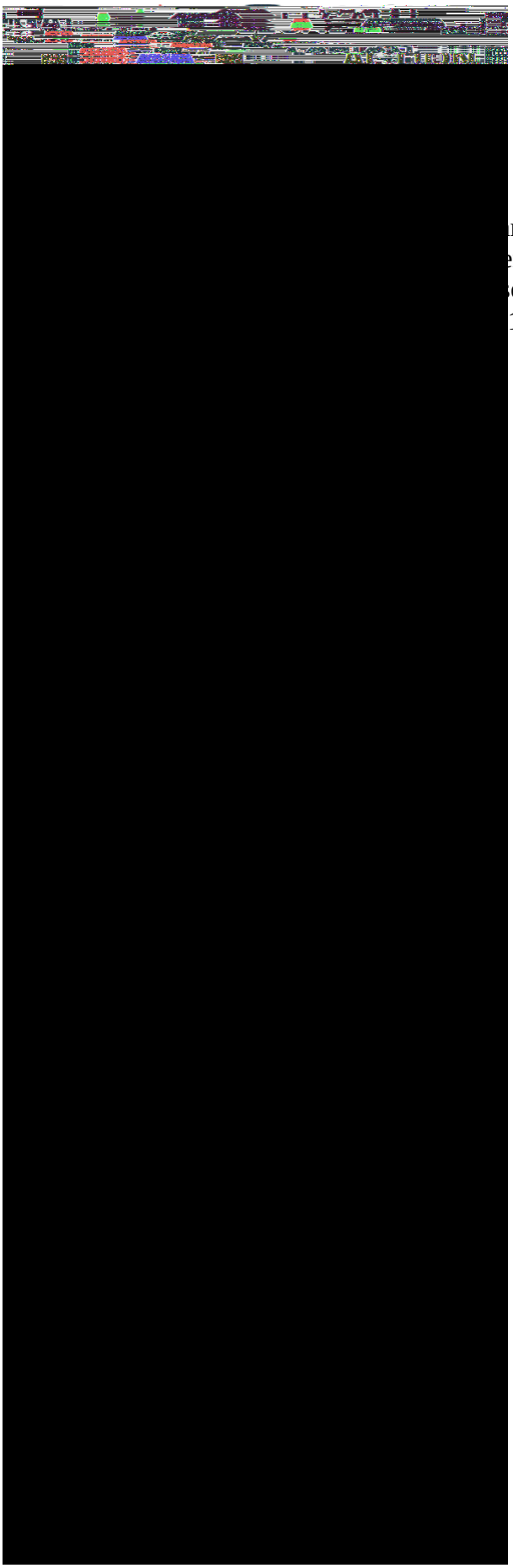

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psychiatric diagnoses are excluded from general hospital surveys (HCAHPS) and there are no patient experience measures for psychiatric hospitals quality review (IPFQR), despite evidence attesting to inpatient psychiatric patients' ability to evaluate their experiences of care and the opportunity to capture nuanced information on patient safety and quality of care.[1] Such data should also be used to revise payment rates.

- Require the Secretary to gather data on patient lengths of stay as well as the number and percentage of patients who hit the 190-day lifetime limit on inpatient psychiatric care.
- Require the Secretary to collect data on the co-morbidities of patients with mental health and substance use disorder diagnoses in the proposed 42 U.S.C. 1395ww(s)(4)(E)(ii)(IV), given the significantly high rate of these co-morbid conditions.[2]
- Amend the proposed 42 U.S.C. 1395ww(s)(5)(B)(iii) to use the correct terminology for substance use disorder treatment and reflect the most current evidence-based treatment. Instead of "detoxification services for substance abuse," we encourage the Committee to use "withdrawal management for substance use disorder and initiation of treatment, including medication for opioid use disorder."

Section 2. Ensuring Adequate Coverage of Outpatient Mental Health Services Under the Medicare Program

LAC also supports the Committee's proposal to amend the definition of partial hospitalization (PHP) services to establish coverage of intensive outpatient (IOP) services under Medicare. We are especially appreciative that coverage of IOP is not dependent on a physician certifying that the patient would otherwise need inpatient treatment. We also commend the Committee for

settings as well as FQHCs and RHCs, to align with the proposed IOP definition and to promote greater continuity of care.

- Remove the requirement that the treating physician must determine the need for both IOP and PHP not less frequently than monthly. Such a requirement is inconsistent with other Part B benefits, and the "not less frequently" may give Medicare Administrative Contractors (MACs) and Medicare Advantage (MA) plans too much latitude to require authorization even more frequently. We believe this type of authorization requirement will deter practitioners from offering IOP based on the burdensome administrative requirement.

B. Committee Print 117-2. Improvements to the Medicare Program Related to Physician Services and Education

Section 1. Coverage of Marriage and Family Therapists and Mental Health Counselor Services

Section 2. Provider Outreach and Reporting on Certain Behavioral Health Integration Services

LAC supports the Committee's proposal to require the Department of Health and Human Services (HHS) to conduct outreach to providers on general behavioral health integration and submit reports to Congress. As a technical amendment, we note that the identified codes are "CPT" codes, not HCPCS. We further encourage the Committee to:

- Make such outreach ongoing, rather than the proposed "one-time" education initiative.
- Expand such outreach and education to include the office-based bundled payments under the Physician Fee Schedule for SUD treatment (G2086-G2088)

Section 3. Outreach and Reporting on Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs

LAC supports the Committee's proposal to require HHS to conduct outreach to providers and beneficiaries on billing and eligibility for OTP services and submit reports to Congress. We further encourage the Committee to:

- Make such outreach ongoing, rather than the proposed "one-time" education initiative.
- Expand such outreach and education extend to all practitioners who can deliver opioid and other SUD treatment services, rather than the limited focus on OTPs. Fewer than 1 in 5 of the 1.1 million Medicare beneficiaries with an opioid use disorder (OUD) received medications for OUD, though the vast majority (73%) received medication from office-based settings rather than OTPs.[5] As such, there is a dire need to expand outreach and education both to OTPs and office-based settings to ensure that all Medicare beneficiaries can access this evidence-based care.

Section 4. Exception for Physician Wellness Programs

LAC supports the Committee's proposal to authorize physician wellness programs as a permissible compensation arrangement under Medicare. During the ongoing MH and SUD workforce shortage and at a time when burnout is so high, it is vital that all practitioners – not just physicians – have access to counseling, MH services, or SUD prevention and treatment for the purpose of preventing suicide, improving MH and resiliency, or providing training in appropriate strategies to promote the MH and resiliency of such practitioners.

Section 5. Review of Safe Harbor Under the Anti-Kickback

benefits. We especially appreciate the joint focus of the report to Congress on coverage of both MH and SUD crisis services, the attention to barriers to crisis services, and the attention to unexpected billing issues.

D. Committee Print 117-5. Improved Information for Network Coverage and Plan Documents in Private Insurance Plans

Section 1. Requiring Disclosure of Percentage of In-Network Participation for Certain Provider Types

LAC supports the Committee's proposal to require group health plans and health insurance issuers to make available information about the number and percentage of in-network providers for behavioral health providers and facilities and SUD providers and facilities. We further