RCPA
REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

September 14, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
Submitted via regulations.gov

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS-1848-P; RIN 0938-AV82)

On behalf of The Rehabilitation and Community Providers Association of Pennsylvania (RCPA), we thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule addressing the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) and other Part B payment and coverage policies (the Proposed Rule).

RCPA represents community-based providers across Pennsylvania that deliver services to older adults, individuals with disabilities, individuals with behavioral health needs, and other vulnerable populations. Our members employ thousands of direct care workers, direct support professionals, nurses, therapists, counselors, and other frontline staff who are essential to maintaining access to care throughout the Commonwealth.

RCPA appreciates CMS' efforts to improve beneficiary access to high-quality behavioral health care, promote efficient and accountable care delivery, reduce unnecessary downstream Medicare spending, and support payment policies that reflect the resources required to furnish clinically appropriate services. Medicare beneficiaries—particularly older adults, people with disabilities, and individuals dually eligible for Medicare and Medicaid—need timely access to the full continuum of mental health and substance use disorder (SUD) services. Yet community behavioral health organizations continue to face workforce shortages, rising labor and technology costs, administrative complexity, and payment methodologies that do not fully reflect the resources required to deliver coordinated, evidence-based care. Addressing these challenges can help preserve beneficiary access, reduce preventable hospitalizations and emergency department utilization, and support prudent stewardship of Medicare resources.

RCPA's principal recommendations are that CMS: (1) ensure adequate valuation of behavioral health services; (2) expand and appropriately value SUD treatment; screening, brief intervention, and referral to treatment (SBIRT); opioid treatment program (OTP) services; and recovery-oriented care; (3) strengthen intensive outpatient programs (IOPs); crisis, safety planning, and post-discharge services; (4) advance bidirectional integration and team-based care; (5) preserve clinically appropriate telehealth access; (6) establish appropriate safeguards for digital mental health treatment; (7) protect access to rural health clinics (RHCs), federally qualified health centers (FQHCs), certified community behavioral health centers (CCBHCs), community mental health centers (CMHCs), and other organizational providers; and (8) align preventive-service, quality-measure, and accountable care organization (ACO) policies with meaningful access to treatment and manageable administrative burdens.

RCPA also supports CMS' ongoing efforts to strengthen Medicare program integrity and reduce fraud, waste, and abuse. Policies intended to improve program integrity should be evidence-based, targeted, and implemented in a manner that protects beneficiary access to medically necessary behavioral health services. Legitimate providers should not face unnecessary administrative barriers that divert resources away from patient care.

RCPA presents its comments by relevant topic below.

I. PFS Rate Setting, Conversion Factors, and Determination of Practice Expense Relative Value Units

CMS proposal. CMS proposes CY 2027 PFS conversion factors of approximately $33.17 for qualifying alternative payment model participants and $32.84 for other practitioners. CMS also proposes to continue revising the practice expense methodology using more objective, routinely updated, and auditable cost information.

We urge CMS to ensure that CY 2027 rate-setting reflects the actual costs of furnishing behavioral health services. Labor is the principal input for outpatient mental health and SUD care, and staffing costs have increased materially as providers compete for psychiatrists, psychologists, clinical social workers, professional counselors, marriage and family therapists, addiction professionals, nurses, peer specialists, care managers, and other essential personnel. Payment policy should recognize the time required for assessment, engagement, care planning, family involvement, safety planning, documentation, interdisciplinary consultation, and coordination with medical and social-service providers. While we understand that CMS' current authority is limited to reform the PFS, we urge it to continuously assess how any payment policy changes could affect the financial viability of behavioral health providers and continued access to these essential providers, especially considering the year-over-year payment reductions PFS-paid clinicians have faced.

II. Valuation of Specific Codes: SUD Treatment, SBIRT, and Recovery-Oriented Care

CMS proposal. In the specific-code valuation section, CMS proposes CY 2027 work, practice expense, and malpractice values for new and revised services and solicits comment on whether those values accurately reflect the resources required to furnish each service. The comments below address annual alcohol misuse screening and brief counseling (Healthcare Common Procedure Coding System (HCPCS) codes G0442 and G0443), annual depression screening (HCPCS code G0444), SBIRT, and other behavioral health and SUD services identified in the Proposed Rule.

RCPA supports Medicare policies that identify SUD earlier and connect beneficiaries to evidence-based treatment. CMS should ensure adequate payment for SBIRT, including services furnished by qualified members of interdisciplinary teams within their lawful scopes of practice. Code descriptors, supervision rules, and documentation standards should reflect how SBIRT is delivered in community settings and should not create barriers that make screening financially or operationally infeasible.

CMS should also recognize that SUD treatment is longitudinal and recovery-oriented. Payment should support medication management, counseling, peer and recovery supports where Medicare authority permits, care coordination, overdose-risk assessment, naloxone education, transitions from hospitals and other institutions, and engagement following missed visits. Our members urge CMS to avoid narrow billing constructs that fragment care or exclude the qualified workforce necessary to reach beneficiaries in underserved communities.

Annual alcohol misuse and depression screening. CMS should maintain adequate valuation for HCPCS codes G0442 (alcohol misuse screening services), G0443 (alcohol misuse counseling services), and G0444 (annual depression screening services), including the clinical labor needed to administer validated tools, clarify responses, document results, assess immediate risk, and arrange meaningful follow-up. Payment for the screening and counseling services should remain separately identifiable from a same-day annual wellness or evaluation and management visit when the applicable coding requirements are satisfied. CMS should also permit billing in CCBHCs, CMHCs, OTPs, and other community behavioral health settings when the billing practitioner and supporting staff satisfy applicable requirements; access should not depend on whether the beneficiary receives the service in a traditional primary care office.

Code-specific valuation recommendations. For G0442, CMS should include sufficient clinical labor to administer and score the screening instrument, clarify responses, identify urgent risk, and document the result. For G0443, the valuation should reflect a full brief counseling intervention, motivational interviewing, treatment-readiness assessment, referral, and facilitated connection to treatment rather than counseling alone. For G0444, payment should include administration and scoring of a standardized instrument, suicide-risk triage when indicated, communication of results, and documented follow-up planning. CMS also should confirm that these services may be reported on the same date as an annual wellness visit or other medically necessary service when the work is distinct and all coding requirements are met, and should avoid frequency, place-of-service, or supervision rules that impede use in community behavioral health settings.

III. Payment for Medicare Part B Services: Intensive Outpatient and Crisis-Continuum Services

CMS proposal. CMS proposes CY 2027 updates to the coding, service-counting, and payment rules governing IOP services furnished in eligible settings. These policies determine which services count toward a program day and how Medicare pays for days involving three services and days involving four or more services.

RCPA supports a robust Medicare behavioral health continuum between routine outpatient treatment and inpatient hospitalization. IOP services are a critical component of that continuum. CMS should ensure that eligibility, service-counting, coding, and payment policies permit community behavioral health organizations to furnish clinically coherent programs that address both mental health and SUD needs.

CMS should maintain distinct, adequate payment for IOP days involving three services and days involving four or more services and should define countable services clearly. The rules should permit clinically appropriate combinations of individual therapy, group therapy, family services, psychiatric and medication services, peer support, care coordination, crisis planning, and transition services on the same day without arbitrary exclusions. Payment policy also should promote parity across CMHCs, RHCs, FQHCs, hospital outpatient departments, and any additional eligible community behavioral health settings, while recognizing legitimate setting-specific costs.

IOP code and rate specificity. In evaluating the IOP per-diem HCPCS codes for three-service days and days involving four or more services, CMS should publish the assumed service mix, discipline, time, and direct-cost inputs supporting each proposed rate. Countable services should expressly include individual, group, and family psychotherapy; psychoeducation; medication management; occupational therapy; peer and recovery support; care coordination; and discharge or transition planning when these services satisfy program requirements. CMS should clarify whether separately payable professional services remain reportable when they are outside the per-diem service package, prevent duplicate payment through clear edits rather than broad exclusions, and provide claim examples for mixed mental health and SUD programs, same-day medication services, and transitions between IOP, routine outpatient treatment, crisis care, and OTP services.

Safety planning and post-discharge follow-up. CMS should preserve and strengthen separate payment under the applicable CY 2027 HCPCS codes for suicide safety planning and post-discharge follow-up after a behavioral health or other crisis encounter. CMS should establish an additional 15-minute unit for safety planning when the beneficiary's needs require more than the base service. The follow-up code should permit the clinically appropriate number and timing of contacts during the post-discharge month, beginning as soon as practicable after discharge. CMS should distinguish completed interactive contacts from documented good-faith outreach attempts and provide partial or separate payment for unsuccessful attempts that consume staff resources. Eligible settings should include CCBHCs, CMHCs, mobile crisis programs, urgent-care and receiving centers, 23-hour observation units, crisis stabilization units, crisis residential programs, and other qualified crisis providers. Follow-up should allow telephone, text, secure

messaging, or another beneficiary-preferred modality, and CMS should minimize beneficiary cost-sharing to the extent permitted by law.

Code-specific crisis intervention recommendations. For HCPCS code G0560 (safety planning interventions), CMS should value the base safety-planning service to include review of warning signs, internal coping strategies, social supports, professional and crisis contacts, lethal-means safety, individualized documentation, and communication with caregivers when authorized. CMS should also establish an add-on unit when medically necessary work exceeds the base time. For HCPCS code G0544 (post-discharge telephonic follow-up), CMS should clarify the applicable episode, frequency, timing, modalities, and documentation; permit multiple clinically necessary contacts during the post-discharge period; and distinguish a completed interactive follow-up from a documented good-faith outreach attempt. CMS should confirm whether these codes are separately payable with evaluation and management, psychotherapy, crisis, care-management, and IOP services when the work is distinct, and should publish examples addressing discharge from emergency departments, inpatient psychiatric facilities, crisis stabilization settings, and SUD treatment programs.

IV. Care Management Services and Behavioral Health Integration: Behavioral Health Integration (BHI) and Advanced Primary Care Management (APCM)

CMS proposal. CMS proposes changes to care management and longitudinal care payment, including policies affecting APCM, BHI, and related team-based services. CMS also seeks stakeholder input on the future design of primary care payment and the role of coordinated, technology-enabled, and accountable care arrangements.

We support CMS' efforts to strengthen BHI, collaborative care, and APCM. These policies should promote bidirectional integration: behavioral health in primary care and physical health services in specialty behavioral health settings. People with serious mental illness and SUD experience high rates of chronic physical illness, and community behavioral health organizations—including CCBHCs—already screen, monitor, coordinate, and partner with medical providers to address whole-person needs.

CMS should permit flexible team composition, recognize behavioral health organizations as integration hubs, and avoid requirements that effectively reserve integrated-care payment for practices that bill a primary care base code. Payment should account for registry functions, validated measurement tools, case review, psychiatric consultation, outreach, care-plan revision, information exchange, and coordination with external practitioners. CMS should also clarify concurrent billing and attribution rules so that beneficiaries may receive complementary integrated services without duplicative payment or disruption of established therapeutic relationships.

APCM, psychiatric collaborative care model (CoCM), and BHI. CMS should expressly permit separate billing for clinically distinct BHI, CoCM, health and behavior assessment and intervention, and interprofessional consultation services furnished to beneficiaries attributed to an APCM practice. This clarification should expressly address BHI services including Current Procedural Terminology (CPT) codes 99492, 99493, 99494, and 99484 and HCPCS code G0323. APCM requirements should include validated depression screening and documented follow-up after a positive screen, including referral and navigation to an available in-network behavioral health provider. CMS should avoid reductions in CoCM and BHI practice expense values; and maintain payment at 100 percent of the applicable PFS amount when services are furnished by an appropriately qualified nonphysician practitioner.

Code-level BHI and CoCM valuation. For CPT codes 99492 and 99493, CMS should retain work and practice-expense inputs that reflect registry maintenance, structured outcome measurement, weekly case review, psychiatric consultation, outreach, care-plan revision, and communication with treating clinicians. CPT code 99494 should remain available for each additional 30 minutes and should not be constrained by an arbitrary monthly unit limit when documented medical necessity supports additional time. For CPT code

99484 and HCPCS code G0323, CMS should account for clinical staff time, supervision, validated assessment tools, care-plan maintenance, and coordination with external behavioral health practitioners. Any APCM add-on or replacement coding should preserve payment distinctions among general BHI, psychiatric CoCM, and more limited care-management functions rather than collapsing services with materially different staffing and intensity.

Moreover, CMS' proposal is understood to blend codes 99213 and 99214. CMS should instead blend codes 99214 and 99215, considering the complexity of multi-disciplinary teams and the investments made by CoCM practices in measurement-informed care and patient registries. CMS should also specify that Collaborative Care is eligible for the new complexity modifiers being developed for evaluation and management codes. This would further encourage ACO participation and support investment in embedding Collaborative Care within core population health activities as primary care physicians coordinate care for patients with complex, longitudinal needs.

Interprofessional consultation. CMS should continue to support consultation among clinical psychologists, clinical social workers, marriage and family therapists, mental health counselors, addiction professionals, physicians, and other qualified practitioners. Consent requirements should be stated in plain language and should not duplicate consent already obtained within an established treatment or referral relationship. CMS should clarify Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR part 2 coordination, concurrent billing, and documentation, and the agency should examine whether separate beneficiary cost-sharing for both the requesting and consulting practitioners suppresses clinically appropriate use.

Caregiver training. CMS should preserve payment for individual as well as group caregiver behavior-management and modification training and should permit telehealth delivery when clinically appropriate. Requirements should accommodate caregivers supporting beneficiaries with serious mental illness, cognitive impairment, co-occurring conditions, and functional limitations, while relying on a beneficiary-centered plan of care and straightforward consent and documentation standards.

Community health integration (CHI), principal illness navigation (PIN), peer support, and health-related social needs services. CMS should clarify eligible personnel, supervision, concurrent billing, and payment for CHI (HCPCS codes G0019 and G0022), PIN (G0023 and G0024), PIN peer support (G0140 and G0146), and health-related social needs risk assessment (G0136). Eligible auxiliary personnel and training standards should align with comparable Medicaid community support and case management requirements. Appropriately trained peer specialists should be permitted to furnish and, where lawful, supervise peer support services, and payment should sustain the peer workforce. G0136 should be separately payable when clinically indicated outside an annual wellness visit, and Medicare should pay for navigation and follow-up after a need is identified. CMS should provide technical assistance and clarify how CHI, PIN, PIN peer support, APCM, and BHI may be billed without unnecessary overlap restrictions.

Code-level CHI, PIN, peer, and social-needs recommendations. For G0019 and G0022, CMS should recognize the initial and additional time required to address barriers that interfere with diagnosis or treatment and should permit reporting with behavioral health services when the navigation work is distinct. For G0023 and G0024, valuation should reflect longitudinal navigation for beneficiaries with serious, high-risk conditions, including outreach, referral completion, information exchange, and coordination across medical, behavioral health, and social-service systems. For G0140 and G0146, CMS should expressly recognize appropriately trained peer specialists as auxiliary personnel and ensure that payment supports wages, supervision, training, documentation, and nonbillable engagement time. For G0136, CMS should preserve separate payment when reassessment is clinically indicated, clarify frequency and same-day billing rules, and pair risk assessment with payable navigation or follow-up rather than treating screening as an endpoint.

V. Medicare Telehealth Services and Other Services Involving Communications Technology

CMS proposal. CMS proposes to implement statutory Medicare telehealth flexibilities through the end of 2027, add five services to the Medicare Telehealth Services List, establish informational modifiers BB and BC for certain third-party platform and incident-to arrangements, increase the originating-site facility fee to $32.65, and revise selected virtual presence and communications technology policies.

RCPA supports adding clinically appropriate behavioral health services to the Medicare Telehealth Services List and the proposed originating-site facility fee increase. CMS should clarify that modifiers BB and BC are informational, do not create new substantive and burdensome conditions of payment, and will not be used to impose inappropriate liability on practitioners for third-party platform conduct outside their control. CMS should also clarify the interaction of those modifiers with incident-to billing, supervision, reassignment, platform fees, beneficiary consent, data use, and record access.

Telehealth remains essential for beneficiaries facing transportation barriers, mobility limitations, clinician shortages, stigma, or long travel distance, especially in Pennsylvania. and urge CMS to preserve broad access to clinically appropriate mental health and SUD services through interactive telecommunications technology, including audio-only services when video is unavailable or unsuitable. Modality should be selected through patient-practitioner clinical judgment, informed by safety, privacy, accessibility, and beneficiary preference.

CMS should use all available authority to minimize the disruptive effects of in-person prerequisites and should issue clear operational guidance concerning established telehealth patients, co-occurring mental health and SUD diagnoses, practitioner changes within the same organization, documentation of exceptions, and application to CCBHCs, FQHCs, RHCs, community mental health centers, and other community behavioral health clinics. Any change should include a transition with sufficient implementation time, beneficiary notice, and billing guidance.

Statutory and regulatory authority. RCPA has recognized and advocated for a permanent nationwide originating-site flexibility and certain in-person-visit requirements are governed by statute. CMS should exercise all available administrative authority to define exceptions, prevent unnecessary disruption, and implement statutory requirements flexibly. When legislation is necessary, CMS should support congressional action to preserve home-based telehealth access for mental health and SUD services.

Beneficiary's home. CMS should continue to interpret the beneficiary's "home" broadly for telehealth purposes to include a homeless shelter, group home, supportive housing, temporary residence, or other setting the beneficiary identifies as home. A beneficiary should not lose access to home-based telehealth merely because the residence is congregate, transitional, or nontraditional.

VI. Digital Mental Health Treatment and Other Technology-Enabled Services

CMS proposal. CMS proposes CY 2027 changes affecting digital mental health treatment, remote physiologic monitoring, remote therapeutic monitoring, initiating visits, staffing, and certain software-based services under the PFS. The Proposed Rule addresses coding, valuation, practitioner responsibility, and the role of technology companies in Medicare-covered care.

As CMS considers expanded use of technology-enabled services, the agency should ensure that payment policies appropriately distinguish legitimate clinical care from technology-only arrangements that lack sufficient practitioner accountability. Clear standards regarding clinical oversight, data security, patient consent, and beneficiary protections will promote innovation while safeguarding program integrity.

We support careful expansion of evidence-based digital mental health treatment when technology supplements—not supplants—access to qualified clinicians and in-person care. Coverage and payment should be tied to clinically meaningful evidence; clear identification of the practitioner responsible for treatment; patient consent; accessible design; interoperability; and transparent information regarding data collection, secondary use, retention, and disclosure.

Coverage should be limited to products that satisfy the applicable Food and Drug Administration (FDA) status and Medicare benefit requirements and should identify the practitioner responsible for diagnosis, ordering, treatment planning, monitoring, and adverse-event response. CMS should distinguish payment for device supply and onboarding from monthly treatment management; clarify whether payment is available when the practitioner incurs no acquisition cost or the beneficiary obtains the product independently; specify any minimum interactive communication and frequency requirements; and address concurrent billing with remote therapeutic monitoring and other care-management codes. Payment must recognize practitioner and staff time, acquisition and licensing costs, data review, onboarding, and treatment adjustment. Vendors should provide clinicians with timely access to patient-level data, transparent terms governing secondary use and retention, interoperability, performance information, and contract terms that do not shift unreasonable compliance or cybersecurity risk to clinicians.

RTM initiating visit, established-patient, and staffing requirements. CMS should not require a separate initiating visit when the monitoring service is ordered during another qualifying in-person or telehealth encounter or when the billing practitioner already has an established treatment relationship and sufficient clinical information. Nor should CMS categorically limit RTM to established patients if an appropriate initiating assessment establishes medical necessity, a treatment plan, and clinical accountability. Clinical staff who furnish RTM under general supervision should not be required to be direct employees of the billing practitioner or practice. Restricting use of contracted employees will limit access to RTM as practices lack the in-house economies of scale to properly manage RTM, thereby limiting use of an important intervention for behavioral health. Instead, contracted personnel should remain permissible when the billing practitioner retains supervisory responsibility, access to the data and medical record, responsibility for treatment decisions, and compliance oversight. CMS should publish behavioral-health-specific billing examples addressing RTM furnished with psychotherapy, evaluation and management, BHI, CoCM, APCM, and digital mental health treatment.

VII. Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Other Part B Policies: Administrative Simplicity and Organizational Provider Participation

CMS proposal. CMS proposes updates to payment and telehealth policies for RHCs and FQHCs, together with other Part B operational and enrollment changes. The proposals affect how organizational providers implement team-based services, report claims, and coordinate professional and facility payment requirements.

Community behavioral health care is inherently team-based. CMS should align enrollment, supervision, incident-to, place-of-service, claims, and documentation policies so that they accommodate organizational providers and interdisciplinary teams while preserving accountability. New policies should be tested for their effects on small and rural practices, safety-net organizations, and providers serving beneficiaries dually eligible for Medicare and Medicaid. CMS should publish examples, billing scenarios, and sub-regulatory guidance before implementation and should allow a reasonable period of education and claims-system testing.

RCPA supports the establishment of a sustainable Medicare pathway for CCBHCs and other state-certified community behavioral health organizations. Federal enrollment, certification, and payment policies should align with existing federal CCBHC criteria and state certification processes, avoid duplicative structures, and recognize the comprehensive nature of these models, including crisis response,

care coordination, peer and family supports, physical health screening and monitoring, and population-based quality improvement.

Medicare recognition and payment for CCBHCs. CMS should evaluate options to establish a sustainable Medicare pathway for CCBHCs that leverages existing state and federal certification processes, minimizes administrative duplication, and promotes accountability and quality. While developing a new provider type or benefit may require legislation; CMS should identify the necessary statutory changes and support congressional action. In the interim, CMS should use existing PFS, CMHC, RHC, FQHC, OTP, and other authorities to clarify how CCBHCs may enroll and bill for covered services without adopting inconsistent provider identities. CMS should coordinate with the Substance Abuse and Mental Health Services Administration (SAMHSA) and state certification agencies, rely on existing federal and state certification, recognize services furnished directly and through designated collaborating organizations, and avoid duplicative conditions of participation.

Modernization of CMHC conditions of participation. CMS should review and modernize the Medicare CMHC conditions of participation so that they reflect contemporary evidence-based behavioral health practice, parity principles, integrated care, team-based service delivery, and the operational realities of IOP and crisis care. Requirements that are outdated, duplicative, or unrelated to quality should not impede beneficiary access, and CMS should not import existing CMHC requirements wholesale into any future Medicare CCBHC framework.

RHC and FQHC protections. CMS should preserve telehealth flexibilities, including reasonable treatment of in-person requirements, and maintain IOP payment for days involving four or more covered services. Certification and payment policies should permit rural clinics and health centers to furnish integrated behavioral health and specialty services without jeopardizing their status. CMS should also ensure that regulatory terminology expressly encompasses mental health and SUD services and avoids outdated or stigmatizing language.

VIII. Medicare Coverage and Payment for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs

CMS proposal. CMS proposes CY 2027 updates to Medicare coverage and payment for opioid use disorder (OUD) treatment services furnished by OTPs, including updates to the bundled payment methodology and applicable HCPCS coding, use of telecommunications technology, intake and periodic assessments, and coordination with health care and community services. CMS also solicits comments regarding the adequacy of payment for particular OUD services, including whether it should consider updates to the rates for HCPCS codes G2086 through G2088 and whether additional coding is needed to describe the American Society of Addiction Medicine (ASAM) Level of Care 1.7.

Bundled payment rates. RCPA urges CMS to ensure that each OTP bundle—HCPCS codes G2067 through G2075, as applicable—covers the full cost of furnishing the medication and non-drug services included in the code descriptor. CMS should separately review the drug and non-drug components and use current, transparent data on medication acquisition, pharmacy and dispensing operations, clinician and counselor compensation, toxicology testing, documentation, compliance, security, and facility costs to reflect a valuation of this service that appropriately meets the resource costs necessary to provide it. The non-drug component should not be held constant across materially different clinical models unless CMS demonstrates that the resource inputs are comparable. Where facility, security, and operational costs differ materially by setting—including between OTPs, office-based practices, and mobile medication ted in the base bundle and should not require OTPs to choose among clinically necessary treatment functions furnished during the same episode of care.

Adequacy of code-specific payment. CMS should evaluate the adequacy of each applicable HCPCS rate rather than relying solely on an aggregate update. For G2067, G2068, G2069, G2070, G2071, G2072,

G2073, and G2075, CMS should confirm that the drug component reflects current acquisition and handling costs for the medication and formulation described by each code and that the non-drug component supports counseling, individual and group therapy, toxicology testing, and medication administration or dispensing. For G2074, which excludes the drug, CMS should ensure that payment fully supports the non-drug clinical services and overhead required during the weekly episode. CMS should likewise evaluate payment for intake, periodic assessment, additional counseling or therapy, take-home medication, overdose-reversal medication, peer recovery support, navigation, care coordination, and IOP-related add-on codes, with particular attention to clinician time, staffing mix, service intensity, and the costs of furnishing services in rural and safety-net settings. In the final rule, CMS should publish the utilization assumptions and resource inputs supporting each rate and provide a mechanism for providers to submit current cost data when a proposed amount does not reflect actual resource costs.

HCPCS coding for ASAM Level of Care 1.7. RCPA is in agreement with CMS' proposal regarding HCPCS codes G2086 through G2088 and the adequacy of existing coding to describe ASAM Level of Care 1.7. Level 1.7 occupies the space between routine outpatient treatment and higher-intensity outpatient care, and it requires a structured, coordinated service array, including regular clinical contact, care coordination, and monitoring, that exceeds what routine outpatient billing reflects. The existing G2086 through G2088 family was designed principally around office-based management of OUD with an initial month and subsequent months of maintenance, and its service assumptions do not clearly correspond to the staffing, frequency, and coordination requirements of Level 1.7 as a defined level of care.

In support of our members, we recommend that CMS update the rates for G2086, G2087, and G2088 so that they reflect current clinician and clinical staff time, care coordination, toxicology testing, and the counseling components described in each code descriptor, as the existing values were established several years ago and have not been revisited against current resource costs. Additionally, if CMS concludes that the existing family can accommodate Level 1.7, it should state expressly which code or codes apply, explain how the service assumptions underlying each code map to the level-of-care requirements, and publish billing examples addressing same-month use with OTP weekly bundles, IOP services, and separately payable evaluation and management or psychotherapy services. Lastly, if CMS concludes the existing coding is insufficient, it should establish either a dedicated Level 1.7 code or a clearly defined add-on that identifies the level of care, specifies the covered service package and minimum program standards, permits appropriate medication and other separately payable services, and avoids overlap with existing OTP and IOP payment.

Any such coding should be available across eligible settings, including OTPs, office-based practices, and other qualified community behavioral health organizations, and payment should be based on the actual clinical labor, care coordination, peer and recovery support, toxicology testing, medication-related services, and administrative resources required to furnish the level of care. RCPA further urges CMS to address the relationship between Level 1.7 and adjacent levels of care in coding and claims guidance, so that programs can document and bill transitions as beneficiary needs change without gaps in coverage or duplicative payment.

IX. Medicare Part B Preventive Services

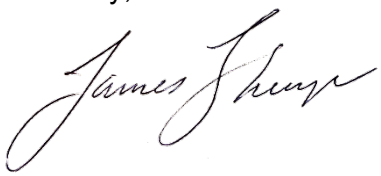
CMS proposal. CMS proposes updates to Part B preventive-service coverage and payment, including rules governing payment methodologies and beneficiary cost-sharing for covered preventive items and services.

RCPA supports broad access to evidence-based preventive services without beneficiary cost-sharing where authorized by law. Prevention is especially important for people with mental health and SUD conditions, who experience elevated rates of chronic physical illness and infectious disease. CMS should ensure that behavioral health organizations can furnish or coordinate preventive services within each

practitioner's scope of practice, that coverage includes necessary administration and counseling, and that payment and referral policies support completion of recommended follow-up care.

RCPA appreciates the opportunity to provide these comments. We welcome any questions about the recommendations described here; please feel free to contact RCPA COO and Director of Mental Health Services Jim Sharp. Thank you for your time and consideration.

Sincerely,



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