FARRAGUT
SQUARE GROUP

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Farragut's Five Things to Know About Behavioral Health

Farragut has been monitoring a number of regulatory and macro developments in the behavioral health space. Below, we break down five things to be aware of in the behavioral health sector from a government perspective:

1. Behavioral telehealth stands out to Farragut for its stability, as most Medicare telehealth flexibilities for the specialty are already permanent.

2. The DEA issued a final telemedicine rule for buprenorphine access and proposed rulemaking focused on telehealth treatment access and patient protections.

3. Farragut anticipates tailwinds for behavioral health under Medicare, driven by CMS support.

4. While most home and community based I/DD services fall under the 80/20 rule, due to their habilitative nature, the waiver falls outside of the regulation's purview.

5. Workforce shortages in behavioral health persist, but states are implementing programs to attract and retain professionals as demand for behavioral analysts and skilled workers grows.

Further Discussion:

1. Behavioral telehealth stands out to Farragut for its stability, as most Medicare telehealth flexibilities for the specialty are already permanent.

Several telehealth flexibilities for Medicare are operating on a temporary basis – with Congressional intervention necessary to continue beyond March. However, Congress has already extended and made permanent the flexibility for tele-behavioral health regardless of whether the patient is in a rural vs urban location or in their own home. So, while Medicare's geographic and originating site flexibility for behavioral health services is permanent, the extension of originating site flexibilities continues to operate under only temporary relief for non-behavioral telehealth services.

That said, there are other behavioral health flexibilities that will need to be renewed. Congress extended several COVID-19 pandemic Medicare telehealth flexibilities, originally set to expire on December 31, 2024, through March 31, 2025. The most recent extension delays the in-person visit requirement for behavioral and mental health services within six months of an initial Medicare telehealth visit, and annually thereafter, until March 31, 2025.

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Although short-term, *Farragut views this extension as a sign of bipartisan support for telehealth services and a step toward the permanent establishment of Medicare telehealth flexibilities for non-behavioral services.*

2. The DEA issued a final telemedicine rule for buprenorphine access and proposed rulemaking focused on telehealth treatment access and patient protections.

Most recently, in mid-January, the DEA announced final and proposed rules to make permanent some temporary telehealth flexibilities implemented during the public health emergency and to establish new patient protections. Notably, *the rule expands remote access to buprenorphine via telehealth, allowing patients to receive a 6-month supply without a prior in-person visit.* The effective date of the final rule was set for February 18; however, the agency has delayed implementation until March 21.

The DEA's announcement also includes a proposed rule to establish special registrations allowing patients to receive prescribed Schedule III-IV medications through telemedicine visits without an initial in-person visit. Additionally, the proposal expands the medical specialists authorized to issue Schedule II medications and introduces a new rule exempting VA practitioners from special registration requirements, allowing them to prescribe controlled substances through telemedicine following an in-person medical examination by a VA practitioner.

3. Farragut anticipates tailwinds for behavioral health under Medicare, driven by CMS support.

Generally, *behavioral health under Medicare benefits from stable support from Washington, D.C., and CMS.* At Farragut, we expect this trend to continue due to recent tailwinds we've tracked in the space, including the permanence of telehealth flexibilities for behavioral health, coverage expansions, and rate increases.

Telehealth saw a permanent extension of Medicare telehealth flexibilities for behavioral health, allowing Medicare beneficiaries to utilize telehealth services regardless of location (including in-home settings) and geography (urban vs rural). Additionally, Congress granted coverage expansions in CY 2024 to include Medicare coverage for marriage and family therapists and mental health counselors. Further, CMS has extended this definition to include addiction counselors. A second Medicare coverage expansion granted by Congress in CY 2024 applied to Intensive Outpatient Programs (IOPs) in hospitals, community mental health clinics, and Rural Health Clinics (RHCs). Lastly, from CY 2024 to CY 2027, the PFS continues to phase-in targeted rate increases for timed behavioral health services codes. The CY 2025 PFS also included increased rates for OTP intake activities and periodic assessments, accounting for the value of Social Determinants of Health risk assessments; new payment opportunities related to OUD care coordination, patient navigation, and peer recovery support; as well as separate payments for safety planning interventions and digital mental health treatment devices.

CMS has long advocated for integrating behavioral health and primary care. Early last year, the agency announced its Innovation in Behavioral Health model, a state-based initiative led by Medicaid agencies to integrate behavioral and physical health through community-based practices. CMS selected **Michigan, New York, Oklahoma,** and **South Carolina** to implement the eight-year model, starting January 1, 2025.

4. While most home and community based I/DD services fall under the 80/20 rule, due to their habilitative nature, the waiver falls outside of the regulation's purview.

Farragut has been closely monitoring CMS' 80/20 rule, which aims to raise direct care worker wages by passing 80% of Medicaid rates on to direct care workers for services such as homemakers, home health aides, and personal care workers. Although the timeline for implementation has been extended by CMS in the final rule to six years after the effective date (instead of four years), pushing it out until July 10, 2030, Farragut generally believes the rule is unlikely to be implemented due to the long timeline, the high likelihood of it being struck down in the courts, or potential congressional or regulatory intervention to "permanently delay" or rescind the provision.

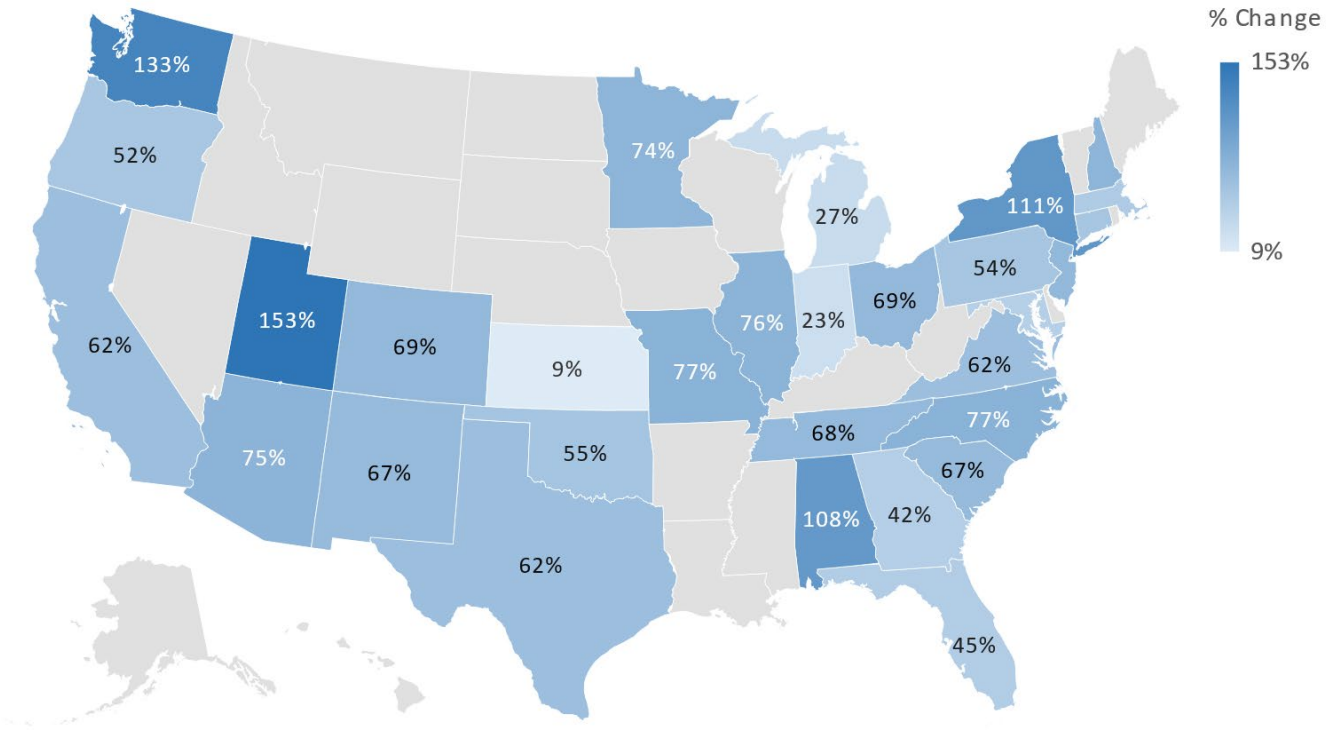
As a point of further stability for behavioral health operators providing I/DD services, **I/DD services are considered habilitative in nature and are therefore already excluded from the 80/20 rule**.

5. Workforce shortages in behavioral health persist, but states are implementing programs to attract and retain professionals as demand for behavioral analysts and skilled workers grows.

Nationwide workforce shortages continue to challenge the behavioral health field, albeit not with as much pressure as during the pandemic. Specifically, staffing shortages remain one of the biggest challenges in autism treatment and ABA therapy, as the demand for skilled professionals continues to outpace the supply.

From 2023 to 2024, the demand for behavioral analysts increased by 58%, with the highest demand in the following states: **California** (accounting for 19% of the increase), **Massachusetts, Texas, New Jersey,** and **Florida,** where demand rose by 45-70%. Meanwhile, **Utah, Washington, New York, Alabama, Missouri,** and **North Carolina** saw the largest percentage increases in demand, ranging from 77% to 153% from 2023 to 2024.

Demand for BCBA/BCBA-D Certification in the Top 30 States (2023–2024)



States are adopting initiatives to address staffing gaps and retain skilled professionals across the continuum of behavioral healthcare. Historically, loan repayment programs have been a successful strategy for addressing shortages. States such as **Michigan, Pennsylvania, Massachusetts**, and **Georgia** are leveraging substantial loan repayment programs and incentives to attract behavioral health professionals—including psychiatrists, psychologists, social workers, and counselors—to practice in underserved areas and communities with mental health service shortages. To boost retention, programs in other states offer up to four-year contracts to provide services to Medicaid recipients or in eligible settings, such as community health centers and inpatient psychiatric hospitals. For example, **Georgia** and **Massachusetts** offer loan repayment assistance ranging from $10,000 to $150,000 in Georgia and up to $300,000 in Massachusetts.

In addition, some states, including **Arizona**, **New Jersey**, and **Washington**, are taking a different approach by reducing the financial burden on students entering the behavioral health field. These states are investing in grants and scholarship programs to attract new professionals by making behavioral health degrees more accessible.

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