National Association for Behavioral Healthcare

Access. Care. Recovery.

31 August 2022

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically

Re: Request for Information Regarding Medicare Advantage Program

Dear Administrator Brooks-LaSure:

The National Association for Behavioral Healthcare (NABH) respectfully submits the following comments on the request for information on various aspects of the Medicare Advantage program that the Centers for Medicare and Medicaid Services (CMS) issued on Aug. 1, 2022.

NABH represents behavioral healthcare systems that provide mental health and addiction treatment services across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility-based outpatient programs, including medication assisted treatment (MAT) centers. Our membership includes behavioral healthcare providers in 49 states and Washington, D.C. We appreciate this opportunity to provide comments regarding how Medicare Advantage (MA) plans can increase the number of behavioral healthcare providers and facilities in their networks and improve access to mental health and addiction treatment.

The Covid-19 pandemic has highlighted and amplified the need for mental health and addiction treatment. Studies have consistently found significantly higher levels of anxiety and depression and suicidal ideation since 2020.[i, ii] In addition, alcohol consumption has increased significantly, [iii] and drug overdose deaths continue to accelerate, reaching about 100,000 deaths during the 12-month period ending in June 2021.[iv]

Suicide rates have remained high, with troubling increases among certain groups, including Black Americans and adolescent girls. [v] Moreover, experience with past epidemics indicates that the impact on behavioral health may continue for years to come.[vi] The number of people needing behavioral healthcare following the pandemic is predicted to increase by 50% compared with pre-pandemic levels.[vii]

Serious behavioral health conditions are highly prevalent among Medicare beneficiaries. Serious mental illness affects 23% of beneficiaries in traditional Medicare, and 12% of those in MA plans.[viii] Beneficiaries under 65 years old have high rates of serious mental illness (34%) in addition to the 26% who experience mild-to moderate mental illness.[ix] More than 50% of inpatient stays by Medicare beneficiaries under 65 were related to mental health or addiction in 2016 (not including state psychiatric hospitals).[x] Furthermore, more than 3.4 million individuals 65 and older reported having an alcohol or illicit drug disorder in 2020.[xi]

Unfortunately, Medicare beneficiaries do not have adequate access to mental health and addiction treatment. According to a CMS Data Brief, "…beneficiaries with depression, regardless of age, were more likely to report having trouble getting healthcare, obtaining prescription medicines, and not seeing doctors than those without depression."[xii] In addition, Medicare beneficiaries with depression regardless of age, were more likely to report that they have no usual source of care due to high cost."[xiii]

These difficulties accessing behavioral healthcare undoubtedly result from MA plans disproportionately

lacking in-network behavioral healthcare providers. A recent study found that MA networks included only 23% of psychiatrists in a county on average — lower than all other medical specialties.[xiv] Not surprisingly, MA enrollees with depressive symptoms report more difficulty accessing needed treatment and rated their experience with the MA plans as worse than in traditional Medicare.[xv]

The lack of behavioral healthcare providers' participation in MA plans results from a host of challenges. Below are some of the issues our members experience in trying to work with MA plans.

- There is limited oversight to ensure that MA plans meet minimum network adequacy requirements for inpatient or outpatient behavioral health services. Therefore, plans do not place a high priority on meeting the requirements for realistic patient access or treatment in an appropriate environment.

- Plans typically offer rates and fee schedules at or below traditional Medicare pricing parameters. Providers may be pressured into accepting sub-par pricing from plans based on the implication of plans' patient steerage or restricted access for altogether.

- Traditional Medicare pricing provides some financial accommodation to providers where patients are unable to meet the financial obligation of copayments and deductibles. MA plans do not make any such accommodation and are rarely willing to provide premium pricing to compensate.

- Plans intentionally restrict members' access to care at all levels. Under the guise of "managed care," plans deny members' access to services they may receive under traditional Medicare. Prior authorization requirements, utilization management, and peer review processes of plans are rarely consistent or comparable with processes under traditional Medicare.

- Plans typically do not follow Medicare Local Coverage Determinations that CMS has specified, and they often misinterpret level-of-care and/or medical necessity criteria as that the attending physician/clinician has attested. This results in limited access to care, restriction of necessary care, or excessive denials where appropriate care was provided.

- Billing and payment issues are commonplace with MA plans for in-network and out-of-network providers. There is limited-to-no oversight or accountability for accurate and timely claims payment, ultimately resulting in a reluctance to provide care or services to MA plan members.

- Specific to opioid treatment programs (OTPs), MA plans egregiously limit the use of OTPs through heavy-handed prior authorization, primary care referral requirements for OTP services, and co-pay requirements to access Opioid Use Disorder (OUD) treatment in an OTP. Many people with OUD who use OTP services do not have primary care physicians. These practices are becoming more widespread and are needlessly restricting access to lifesaving care. The use of co-pays disincentivizes this cash-poor treatment population for accessing services. Research shows that even the smallest number of co-pays will extinguish treatment-seeking behaviors. CMS must enforce network adequacy requirements for OTPs in MA provider networks and allow for any willing OTP provider to participate in-network to ensure convenient and timely access to care. Also, CMS should instruct plans to cover OTP services without prior authorization; remove primary care referral requirements; and eliminate copayments/coinsurance, just as it is in the traditional Part B benefit.

NABH is pleased to respond to your detailed requests for information on the specific issues below identified below.

A. Advance Health Equity

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes" (*https://www.cms.gov/pillar/health-equity*). The CMS Framework for Health Equity (*https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/framework-for-health-equity*) lays out how CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. We seek feedback regarding how we can enhance health equity for all enrollees through MA.

What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:

- **Enrollees from racial and ethnic minority groups.**
- **Enrollees who identify as lesbian, gay, bisexual, or another sexual orientation.**
- **Enrollees who identify as transgender, nonbinary, or another gender identity.**
- **Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life.**
- **Enrollees with diverse cultural or religious beliefs and practices.**
- **Enrollees of disadvantaged socioeconomic status.**
- **Enrollees with limited English proficiency or other communication needs.**

Response:

NABH recommends that CMS apply parity to MA plans along with requirements to use generally accepted standards of care for utilization management and stronger network adequacy rules.

Given the numerous indications that MA enrollees do not have adequate access to behavioral healthcare, we urge CMS to require MA plans to comply with the *Mental Health Parity and Addiction Equity Act* (MHPAEA) just as Medicaid managed care plans are required to do.[xvi]

CMS has already used its administrative authority to require that MA Special Needs Plans (SNPs) comply with parity. In the *Medicare Managed Care Manual,* CMS has specified that SNPs must provide "[p]arity(equity) between medical and mental health benefits and services."[xvii] We urge CMS to extend full parity requirements to all MA plans. This policy would be consistent with the prohibition on discrimination against beneficiaries included in the general MA regulations that specifically prohibits discrimination based on "medical condition, including mental as well as physical illness".[xviii]

Parity requirements for Medicare Advantage plans also should include the new parity documentation requirements enacted as part of the *Consolidated Appropriations Act, 2021*[xix] that CMS also extended to QHPs through a recent rulemaking.[xx]

Moreover, provisions applying MHPAEA requirements to MA plans should clarify that as a result, this coverage will no longer incorporate the 190-day lifetime limit. According to CMS staff, although Part C

plans may provide additional inpatient psychiatric care beyond the 190-day lifetime limit, only about 9% of plans offer a supplemental benefit of “inpatient psychiatric additional days”.

We also encourage Congress to direct CMS to use its authority regarding supplemental benefits[xxi] in the MA program to ensure plans offer comprehensive coverage of mental health and addiction treatment. A key step CMS could take in this regard would be to include network adequacy standards for behavioral healthcare providers across the full continuum of behavioral healthcare, including outpatient, intensive outpatient, partial hospitalization, residential, and inpatient care. These levels of care have been specified in leading practice guidelines for addiction treatment and mental health treatment, e.g., the ASAM Criteria from the American Society for Addiction Medicine[xxii] and Level of Care Utilization System (LOCUS) from the American Association of Community Psychiatrists.[xxiii] Time-and-distance standards for determining network adequacy should apply to each of these levels of care that are widely recognized as critical components of the continuum of care for individuals with mental illness or SUD.

In addition, CMS should establish separate network adequacy standards for mental health and addiction treatment providers instead of combining them. Several states have recognized the need to improve access to both types of providers and thus have established time-and-distance standards for addiction treatment that are distinct from mental health treatment.[xxiv] Combining the two sets of treatment providers will result in lack of specific data for federal and state policymakers who seek to improve access for either mental health or substance use providers. We recommend that CMS collaborate with the U.S. Labor Department to also separate out mental health from substance use providers in their job classification and data systems.

Reimbursement rates are a key factor influencing provider participation in MA plan networks. Behavioral healthcare providers at all levels of care struggle with lower reimbursement rates; for example, average in-network reimbursement rates in MA and commercial plans for primary care were almost 24% higher than reimbursements for behavioral healthcare office visits in 2014.[xxv]

Another study found that MA and commercial plans paid 13% to 14% less than the Medicare fee-for-service (FFS) rate for in-network mental health services while paying significantly more than Medicare FFS rates for the same services when provided by non-behavioral healthcare providers.[xxvi] This study also found that lower in-network reimbursement for mental health services did not reduce costs for patients because they had to access treatment so often out of network. These findings are consistent with other research showing that psychiatrists receive between 13% and 20% less in reimbursement for the same in-network services compared with other physicians.[xxvii] We urge Congress to require that MA plans demonstrate that their reimbursement rates for mental health and addiction treatment are consistent with Medicare fee-for-service rates for the same services and comparable with their rates for the same or similar services when provided by medical/surgical providers.

Finally, we urge CMS to require that medical necessity decisions and other non-quantitative treatment limitations (NQTLs) by MA plans be based on generally accepted standards of care developed by leading clinical professional societies, such as the ASAM Criteria and LOCUS. Nonetheless, the President Biden’s budget for fiscal year 2023 included this requirement, and a number of states including California, Illinois, and Oregon[xxviii] are incorporating this standard for utilization management into their requirements for state-regulated health plans.

In addition, we request that CMS prohibit MA plans from requiring pre-authorization or primary care referral for OTP services. These are barriers to life saving care and out of line with the traditional Medicare benefit.

What are effective approaches in MA for screening, documenting, and furnishing healthcare informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?

CMS requests comments on which additional patient characteristics, typically referred to as social determinants of health, affect the cost of providing IPF services. CMS also requests public comments on suggestions for how to better identify these patient characteristics and their effects on cost.

Response:

NABH agrees that social determinants of heath are important considerations for assessing health disparities and encourages CMS to continue exploring the best means for identifying this information in claims data. One of the reasons the existing IPF PPS methodology has been (and continues to be) so effective is CMS' reliance on claims data. Utilizing claims-based data allows IPFs to maintain lower administrative costs and work more efficiently while still providing sufficient data for CMS to assess any necessary adjustments to account for differences between patients and facilities. Overall, this decreases the administrative burden for all parties, including CMS.

NABH supports additional research into the most effective and least disruptive means to assess these impacts and incorporate any additional information collection into hospital reporting. This research would be beneficial for assessing the appropriate payment methodology but also for considering other beneficial programs CMS and the hospitals can pursue to improve care for vulnerable populations. Because social determinants of health impact all patient populations and not only Medicare beneficiaries, it is also important to ensure any analysis is not overly stratified for specific payor groups to avoid unintentional negative outcomes from any related changes.

NABH encourages CMS to continue pursuing additional data collection through the robust use of claims data regarding social determinants of health and how these patient characteristics impact the cost of providing IPF services.

B. Expand Access: Coverage and Care

CMS is committed to providing affordable quality healthcare for all people with Medicare. We seek feedback regarding how we can continue to strengthen beneficiary access to health services to support this.

What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

Response:

Beneficiaries in select states currently find themselves with plans that limit access to life-saving behavioral healthcare emergency services, due to pre-authorization, primary-care referral requirements. These requirements should be prohibited.

What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

Response:

Behavioral healthcare service costs and network limitations are not clear and should be clearly enumerated to beneficiaries so they may select their plans accordingly.

How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?

Response:

MA plans in select states require pre-authorization or primary-care referrals to receive OTP services. These are unreasonable barriers to life-saving care and out of line with the traditional Medicare benefit. Pre-authorization and primary-care referral requirements should be prohibited with respect to OTP services.

Additional policies for CMS to consider include:

Eliminate the psychiatric inpatient 190-day lifetime limit, a significant barrier to access and appropriate, cost-effective care for individuals with chronic behavioral health conditions. Attempting to track the 190-day lifetime limit is a complex and cumbersome process that is difficult for free standing psychiatric hospital providers to navigate, and a limitation that Medicare members do not understand – nor should they have to.

Increase access through network adequacy standards and allowance of additional licensure types to obtain Medicare IDs.

In addition to psychiatric inpatient services and psychiatry, consider network adequacy standards for master's level behavioral health clinicians.

Broadening the number of clinicians available to render services to Medicare beneficiaries and increasing access to specialized focus areas of behavioral health therapy. CMS should allow additional master's level provider licensures to obtain Medicare ID numbers, such as licensed professional counselors, licensed chemical dependency counselors, and licensed marriage and family therapists.

What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

Response:

One positive outcome of the pandemic has been broader awareness of how helpful telehealth can be for increasing access to mental health and addiction treatment. This is especially true in communities without local providers and for individuals who have difficulty attending in-person appointments.

Telehealth is particularly effective in behavioral healthcare delivery, especially psychiatric and psychological services.[xxix] Examples of behavioral health services that can be delivered effectively via telehealth include depression screening, follow-up care after hospitalization, behavioral counseling for substance use disorders, medication management, and psychotherapy for mood disorders.[xxx] Telehealth has been found to increase retention for addiction treatment, including MAT, especially when treatment is not otherwise available or requires lengthy travel to treatment.[xxxi]

We urge CMS to use its authority to ensure continued coverage of behavioral healthcare services via telehealth in MA plans. This continued coverage of telehealth should include coverage of audio-only telehealth for mental health and addiction treatment.

Coverage of services provided via audio-only technology is particularly important for certain vulnerable populations, including Medicare beneficiaries who are older and/or challenged with disabilities. These individuals often face additional barriers to accessing care through the newer video-based technologies and platforms. Among Medicare beneficiaries who had a telehealth visit in the summer and fall of 2020, more than half of them accessed care using a telephone only.[xxxii] A recent study found that among telehealth users, individuals who are older, Black, American Indian, male, or non-native English speakers have been significantly less likely to use video technology. [xxxiii] Our members are also concerned that many of their more vulnerable patients are unemployed or under-employed and sometimes homeless and simply do not have access to internet service to support video technology.

However, telehealth services should not be counted as equivalent to in-person services for purposes of determining network adequacy. MA plans should receive some credit toward network adequacy standards for making treatment via telehealth available, but it should not entirely replace availability of in-person care in terms of network adequacy. Network adequacy standards should support availability of mental health and addiction services both in-person and via telehealth. Counting telehealth as equivalent to in-person care in terms of network adequacy would undercut the utility of network adequacy requirements and likely undermine policies designed to improve availability of behavioral healthcare services particularly in rural areas.

What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

Response:

NABH appreciates CMS' interest in increasing mental health and addiction treatment providers' participation in MA plan provider networks. Thus, we support CMS' proposal to require MA plans to demonstrate compliance with network adequacy requirements prior to Medicare-participation approval.

Furthermore, we urge CMS to expand the types of providers included in MA network adequacy requirements beyond psychiatry and inpatient psychiatric facility services. As you know, CMS recently proposed to establish time-and-distance standards for Qualified Health Plans (QHPs) with standards for additional types of behavioral health providers including outpatient clinical behavioral health and residential treatment.[xxxiv] In addition, CMS proposed to establish appointment wait time standards for behavioral health services as part of the QHP network adequacy requirements. In keeping with these proposals, we urge CMS to expand time and distance standards for MA plans to include additional types of behavioral health providers and levels of care, and to add appointment wait time standards to MA network adequacy rules to help improve access to care for Medicare beneficiaries with mental illness or addiction.

We urge CMS to use fully the flexibility in the MA program and the authority for supplemental benefits[xxxv] in this program to ensure MA plans offer comprehensive coverage of mental health and addiction treatment. A key step would be to include network adequacy standards for behavioral healthcare providers across the full continuum of behavioral healthcare, including outpatient, opioid treatment programs, intensive outpatient, partial hospitalization, residential, and inpatient care. These levels of care have been specified in leading practice guidelines for addiction treatment and mental health treatment, e.g., the ASAM Criteria from the American Society for Addiction Medicine[xxxvi] and Level of Care Utilization System (LOCUS) from the American Association of Community Psychiatrists.[xxxvii] Time-and-distance standards for determining network adequacy should apply to each of these levels of care that are widely recognized as critical components of the continuum of care that individuals with mental illness or addiction may need.

In addition, we urge CMS to establish separate network adequacy standards for mental health and addiction treatment providers instead of combining them. We urge CMS to ensure better access to both types of providers, especially during this time when so many people are struggling with mental health conditions and/or addiction. We urge CMS to follow the lead of those states that have recognized the need to improve access to both types of providers and thus have established time-and-distance standards for addiction treatment that are distinct from mental health treatment.[xxxviii]

What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization management techniques? How could MA plans align on data for prior authorization and other utilization management techniques to reduce provider burden and increase efficiency?

Response:

NABH urges CMS to clarify that MA plan utilization review must be based on generally accepted clinical standards of care developed by leading clinical professional societies, such as the ASAM Criteria and LOCUS that the federal court in *Wit v. United Behavioral Health* require. [xxxix] This federal court decision prohibited discriminatory health plan practices that restrict access to mental health and addiction treatment. CMS should follow the lead of states that are incorporating this standard for utilization management into their requirements for state-regulated health plans as in California, Illinois, and Oregon.[xl]

CMS should require MA plans to provide quality metrics for traditional Medicare vs. Medicare Advantage in an easy and accessible format and ensure data are complete and accurate. Particular attention should be focused on metrics specific to behavioral health diagnoses, so they do not get buried in physical healthcare data.

Behavioral health facilities are forced to spend administrative dollars on multiple skilled resources to navigate the managed care organization authorization process. CMS should consider mandating a certain number of authorized days "up front" to eliminate a portion of the administrative burden when CMS mandated quality metrics are met.

CMS should require MA plans to include the exact (specific) areas where the beneficiary did not meet coverage criteria on all authorization denial letters and monitor plan denial letters to ensure compliance.

CMS should also consider requiring MA plans to complete an analysis of the number of denied days and the number of concurrent reviews completed for behavioral health care vs. physical healthcare.

CMS should also consider requiring MA plans to report on the number of appeals and subsequent overturned appeals completed for behavioral health care vs. physical health care. For accurate comparison, CMS should ensure all levels of behavioral healthcare are considered (inpatient, partial hospitalization, outpatient services) in the analysis.

C. Drive Innovation to Promote Person-Centered Care

As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?

Response:

CMS should focus on the potential incentive for Medicare Advantage organizations (MAOs) to deny beneficiary access to services and deny payments to providers in an attempt to increase profits, as outlined in the HHS-OIG's April 2022 report, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*.

Do certain value-based arrangements serve as a "starting point" for MA plans to negotiate new value-based contracts with providers? If so, what are the features of these arrangements (that is, the quality measures used, data exchange and use, allocation of risk, payment structure, and risk adjustment methodology) and why do MA plans choose these features? How is success measured in terms of quality of care, equity, or reduced cost?

Response:

Many managed care organizations are interested in pursuing value-based contracts with psychiatric inpatient providers, but they share very limited quality and financial information prior to contract execution and during contract term.

Most behavioral health value-based contracts are focused on a reduction in readmission rates and the percentage of patients that complete seven-day and 30-day post discharge follow up appointments with an outpatient behavioral health clinician (Healthcare Effectiveness Data and Information Set (HEDIS)-driven).

Performance target benchmarks appear arbitrary and differ by managed care organization-- some do not take into consideration market dynamics (local environmental or socioeconomic factors), market

performance (peer hospital), or lack of behavioral health providers in their network when determining performance targets (particularly around seven-day and 30-day follow-up after hospitalization (FUH).

CMS should consider a requirement that managed care organizations must share a minimum amount of information for reimbursement increases to be directly correlated to quality metrics. Examples:

- Redacted peer hospital quality metric information (readmission rates, seven-day FUH, 30-day FUH)
- Market quality metrics at an MSA, state and national level
- Total cost of care for members: physical health + behavioral health
- MCO performance in specific BH measures in comparison to traditional Medicare performance

CMS should require managed care organizations to share data openly with behavioral health providers willing to engage in value based contracting opportunities.

How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?

Response:

The Medicare Star Rating program is intended to help beneficiaries and providers compare the quality and performance of MA plans.[xli] In addition, MA plan ratings on the measures included in the Star Rating program affect plans' eligibility for bonus payments. However, there are no measures assessing access to SUD treatment included in this measure set, and the only measure focused on mental healthcare is a short beneficiary survey on improvement or maintenance of mental health.

Moreover, CMS announced that even this one mental health measure will not be incorporated into the Star Rating calculations for 2022 and 2023 due to the impact of Covid-19 on data collection.[xlii] We urge Congress to require CMS to improve the measures in the MA Star Rating program to more effectively assess access to mental health and SUD treatment services among MA enrollees and require that these measures be assigned the highest weight in the calculation of MA plan Star Ratings.

E. Engage Partners

What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?

CMS should respond to the key comments and recommendations in the OIG's April 2022 report, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*.

Thank you for considering our concerns and recommendations. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100.

National Association for Behavioral Healthcare

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Sincerely,

Shawn Coughlin
President and CEO

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