National Association for Behavioral Healthcare

Access. Care. Recovery.

27 January 2022

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

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 Proposed Rule [CMS-9911-P]

Dear Administrator Brooks-LaSure:

The National Association for Behavioral Healthcare (NABH) respectfully submits the following comments on the Notice of Benefit and Payment Parameters for 2023 Proposed Rule published by the Centers for Medicare and Medicaid Services (CMS) on Jan. 5, 2022.

NABH represents behavioral healthcare systems that provide mental health and addiction treatment 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 centers. Our membership includes behavioral healthcare providers in all 50 states and Washington, D.C.

The pandemic has highlighted and amplified the need for improved access to mental health and addiction treatment. Studies have consistently found significantly higher levels of anxiety and depression and suicidal ideation over the past couple of years.[i, ii] In addition, alcohol consumption has increased significantly, [iii] and drug overdose deaths increased almost 30% in 2020 reaching more than 90,000, the highest number ever recorded over a 12-month period[iv] Overdose deaths in 2021 are expected to reach over 100,000.[v] Suicide rates have remained high with troubling increases among certain groups including Black Americans and adolescent girls. [vi]

Moreover, experts expect mental health and substance use disorders to remain elevated for many people long after the pandemic ends. Experiences with epidemics in the past indicate that the impact on behavioral health may continue for years to come.[vii]

NABH supports strengthening network adequacy requirements for qualified health plans and urges additional provider classifications for addiction treatment and pediatric care.

As CMS appropriately notes, qualified health plans (QHP) continue to lack adequate behavioral healthcare providers in their networks. In general, individuals with behavioral healthcare needs are much more likely to access these services out-of-network[viii] which indicates widespread lack of network adequacy. Therefore, NABH supports CMS' efforts to established time and distance standards to monitor and hopefully improve inclusion of behavioral healthcare providers in QHP networks.

Nevertheless, we urge CMS to improve upon their proposals by establishing separate network adequacy standards for mental health and addiction treatment providers instead of combining them. Providers that specialize in mental health or addiction treatment are not interchangeable. Moreover, not all outpatient behavioral health clinics that CMS proposes to add to the list of provider specialty types have professionals trained to provide addiction treatment. 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 addiction. In 2020, 40.3 million people aged 12 or older (or 14.5 %) had an SUD in the past year, but just 6.5% of them received any treatment.[ix] We urge CMS to follow the lead of those states that have recognized the need to

track these types of providers separately and have established time and distance standards for addiction treatment that are distinct from mental health treatment standards.[x]

We also encourage CMS to establish specific time and distance standards for pediatric behavioral healthcare providers. Shortages of these types of providers are even more severe than providers of behavioral healthcare services for adults. As a result, accessing providers for behavioral healthcare out of network is much more common for children and adolescents than adults.[xi] Furthermore, we know that the pandemic has had particularly detrimental impacts on the behavioral health of children and adolescents: the Centers for Disease Control and Prevention (CDC) reported a 50% increase in emergency department visits for suspected suicide attempts among girls ages 12-17 in early 2021 compared with the same period in 2019, and a 31% increase in mental health-related emergency department visits among all adolescents during this period.[xii] Children and adolescents are at increased risk of depression and anxiety even after the pandemic ends according to studies on the impact of social isolation.[xiii] Some states have already established specific time and distance standards for pediatric behavioral health providers and specific types of services that could serve as models for specific pediatric behavioral healthcare time and distance standards for QHPs.[xiv]

NABH opposes combining inpatient and residential behavioral health services in one category for determination of network adequacy.

While we appreciate CMS's recognition of the importance of ensuring access to both inpatient and residential treatment for behavioral health conditions, we are concerned that combining those levels of care into one facility specialty type for time and distance standards may not help improve access to both these levels of care. Inpatient and residential treatment facilities provide levels of care that address distinct needs and should not be treated as interchangeable. Both are critical levels of care that should be available for QHP enrollees that have serious behavioral health conditions. Below is a summary of some key characteristics of these levels of care.

Inpatient behavioral healthcare is generally provided in hospitals or similarly credentialed facilities by an interdisciplinary team made up of physicians, registered nurses, addiction counselors, and behavioral health specialists. In inpatient settings, individuals with serious behavioral or emotional conditions, as well as those with serious biomedical conditions, withdrawal, or cognitive complication receive stabilizing care including directed evaluation, observation, medical monitoring, 24-hour nursing care and treatment including cognitive, behavioral, motivational, pharmacologic, and other therapies provided in an individual or group basis. In addition, physical health interventions may be provided as well as health education services and services for the patient's family or guardian.

Residential behavioral healthcare is provided in facilities that are not licensed as psychiatric hospitals. These facilities generally provide individually planned programs of mental health treatment for individuals who require a 24-hour stable living environment that promotes recovery skill development. Patients receive individual, group, or family therapy, or some combination thereof, as well as medication management, and psychoeducation. Recovery is aided by time spent living in a structured environment where patients can practice coping skills and make connections to the community including work, education, and family members. Services are provided by an interdisciplinary team of clinical staff including counselors, social workers, and allied health professionals, but physicians are not required to be on-site.

NABH urges strict requirements for any QHP exemptions from time and distance standards for behavioral healthcare.

We note that CMS is proposing to allow QHPs to justify and be excused from meeting the proposed time and distance standards for network adequacy. We urge CMS to set strict requirements for QHPs to receive an exemption from these standards. For example, QHPs should be required to demonstrate that their reimbursement rates for mental health and addiction treatment are comparable to the rates for similar medical/surgical services in the same or similar types of facilities. Reimbursement rates offered by healthcare coverage plans and programs greatly affect network participation among providers. Behavioral healthcare providers at all levels of care struggle with lower reimbursement rates; for example, average in-network

reimbursement rates for primary care were almost 24% higher than reimbursements for behavioral healthcare office visits in 2017.[xv]

Moreover, this requirement to set comparable reimbursement rates for behavioral healthcare providers already applies to QHPs since federal parity requirements apply to these plans. The federal parity regulations include "standards for provider admission to participate in a network, including reimbursement rates" as an example of non-quantitative treatment limitations.[xvi] Therefore, under federal parity rules, the standards for provider network admission, including the reimbursement rates offered, may not be more restrictive for mental health and substance use disorder treatment than medical/surgical treatment in the same benefit classification.

NABH urges CMS to require that QHPs cover out-of-network providers with the same cost-sharing as in-network in those areas where they do not meet the time and distance standards for behavioral healthcare.

If QHPs are allowed to apply for an exemption from time and distance standards, the financial impact of this exemption should not fall on individual enrollees. Instead, CMS should require plans to allow enrollees to access out-of-network providers with in-network cost-sharing in those areas where the QHP receives an exemption from meeting the time and distance standards. The proposed time and distance standards will be meaningless if plans are allowed to evade them with impunity.

NABH supports refining the essential health benefit (EHB) nondiscrimination policy to ensure coverage of the full continuum of mental health and addiction treatment and use of generally accepted clinical standards of care.

We support CMS' proposal to clarify that the nondiscrimination policy that applies to EHBs under 42 C.F.R. §156.125 requires the use of clinical evidence, e.g., peer-reviewed studies and practice guidelines, in setting QHP benefit limits and coverage requirements. Specifically, CMS proposes "that a nondiscriminatory benefit design that provides EHB is one that is clinically based, that incorporates evidence-based guidelines into coverage and programmatic decisions and relies on current and relevant peer-reviewed medical journal articles, practice guidelines, recommendations from reputable governing bodies, or similar resources."[xvii]

In accordance with this policy, NABH urges CMS to clarify that QHPs are required to cover mental health and addiction treatment services in all levels of care including inpatient, residential, partial hospitalization, intensive outpatient, and outpatient. These levels of care have been specified in the leading practice guidelines for addiction treatment and mental health treatment, e.g., the ASAM Criteria developed by the American Society for Addiction Medicine[xviii] and Level of Care Utilization System (LOCUS) developed by the American Association of Community Psychiatrists.[xix] 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 health or substance use disorder conditions may need.

NABH also urges CMS to clarify that this nondiscrimination policy means that utilization review must be based on generally accepted clinical guidelines developed by leading clinical professional societies including the ASAM Criteria and LOCUS as required by the federal court in the ground-breaking *Wit v. United Behavioral Health* decision prohibiting discriminatory health plan practices that unlawfully restrict access to mental health and addiction treatment.[xx]

NABH calls for requirement that QHPs cover services delivered via telehealth as a component of EHBs but agrees that availability of services via telehealth should not affect determinations of network adequacy.

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.[xxi] 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.[xxii] Telehealth has been found to increase retention for SUD treatment, including MAT, especially when treatment is not otherwise available or requires lengthy travel to treatment.[xxiii]

Since the Department of Health and Human Services is required to periodically update the EHBs to account for changes in medical evidence or scientific advancement,[xxiv] we urge CMS to use this authority to ensure continued coverage of behavioral healthcare services via telehealth by QHPs. However, we also agree with CMS' statement that telehealth services should not be counted in place of in-person services for purposes of determining network adequacy.

To improve health equity, NABH recommends that health plans be required to submit data on race and ethnicity for enrollees by geographic area

CMS could consider requiring plans to submit race and ethnicity data of enrollees in each geographic region established for monitoring network adequacy. These data could then be used to improve health equity by ensuring that time and distance standards are being met in those areas with high percentages of disadvantaged groups by setting higher requirements for exemptions for those areas.

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, or contact NABH Director of Policy and Regulatory Affairs, Kirsten Beronio at kirsten@nabh.org or 202-393-6700, ext. 115.

Sincerely,

Shawn Coughlin
President and CEO

About NABH

The National Association for Behavioral Healthcare (NABH) represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in all 50 states and Washington, D.C.. The association was founded in 1933.

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