National Association for Behavioral Healthcare

Access. Care. Recovery.

January 27, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Submitted Electronically

RE: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024 [CMS–9899–P]

Dear Administrator Brooks-LaSure:

The National Association for Behavioral Healthcare (NABH) respectfully submits to the Centers for Medicare & Medicaid Services (CMS) the following comments on the Contract Year (CY) 2024 proposed rule related to federal and state health exchanges. NABH represents behavioral healthcare systems providing the full continuum of behavioral healthcare services and addiction treatment, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility-based outpatient programs, and medication assisted treatment centers. Our membership includes behavioral healthcare practitioners in 49 states and Washington, D.C.

In general, NABH supports the overall aim of this proposed rule and, in particular, appreciates CMS' multiple proposals to assist consumers seeking to enroll in exchange-based health plans and, ultimately, to access mental health and substance abuse disorder treatments. That said, several of these provisions require refinement if they are to yield the level of assistance needed by enrollees who require behavioral healthcare services.

Proposed Network Adequacy Expansions Are Helpful But Fall Short

NABH strongly supports CMS proposal to expand its network adequacy criteria by creating two distinct essential community provider categories for mental health facilities and substance use disorder (SUD) treatment centers. To construct each county-level network, the rule would require insurers on the health exchanges *to attempt* to contract with at least one SUD Treatment Center and at least one Mental Health Facility.

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While we applaud the direction of this proposal, the urgency of the current mental health crisis in the United States demands further intervention by policymakers. **Specifically, the proposal to merely require insurers *to offer* a contract falls short given the scale and entrenched nature of current behavioral healthcare access barriers.**

As widely studied and acknowledged, the COVID-19 pandemic greatly exacerbated the nation's shortage of mental health services, which is expected to persist following the pandemic. **This dire situation calls for CMS to go further in the final rule by setting a minimum threshold for each provider network for both mental health facilities and SUD treatment centers.** Doing so will align with CMS' proposal in this rule to require plans to contract with at least 35 percent of available federally qualified health centers and at least 35% of qualifying family planning providers. We recognize that CMS already has plans to consider in the future whether to apply the proposed FQHC percentage threshold to other essential providers, but patients affected by current behavioral health shortages, especially those who are at risk of harm to self or others, simply cannot wait.

Provider Network Integrity

On a related note, we raise our concern pertaining to the network expansion practice of "deeming," which can result in networks that are larger in appearance than in practice. When exercising the deeming process, under common insurer-provider contract terms that providers often cannot opt out of, insurers unilaterally add behavioral health providers and/or specific services to their networks. Generally, deeming involves minimal communication and simply notifies the provider of the locations and/or specific services that have been deemed. From the perspective of our members, this one-sided practice bypasses the actual pre-deeming contract terms under which the provider only had agreed to limited network participation with out-of-network reimbursement for non-contracted services. Limited network participation usually means that the provider only agreed to include certain locations and/or services in the network because in-network reimbursement was inadequate for remaining sites and services.

Deemed sites and services are problematic for enrollees for multiple reasons. When insurers only contract with a portion of a provider's sites and services, accessing care becomes more complicated for the enrollee who may face additional navigation steps to the already complicated process to identify those services that actually are in-network.

In addition, the in-network services available to the enrollee are less likely to include the full scope of services required by the patient. Collectively, these challenges can reduce

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the patient's compliance with the prescribed treatment plan, which threatens short-term clinical outcomes and may increase longer-term costs related to readmissions or other otherwise preventable care.

Further, it is more likely that the enrollee will face higher out-of-pocket costs if the patient inadvertently accesses care from a non-deemed out-of-network site associated operated by a deemed organization. From the provider perspective, both deemed and out-of-network care in this scenario will be delivered under the auspices of a health plan contractual relationship that the provider already rejected – an unfair and unsustainable situation.

To avoid this form of nominal network expansion, we urge CMS to study current deeming practices and consider alternatives to create a balanced insurer-provider relationship for all protocols establishing both initial, contracted network participation and any subsequent deeming additions. Ultimately, we support interventions to assist enrollees who need and are seeking behavioral health services by mitigating skewed and non-transparent network expansions that can occur through deeming.

As such, we also ask CMS to phase out any deeming protocols that lack full transparency for affected providers and enrollees, including any outdated or inaccurate references in provider directories, and the unilateral application of in-network level reimbursement that already was rejected by providers prior to the deeming process for their self-selected out-of-network sites and services. In addition, if the deeming practice persists, we urge requiring health plans to expressly identify in their directories any limitations resulting from the initial contracting and/or deeming process, such as excluded sites, service, or health plan product lines. Likewise, it is critical that enrollee coverage documents specify the limits of their coverage and out-of-cost liabilities when utilizing (non-emergency) out-of-network services obtained.

In addition, we note that earlier this month the Medicare Payment Advisory Commission discussed its concern regarding the high rate of behavioral health providers who do not accept Medicare payment. To study this issue, the Commission is, among other analyses, comparing mental health service utilization for traditional Medicare versus Medicare Advantage. Perhaps policymakers would gain useful insights by also comparing service utilization, wait times and other access to care metrics for plans on the federal and state health exchanges versus traditional Medicare and Medicare

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Advantage. Such benchmarking could help identify strategies to improve network adequacy for plans on the marketplace exchanges.

Assessing and Ensuring Meaningful Coverage

In alignment with this rule's focus on expanding access to care, we raise our concern that many insurance products on marketplace exchanges are offering a scope of coverage that is too narrow for patients with serious behavioral health needs. We are similarly concerned that these products are improperly treated as equivalent to health plans' off-exchange commercial products, despite marketplace products tending to offer far skimpier behavioral health coverage. **Our members report that this gap in mental health coverage can be material and, as such, we urge CMS to evaluate the current level of coverage sufficiency for mental health services in federal and state marketplace offerings.**

For example, copayments, deductibles and coverage gaps for mental health and SUD services can be significant, with some deductibles exceeding the typical cost of care—and this problem is exponentially compounded when patients must seek out-of-network services due to unmitigated network inadequacy. To learn more about this dynamic, NABH and our members welcome the opportunity to meet with CMS to discuss current coverage levels and to support an assessment of the scope of mental health coverage in a sample of marketplace plans. Such an assessment should apply to the full range of behavioral health services, including inpatient mental health services.

Proposed Improvements for Consumers:

NABH welcomes the proposed process improvements aimed to help consumers when enrolling in an exchange marketplace as well as when accessing care. In addition to these consumer assistance items below, we view as positive the proposed expansion of the navigator role and other measures to increase insurer transparency and accountability.

More Accurate Plan Marketing

To mitigate confusion during enrollment in federal or state health exchanges, the rule proposes stricter standards relative to the accuracy of the names used to market insurance products. The rule would prohibit the current marketing practice of using names with incorrect or misleading information that misrepresent the product's actual level of cost-sharing, drug coverage, coverage limits, or other benefit details. **NABH supports thorough enforcement of this prohibition during the annual certification**

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process through the proposed joint federal and state process described in the rule.

Oversight of Appointment Wait Times

To facilitate more timely access to care, the rule proposes to implement in plan year 2024 new standards for appointment wait times that were finalized in prior rulemaking but delayed. **NABH supports the implementation of the maximum appointment wait time standards that have been established by CMS in this 2022 Letter to Insurers.** This additional oversight is essential to ensure that enrollees can obtain provider services within a reasonable timeframe. As discussed in the rule, we encourage rigorous assessment of compliance with these standards through the proposed insurer attestation process, which would include supporting data from providers in each network.

Limiting the Number of Non-Standardized Plan Options

NABH endorses CMS' proposal to address concerns about "plan choice overload." Specifically, the rule would materially reduce the number of non-standardized plans that issuers can offer through the federal and state to two per product network type and metal level, per service area. The estimated impact of this change is worthwhile: a reduction of the average number of non-standardized plan options from 108 in plan year 2022 to 37 in plan year 2024, which does not include standardized plan offerings. We agree that too many plan offerings can result in frustration and poor enrollment decisions, and that volume of plan offerings has increased beyond a point that benefits consumers.

In addition, NABH supports the general direction of the agency's proposal to reinstate a new version of the "meaningful difference" policy, which also is intended to mitigate confusion during the enrollment process. This policy requires that each's insurers offerings have distinctive features related to key elements such as cost-sharing, provider networks, or covered benefits. We support the oversight proposed through a new process to identify non-compliant plan offerings, including assessing compliance with the requirement for deductibles for the array of an insurer's products to differ by more than $1,000.

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

Sincerely,

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