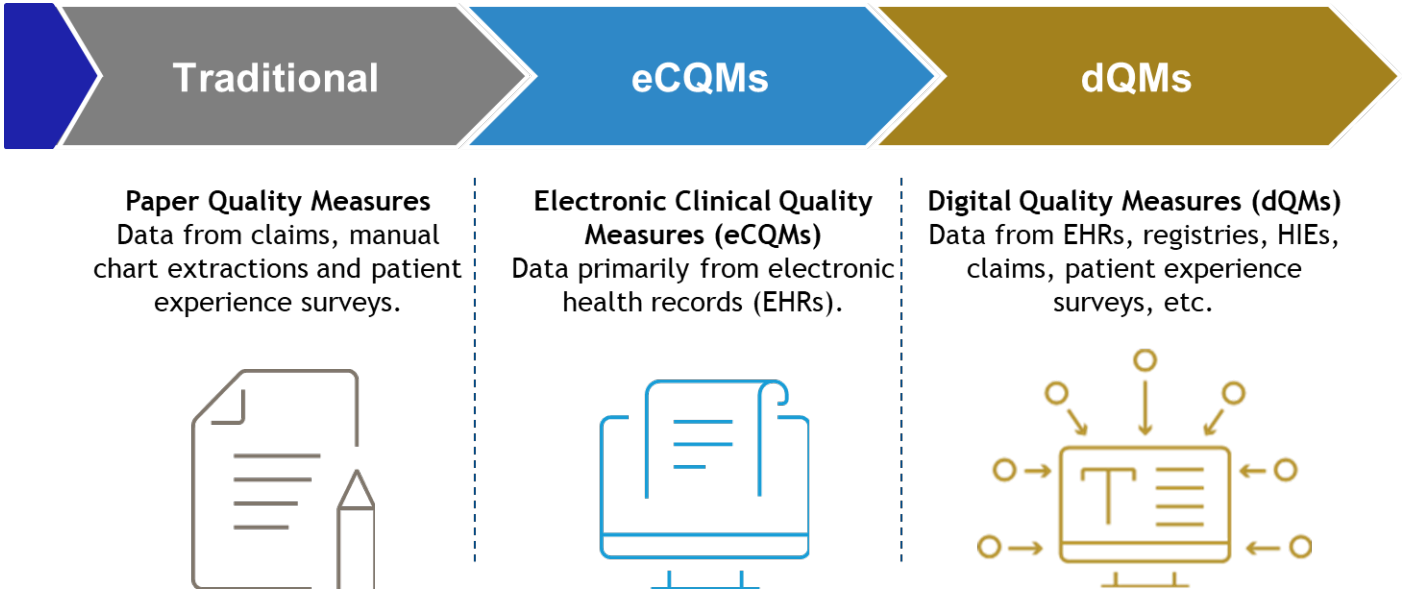
Embed Quality Across the Care Journey

KEY TAKEAWAY

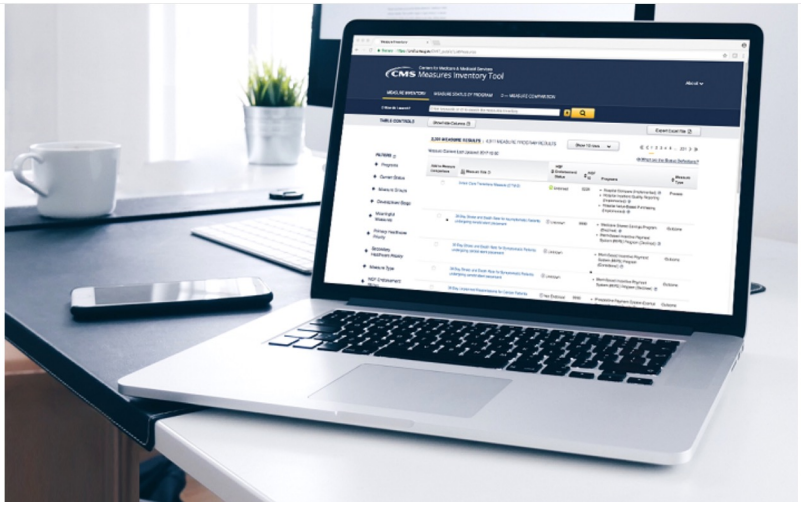
Incorporate quality as foundational component to delivering value. Quality includes ensuring optimal care and best outcomes for individuals of all ages, backgrounds, across all settings. Quality also extends across payers.

- Improve performance metrics: goal is GLOBAL top quartile
- Focus on high impact areas – maternal health, mental health, equity, safety
- Support individuals with greatest needs
- Consider national quality dashboard for select metrics
- Advance alignment of measures across continuum of care and include data from all CMS payers (Medicare, Medicaid, Marketplace) where feasible

Evolution of quality measures: the journey from paper to digital



CMS Measures Inventory Tool (CMIT)



- CMIT is the repository of record for information about the measures which CMS uses to promote healthcare quality and quality improvement. CMIT includes measure info details across 26 quality reporting programs, CMMI models, and Medicaid. CMIT does not contain measure performance data, which is available on various CMS public reporting websites.

- Measure information available in CMIT includes: Description, Numerator, Denominator, Exclusions, CBE Endorsement Status, Care Setting, Data Source, Reporting Status, Population, Meaningful Measure Area

CMIT is at: https://cmit.cms.gov/cmit/#/

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- Bill passed on September 18, 2014, and signed into law October 6, 2014

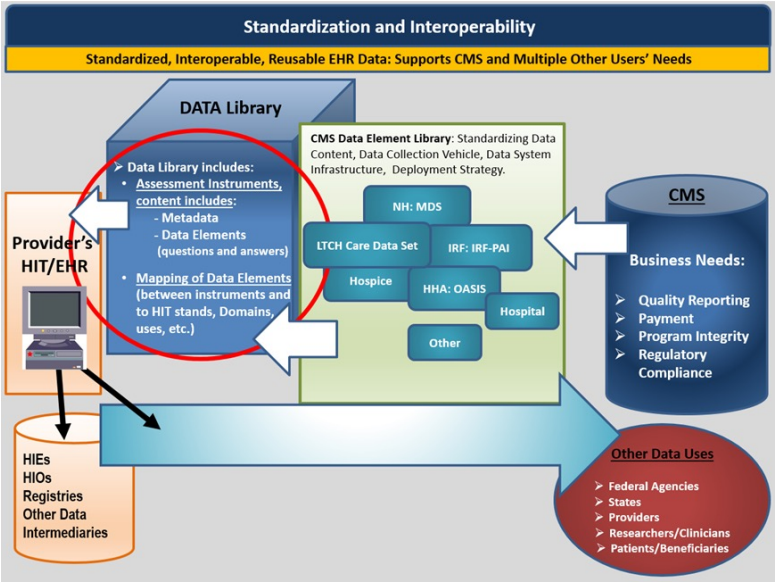
- **The Act requires the submission of standardized patient assessment data elements by:**
  - Long-Term Care Hospitals (LTCHs): LCDS
  - Skilled Nursing Facilities (SNFs): MDS
  - Home Health Agencies (HHAs): OASIS
  - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI

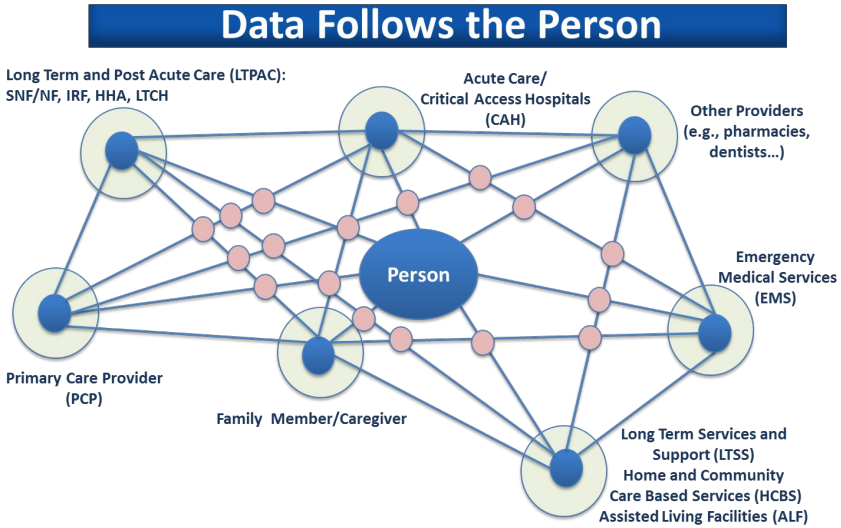
- **The Act specifies that data** "… be **standardized and interoperable** so as to allow for the **exchange of such data among such post-acute care providers and other providers** and the use by such providers of such data that has been so exchanged, including by **using common standards and definitions** in order to provide access to **longitudinal information** for such providers to **facilitate coordinated care** and **improved Medicare beneficiary outcomes**…".

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

The CMS Data Element Library: Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

Visit the DEL here: https://del.cms.gov





FUNCTION – MOBILITY, SELF-CARE, COGNITION, SYMPTOMS, CARE PLANS

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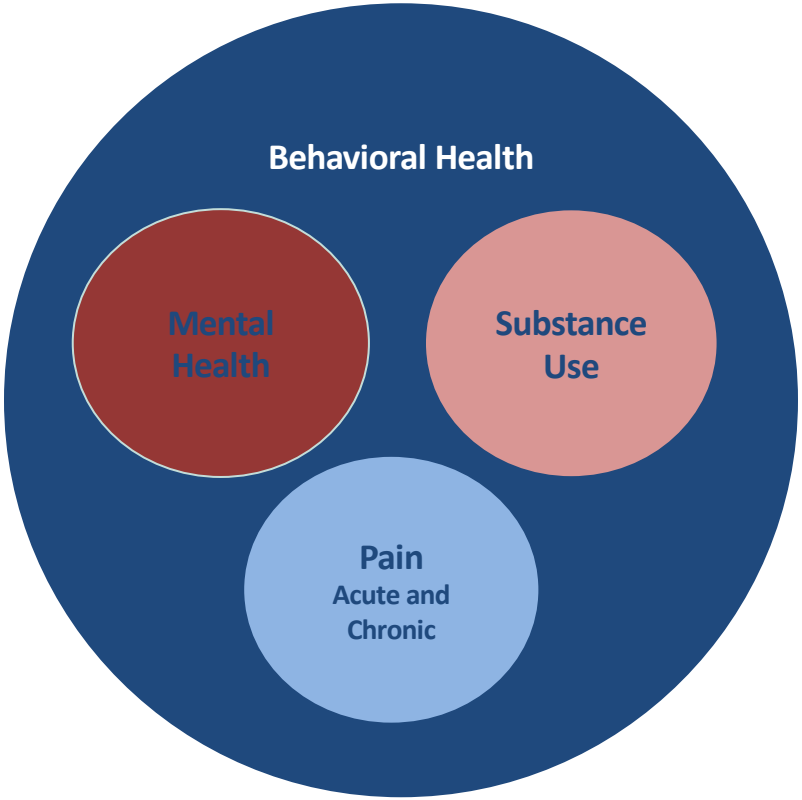
CMS's Behavioral Health Focus



Three key areas are aligned with the Agency's strategic focus on four health outcomes-based domains: *coverage and access to care, quality of care, equity and engagement, and data and analytics.*

At all times we are focused upon the needs of the people of all ages who we serve at every stage of life - people with or at risk of developing substance use disorders, people with acute or chronic pain, and people with mental health challenges.

~

Behavioral Health Mission and Vision

Mission	To ensure that high quality behavioral health services and supports are accessible to beneficiaries and consumers.
Vision	Beneficiaries and consumers with behavioral health needs have access to person-centered, timely, affordable care that enables optimal health and wellness.

Check-out the website here: https://www.cms.gov/cms-behavioral-health-strategy

Behavioral Health Strategy Action Plan Domains

I. Coverage & Access to Care	II. Quality of Care	III. Equity & Engagement	IV. Data & Analytics
Ensure coverage of and access to BH providers and services across the care continuum, including all provider types and settings, with parity to physical health for all age groups and geographies	Measure quality, including safety and efficiency of care delivery, to drive quality improvement and inform development of quality improvement resources	Create coverage and care pathways that center health equity and engage people from historically marginalized communities in integrated, person-centered care	Aggregate and analyze data to identify disparities in behavioral health care and outcomes by demographic factors and across CMS programs to drive policy and operational changes

CMS Behavioral Health Strategy Website

CMS Behavioral Health Strategy Website

CMS Behavioral Health Fact Sheet

Behavioral Health is a cross cutting initiative under the **CMS Strategic Plan.**

CMS Behavioral Health Strategy

The CMS Behavioral Health Strategy focuses on three key areas: 1) substance use disorders prevention, treatment and recovery services, 2) ensuring effective pain treatment and management, and 3) improving mental health care and services. These areas are aligned with CMS's overall focus on four health outcomes-based domains: *coverage and access to care, quality of care, equity and engagement, and data and analytics*. Our vision is for all the people we serve to get access to person-centered, timely, and affordable care.

CMS's behavioral health priorities advance the HHS Roadmap for Behavioral Health Integration, the HHS Overdose Prevention Strategy, and the HHS Pain Management Task Force Report.

Behavioral Health Cross Cutting Initiative

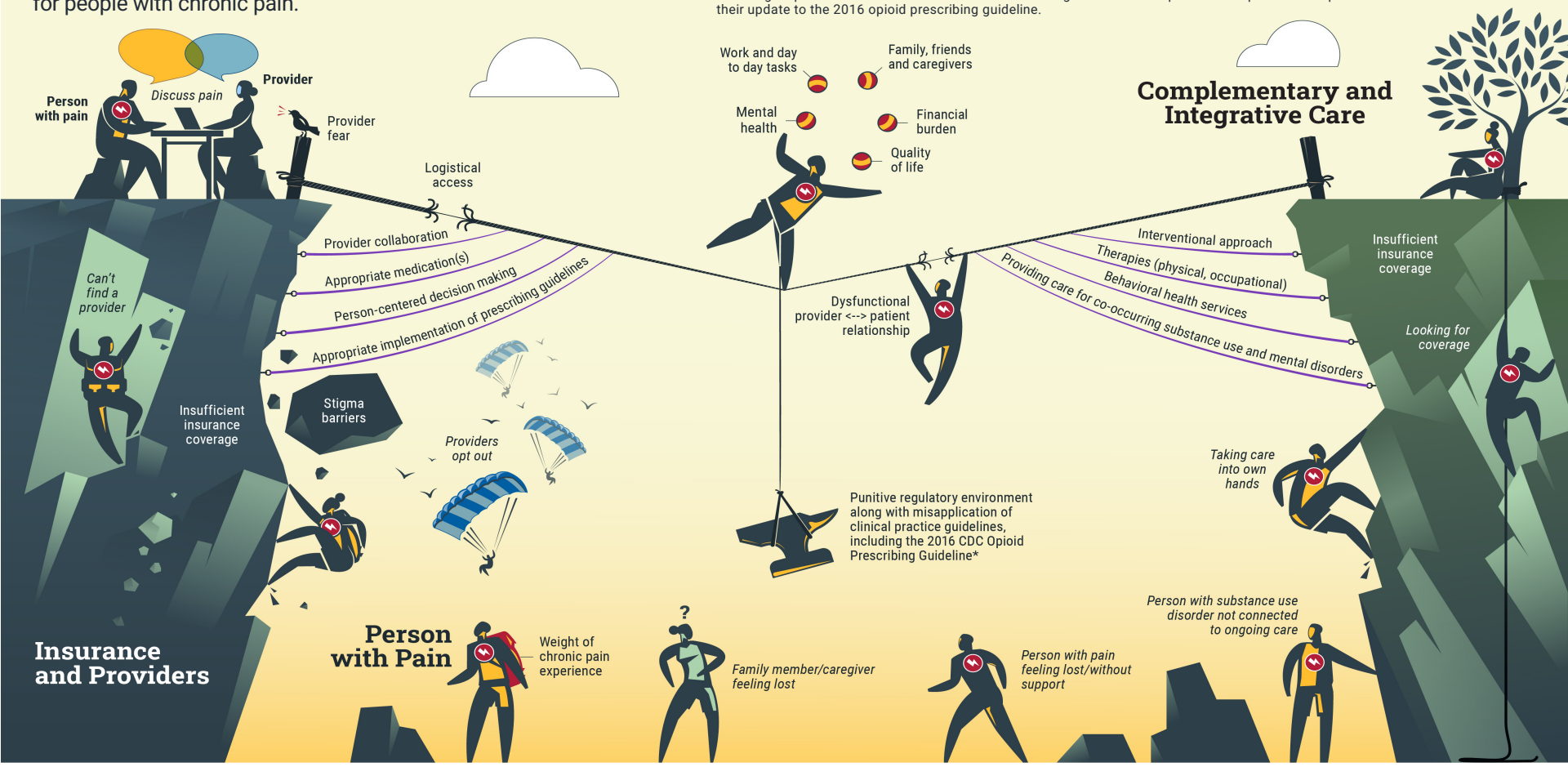
CMS has 12 cross-cutting initiatives as part of the CMS Strategy (PDF), including behavioral health. The Behavioral Health Cross-Cutting Initiative investments and outcomes are described in this Fact Sheet.

Chronic Pain Experience

Released May 2022 https://www.cms.gov/files/document/cms-chronic-pain-journey-map.pdf

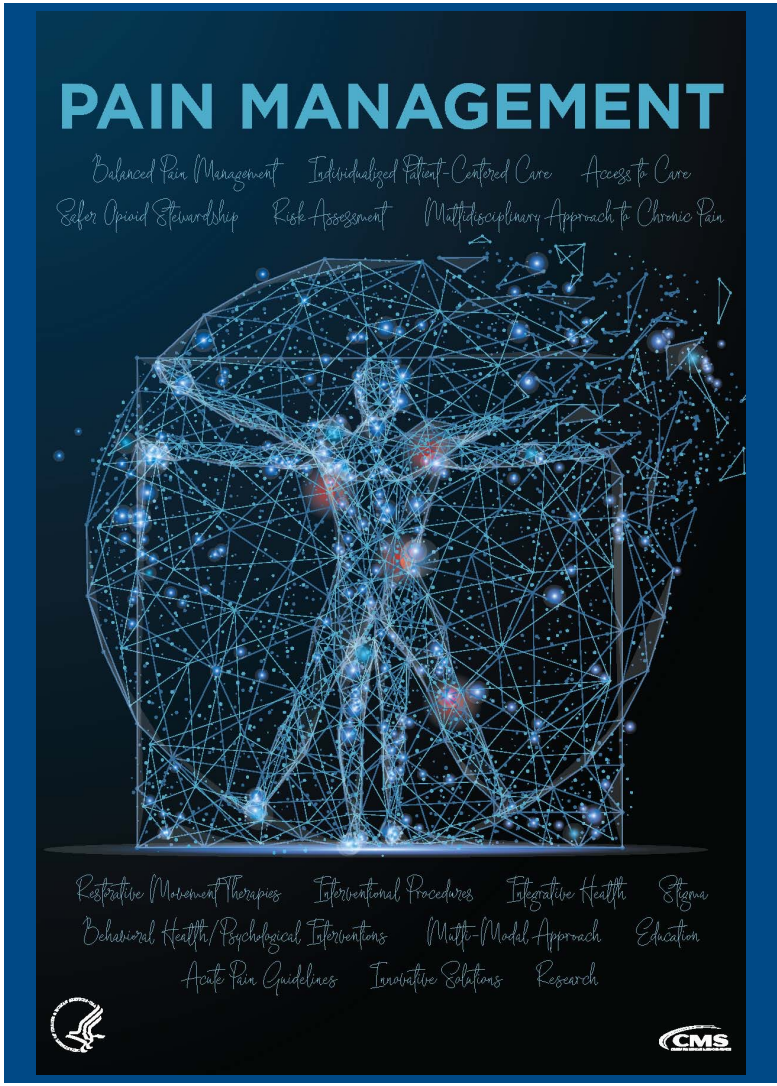
Understand access to covered treatment and services for people with chronic pain.

This visual is derived from stakeholder interviews focusing on the experiences of those living with and treating chronic pain. Its intent is to highlight the most prominent barriers experienced by people accessing care and the influencers acting on providers, ultimately affecting the person with chronic pain, their quality of care, and their quality of life. These sentiments were derived from requests for information (RFIs) conducted by CMS and CDC, including as part of CDC's efforts to understand and integrate the lived experiences of patients and providers into their update to the 2016 opioid prescribing guideline.

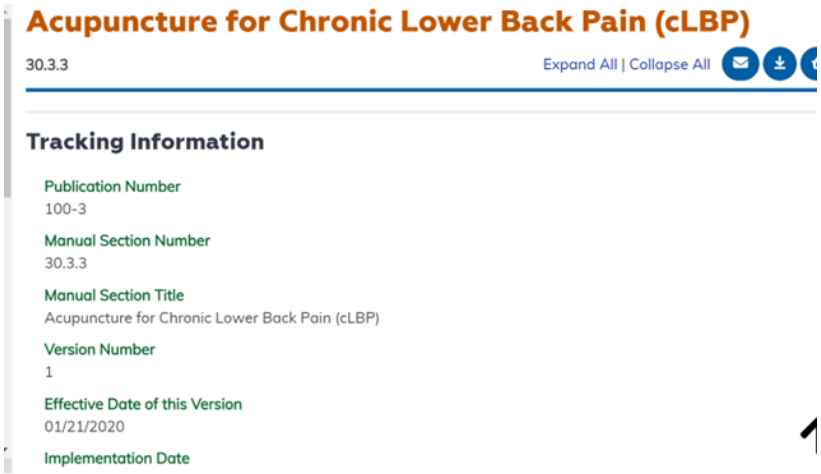


Five Opportunity Areas Identified

1. Covering the extra work needed to furnish effective pain care
2. Facilitating flexibility in policy and guidelines to assure person-centered care
3. Expanding coverage across programs
4. Alleviating clinician fear in rendering treatment to people with pain
5. Reducing stigma associated with chronic pain, especially for people using opioid medications



Acupuncture for Low Back Pain



Acupuncture for Chronic Lower Back Pain (cLBP)

30.3.3 Expand All | Collapse All

Tracking Information

Publication Number
100-3

Manual Section Number
30.3.3

Manual Section Title
Acupuncture for Chronic Lower Back Pain (cLBP)

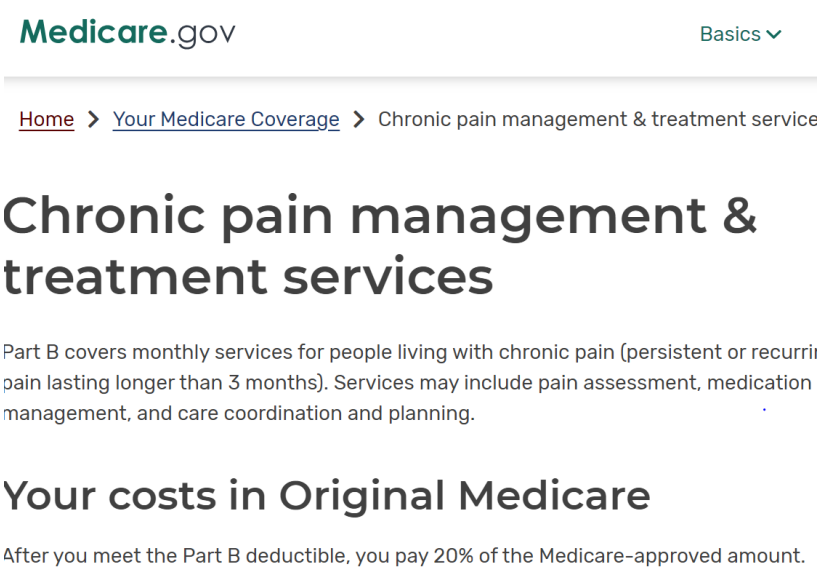
Version Number
1

Effective Date of this Version
01/21/2020

Implementation Date

- CMS began covering acupuncture for LBP in 2020
- There is detailed Medicare Learning Network Guidance (updated 2021)
- Use of the codes has grown steadily since 2020 with the base codes (initial, w/w-o electrical simulation) approximately tripling use since the first year, and fewer claims being denied over time

Chronic Pain Management and Treatment


Medicare.gov Basics

Home > Your Medicare Coverage > Chronic pain management & treatment service

Chronic pain management & treatment services

Part B covers monthly services for people living with chronic pain (persistent or recurri pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.

Your costs in Original Medicare

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

CMS proposed and finalized two CPM codes in the 2023 PFS

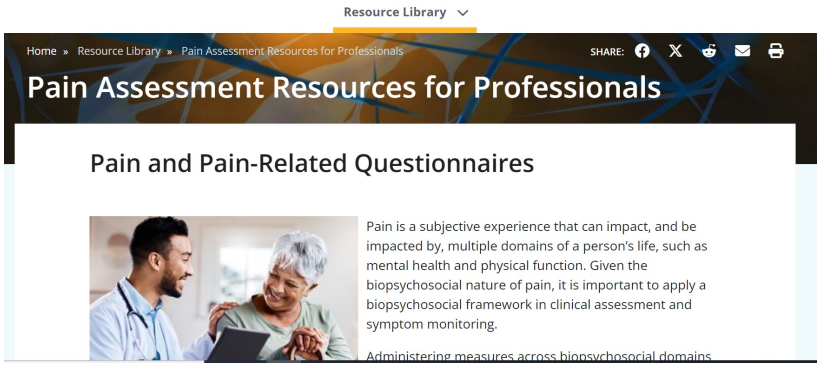
- HCPCS code **G3002**: chronic pain management and treatment by a physician or other qualified health professional
  - Required initial face-to-face visit of at least 30 minutes per calendar month
- HCPCS code **G3003**: each additional 15 minutes, per calendar month

Bundled Service Elements of CPM Codes

Bundled elements *(billing began 1/1/23)*:

- *Diagnosis*
- *Assessment and monitoring*
- *Administration of validated pain rating scale or tool*
- *Development, implementation, revision, and/or maintenance of person-centered care plan that includes strengths, goals, clinical needs, desired outcomes*
- *Overall treatment management*
- *Facilitation/coordination of any necessary behavioral health treatment*
- *Medication management*
- *Pain and health literacy counseling*
- *Any necessary pain-related crisis care*
- *Ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate*

Highlights of CPM Codes



- Defines chronic pain as, "persistent or recurrent pain lasting longer than 3 months" for purposes of regulation
- Requirement for initial visit to be face-to-face, subsequent visits or follow-up can be non-face to face
- Not all bundle elements must be provided every month
- Not limiting the number/type of providers who can furnish
  - But those furnishing must be able to provide all elements
- Includes a new Resources for Pain Assessment for clinicians designed by our NIH partners, listing brief validated measures
- The 30-minute monthly code was billed more than 17,000 times in 2023

The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

The SUPPORT Act (2018) outlines national strategies to help address America's overdose crisis and advances policies to improve the treatment of pain and substance use disorders.

- Section 6032 requires an Action Plan and Report to Congress:
  - HHS Pain Best Practices Task Force developed the Pain Management Best Practices Inter-agency Task Force Report.
- Section 6086 outlines the Dr. Todd Graham Pain Management Study
- Section 2002 requires SUD screening in Medicare's "Welcome" visit and the Annual Wellness Visit
- Section 2003 outlines electronic prescribing of controlled substances (EPCS)

Medicare Opioid Treatment Program (OTP) Benefit

- Section 2005 of the SUPPORT Act established a new Medicare Part B benefit for OUD treatment services provided by OTPs on or after January 1, 2020.
- Under Medicare, OTPs must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body.
- For SAMHSA certification, OTPs must comply with all pertinent state laws and regulations and all regulations enforced by the Drug Enforcement Administration.
- Under Medicare, OUD treatment services provided by OTPs includes the following:
  - FDA-approved opioid agonist and antagonist medications for opioid use disorders (MOUD) including buprenorphine
  - Dispensing and administering MOUD medications (if applicable)
  - FDA-approved opioid antagonist medications, specifically naloxone, for emergency treatments of opioid overdose, as well as overdose education provided in conjunction with opioid antagonist medication
  - Substance use counseling that OTPs may conduct via two-way interactive audio-video communication technology
  - Individual and group therapy that OTPs may conduct via two-way interactive audio-video communication technology
  - Toxicology testing
  - Intake activities
  - Periodic assessments that OTPs may conduct via two-way interactive audio-video communication technology

Behavioral Health: Some Updates from Medicare's CY 2024 Physician Fee Schedule Final Rule

CMS CY 2024 PFS Final Rule finalized changes to support Behavioral Health:

- Principal Illness Navigation
- Marriage & Family Therapists (MFTs) & Mental Health Counselors (MHCs)
- Psychotherapy for Crisis Services
- Payment for Psychotherapy Services

Principal Illness Navigation (PIN)

- Principal Illness Navigation services are to help people with Medicare who are diagnosed with high-risk conditions (for example, dementia, HIV/AIDS, and cancer) identify and connect with appropriate clinical and support resources.
- PIN takes place under general supervision of the billing physician which allows for professionals to coordinate care with greater ease.
- PIN-PS codes were finalized to be more in line with the work in which peer support specialists are trained to do e.g. encourage patients to advocate for themselves rather than the professional doing it on their behalf.

"We know that these services make an enormous difference in people's lives."

- Dr. Jill Biden on her support for PIN codes

Addressing & Improving Behavioral Health

CMS is embarking on a multi-faceted approach to increase access to equitable and high-quality behavioral health services and improve outcomes for people covered by Medicare, Medicaid (including the Children's Health Insurance Program) and private health insurance.

Review the CMS Behavioral Health Strategy, and get more details on our actions to support these goals.

Behavioral Health Strategy Goals

- Strengthen equity and quality in behavioral health care
- Improve access to substance use disorders prevention, treatment and recovery services
- Ensure effective pain treatment and management
- Improve access to and quality of mental health care and services
- Utilize data to inform effective actions and measure impact on behavioral health

Resources

- Read our Behavioral Health fact sheet (PDF) for more details on our strategy
- Behavioral health updates from the 2022 CMS Quality Conference.
- White House Fact Sheet on the Strategy to Address Our National Mental Health Crisis.
- CMS is part of the new Behavioral Health Coordinating Council to coordinate efforts across HHS.
- Follow the Secretary on the National Tour to Strengthen Mental Health.

Featured video

****It is recommended to view the video below with Flash disabled in Chrome, Firefox, or Internet Explorer 11 browsers, due to known usability issues with other browsers.**

View more videos

YouTube requires JavaScript to view videos. You will need the latest version of Adobe Flash Player to watch the video.

CMS Behavioral Health Strategy Website:

https://www.cms.gov/cms-behavioral-health-strategy

CMS Behavioral Health Fact Sheet

Behavioral Health is a cross cutting initiative under the **CMS Strategic Plan**

What can you do to help our system achieve health outcomes and better aging through value-based care?

- **Eliminate** patient harm
- **Focus** on healthier people within the population you serve
- **Engage** in accountable care and other alternative payment contracts that move away from fee-for-service to model based on achieving better outcomes at lower cost
- **Invest** in the quality infrastructure necessary to improve
- **Focus** on data and performance transparency
- **Help us** develop and implement effective service delivery models
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes

Thank you!

Shari.ling@cms.hhs.gov

CMS Deputy Chief Medical Officer

Centers for Medicare & Medicaid Services

Goal 1: Strengthen Equity and Quality in Behavioral Health

OBJECTIVES	CMS ACTIVITIES
Reduce persistent and emerging disparities in health and health care among those CMS serves to improve access to high quality, affordable, person-centered behavioral health care, and ensure parity in access, coverage, and quality for physical and mental health services, including care enabled through technology.	• OMH Health Equity Accelerator • Behavioral Health Quality Measures Inventory, including measures for mandatory reporting for Medicaid Adult Core Set • Medicaid/CHIP Quality Improvement Learning Collaboratives • Medicaid & CHIP TMSIS Data Analysis • Mental Health Parity Laws • CMMI Demos and Models • Medicare Physician Fee Schedule Updates • CMS Campaigns & Initiatives
Improve Quality Measurement by better understanding and improving measures in mental and behavioral health, substance use disorders, and pain management across CMS's programs and the continuum of care.	
Incorporate Health Equity into new care and payment models and optimize whole-person care for beneficiaries with and at risk of behavioral and mental health conditions.	
Provide Effective Outreach and Education on CMS's mental and behavioral health services to inform beneficiaries and providers; utilizing culturally and linguistically appropriate materials and meet the needs of individuals with low literacy, low health literacy, and limited-English proficiency.	
Consider quality and health equity implications across all objectives of the CMS Behavioral Health Strategy to ensure that equity and quality underpin our approach to improving substance use disorder services, pain management services, mental health services, and data and measurement.	

Goal 2: Improve Access to Substance Use Disorders, Prevention, Treatment, and Recovery Services

OBJECTIVES	CMS ACTIVITIES
Improve the Care Experience for individuals with substance use disorders and increase strategic opportunities for enhanced access to high quality, equitable, affordable whole-person care.	• SUD Data Book – TMSIS Data* • Over Prescriber Support Strategy (SUPPORT Act 6052)* • Medicaid Community-Based Mobile Crisis Intervention Services* • Medicaid Section 1115 Substance Use Disorder Demonstrations* • Integrated Care for Kids (InCK) Model* • Maternal Opioid Misuse (MOM) Model* • Medicaid Demonstration Project (SUPPORT Act 1003)* • Value in Opioid Use Disorder Treatment Demo (SUPPORT Act 6042)* • Medicare Opioid Treatment Programs • Medicare Physician Fee Schedule Updates (telehealth, audio-only communication) • Medicaid/CHIP Quality Improvement Learning Collaboratives • OMH Health Equity Accelerator • Beneficiary Experience Illustration • Action Plan & Report to Congress - CMS's plans to address SUD and pain in Medicare and Medicaid (SUPPORT ACT 6032)
Identify and Address Barriers that impede access to evidence-based treatment and recovery services for better detection, diagnosis and management of beneficiaries with and at risk of substance use disorders.	
Strengthen Treatment and Recovery Services through innovative care and payment models, and dissemination of promising and best practices.	
Expand workforce capacity across provider types, including exploring options for training of primary care and specialty residents and current clinicians in the detection, diagnosis and management of substance use disorders.	

*Activities included in the HHS Overdose Prevention Strategy: https://www.hhs.gov/overdose-prevention/

Goal 3: Ensure Effective Pain Treatment and Management

OBJECTIVES	CMS ACTIVITIES
Improve the Care Experience for individuals with chronic pain to identify strategic opportunities for enhanced access to high quality, equitable, affordable whole-person care.	• Beneficiary Experience Illustration (aka Journey Map) • SUPPORT ACT 6086 - Dr. Todd Graham Pain Management Study • MEDICARE Physician Fee Schedule Updates for Pain Management • OMH Health Equity Accelerator • Provider Education – New clinical guidelines for management of dental pain • Collaboration with NIH to enrich evidence on non-pharmaceutical pain treatments
Expand access to evidence-based treatments for acute and chronic pain, including through refreshed guidance to states and prescribing policies, and sharing best and better practices that ensure individualized, effective care.	
Increase coordination between primary care and specialty care through payment episodes, incentives, and care and payment models.	
Expand workforce capacity and capability including exploring options for training of primary care and specialty residents and current clinicians in the diagnosis and management of acute and chronic pain.	

Goal 4: Improve Mental Health Care and Services

OBJECTIVES	CMS ACTIVITIES
Increase detection and better management of mental health conditions through coordination and integration between primary and specialty care providers.	• Medicaid Mobile Crisis Services • Medicare Annual Wellness Visit Campaign • Certified Community Behavioral Health Clinics (CCBHCs) • Medicare Care Coordination • Connecting Kids to Coverage - Mental Health Campaign • Antipsychotic Use in Nursing Homes • 988 Crisis Intervention Campaign
Improve access to short-term crisis care to effectively respond, stabilize and follow-up with appropriate care.	
Expand access to community-based mental health services and resources such as peer supports, community health workers, housing, home and community-based services, oral health care, and social supports.	
Mitigate the adverse effects of emergencies and disasters such as the COVID-19 pandemic on the mental health of beneficiaries, and care providers.	
Expand workforce capacity and capability including exploring options for training of primary care and specialty residents and current clinicians in the detection, diagnosis and management of mental disorders.	

Goal 5: Utilize Data for Effective Actions and Impact

OBJECTIVES	CMS ACTIVITIES
Evaluate the CMS Behavioral Health Strategy across Medicare, Medicaid, and the Marketplace including equity and quality; supplement evaluation with external data sources where necessary.	• Transformed-Medicaid Statistical Information System (TMSIS) Data Analysis – Substance Use Disorder Data Book • Mapping Medicare Disparities Tool • Quality Measures Inventory and Data • CMS Public Data Use Files for Research • Collaborate and Coordinate with other federal agencies on data for actions and impact.
Build on and Support Cross-Department & Interagency Collaborations beginning with the HHS Behavioral Health Coordinating Council goals, strategies & actions, Agency Priority Goals, and ONDCP actions	
Support evidence generation and research and provide data for internal and external analysis, process and quality improvement, to improve beneficiary/consumer outcomes.	

Medicaid Benefits in the Regular State Plan

- **MANDATORY**
  - Inpatient hospital services
  - Outpatient hospital services
  - EPSDT: Early and Periodic Screening, Diagnostic, and Treatment services
  - Nursing Facility services
  - Home Health services
  - Physician services
  - Rural Health Clinic services
  - Federally Qualified Health Center services
  - Laboratory and X-ray services
  - Family Planning services
  - Nurse Midwife services
  - Certified Pediatric and Family Nurse Practitioner services
  - Freestanding Birth Center services (when licensed or otherwise recognized by the state)
  - Transportation to medical care
  - Tobacco Cessation counseling for pregnant women
  - Medication for Opioid Use Disorders (MOUD)

- **OPTIONAL**
  - Prescription Drugs
  - Rehabilitative Services
  - Clinic services
  - Therapies – PT/OT/Speech/Audiology
  - Respiratory care services
  - Podiatry services
  - Optometry services
  - Dental Services & Dentures
  - Prosthetics
  - Eyeglasses
  - Other Licensed Practitioner services
  - Private Duty Nursing services
  - Personal Care Services
  - Hospice
  - Case Management & Targeted Case Management
  - TB related services
  - Home and Community Based Services (1915(c)
  - State Plan HCBS - 1915(i)
  - Community First Choice Option - 1915(k)
  - State Plan IMD Option
  - Health Home
  - Mobile Crisis Services (section 1947)

Home & Community-Based Services

- There are multiple HCBS available through the State plan - 1905(a) and other State plan authorities:
  - —Personal Care Services
  - —Home Health (mandatory: skilled nursing, home health aide, medical supplies, equipment and appliances; optional: PT/OT/Speech/Audiology)
  - —Rehabilitative Services
  - —State plan HCBS- 1915(i)
  - —Self-directed Personal Care – 1915(j)
  - —Community First Choice Option- 1915(k)

  (Some states also furnish HCBS through section 1115 demonstration authority)

Managed Care Authorities

- The Social Security Act provides different ways for states to operate managed care programs (numbers below reference sections of the Act):
  - 1915(a) - Voluntary Program
  - 1932(a) - State Plan Amendment
  - 1937 – Alternate Benchmark Plans
  - 1915(b) - Managed Care Waiver
  - 1115(a) - Research & Demonstration Waiver
  - 1115(A) – Duals Demonstrations (Medicare/Medicaid)

§1115 Research and Demonstration Waivers

- Must assist in promoting the objectives of the Medicaid or Children's Health Insurance Program statute, as determined by the Secretary
- Provides waivers from statutory and regulatory requirements not available under SPAs or other waivers
- Allows States to receive Federal match for activities not otherwise considered medical assistance
- Many more states over the past decade using these waivers to expand coverage and care
- CMS has offered templates/instruction for certain groups – people with SUD, inmate re-entry, SMI/SED

Dually Eligible Beneficiaries

- About 17 percent of all Medicare beneficiaries have Medicaid, too
- Some are older with limited resources, others are younger and disabled – the two paths to Medicaid
- About 87 percent have income < $20K/year
- Nearly half are people of color
- More than one live in a nursing home or other institutional facility
- These people are in worse health, have more chronic conditions, and experience more mental health issues including dementia

Medicaid - Improving Transitions from Jails/Prisons to Communities

- The **SUPPORT Act** requires HHS to:
  - **Convene a stakeholder group** for input regarding health care transitions for individuals leaving jails and prisons
  - **Submit a Report to Congress** on best practices for ensuring continuity of health care coverage (Jan 2023)
  - **Release CMS guidance** to announce a section 1115 demonstration:
    - **State Medicaid Director Letter #23-003**: "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated"
- **CA Reentry Demonstration Initiative** - amendment to Sec. 1115 Demo (Jan 2023)

A searchable state waiver list can be found here: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html

Medicaid - SUD Section 1115 Demonstration Initiative

- **State Medicaid Director Letter #17-003**: "Strategies to Address the Opioid Epidemic"

- **Demonstration Milestones** – focused on improving following key elements of a SUD service delivery system:

1. Access to critical levels of care;
2. Evidence-based, SUD-specific patient placement criteria;
3. SUD-specific program standards for residential treatment;
4. Sufficient provider capacity at critical levels of care, including medication assisted treatment;
5. Comprehensive opioid prevention and treatment strategies; and
6. Improved care coordination and care transitions.

Medicaid - SUD Section 1115 Demonstration Initiative Impact

- **35 States Approved**:

  AK, CA, CO, CT, DC, DE, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MT, NC, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, UT, VA, VT, WA, WI, WV

- **5 States Pending**:

  AZ, MA, MO, NY, WA

- **Implementation:**

  - States submit implementation plans demonstration addressing milestones. Once approved, federal Medicaid match for services in specialty inpatient and residential treatment settings becomes available
  - Monitoring Protocol and Metrics and Reporting Requirements
  - Recent Findings from Rapid-Cycle Reports are posted online

Medicaid - Mobile Crisis Team Funding

- The **American Rescue Plan Act** authorized increased Medicaid support for community-based mobile crisis services
    - **85% federal match for expenditures on qualifying services for 12 fiscal quarters** (April 1, 2022 through March 31, 2027)
    - **$15 million in planning grants** awarded to 20 states in September 2021*
- **State Health Official Letter #21-008**: "Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services"
  – Including how to implement mobile crisis intervention services to qualify for the increased federal match

*The mobile crisis grantee states are AL, CA, CO, DE, KY, MA, MD, ME, MO, MT, NC, NM, NV, OK, OR, PA, UT, VT, WI, & WV.

Payment for Psychotherapy Services

- CMS implemented new codes under the PFS for psychotherapy for crisis services furnished on or after January 1, 2024 anywhere the non-facility rate for psychotherapy for crisis services applies (other than the office setting), including the home or a mobile unit.
- The Agency also finalized our proposal to apply an adjustment to the work RVUs for psychotherapy codes payable under the PFS, which will be implemented over a four-year transition.
- The adjustment will be applied to psychotherapy codes billed with an E/M visit and to the HBAI codes to address distortions in valuing time-based behavioral health services.

Marriage & Family Therapists (MFTs) & Mental Health Counselors (MHCs)

- CMS finalized a proposal to provide Medicare Part B coverage and payment under the Physician Fee Schedule for services billed by marriage and family therapists (MFTs) and mental health counselors (MHCs).
- The Agency also finalized a proposal to allow addiction counselors or drug and alcohol counselors who meet requirements to enroll in Medicare as MHCs.
- And CMS made changes to the Behavioral Health Integration codes to allow MFTs and MHCs to bill for these services.
- CMS also allowed Health Behavior Assessment and Intervention (HBAI) services to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists.

Community Health Integration (CHI)

- Community Health Integration services are to address unmet SDOH needs that affect the diagnosis and treatment of the Medicare patient's medical issues.
- Billing for these codes occurs in 60 + 30 minute increments.