

# National Association for Behavioral Healthcare



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1 January 2023

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: CMS-4205-P. Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Dear Administrator Brooks-LaSure:

The National Association for Behavioral Healthcare (NABH) respectfully submits the following comments on proposed rule [CMS-4205-P](#), which addresses multiple federal programs, including proposed contract year (CY) 2025 updates to the Medicare Advantage (MA) program. We appreciate the rule's proposed changes that would increase MA accountability and oversight, building upon the positive improvements that the Centers for Medicare & Medicaid Services (CMS) already implemented through its CY 2025 final rule, including more closely aligning MA coverage and access with Traditional Medicare.

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 on continuing to improve the MA program.

NABH continues to be concerned with MA plan practices that block or delay access to behavioral healthcare services. As such, our letter endorses these positive provisions in this rule, as well as makes recommendations:

- Incentivizing MA coverage for additional behavioral healthcare practitioners, and inclusion in a health plans' provider networks;
- Annually analyzing the health equity level of MA plans relative to underserved populations; and
- Laying the groundwork for increased data collection on MA coverage decisions, appeals and decision rationales.

In addition, NABH encourages CMS to modify its proposal in this rule, which would improve the appeals process for MA enrollees in certain settings to include behavioral healthcare settings, as discussed below.

## Finalize Two Behavioral Healthcare Network Categories

NABH greatly appreciates CMS' extensive rulemaking in recent years to meaningfully expand access to behavioral healthcare services by increasing the types of covered behavioral healthcare practitioners, including those listed below. Consistent with these much-needed expansions, NABH conceptually supports the current proposal to add a new behavioral healthcare category to MA network adequacy



requirements, “outpatient behavioral health.” Specifically, the rule proposes a new outpatient behavioral healthcare network category that would include services provided by the following practitioners.

- Marriage and family therapists;
- Mental health counselors;
- Community Mental Health Centers;
- Opioid treatment programs (OTP);
- Addiction medicine physicians; and
- Other providers who furnish addiction medicine and behavioral health counseling or therapy services.

Due to the persistence and growing magnitude of the country’s behavioral healthcare crisis and shortage of practitioners, behavioral healthcare leaders such as CMS need more detail about local service availability to effectively improve the trajectory of the crisis. Given the dearth of information on the availability of specific behavioral healthcare providers from which MA networks would recruit, all behavioral healthcare stakeholders would benefit from a more specific behavioral healthcare network structure. **Therefore, we urge CMS to go a step beyond the proposed network category to instead implement two separate categories: one for “mental health” and a second for “substance use disorder (SUD) treatment” providers.** Separate network categories would provide the targeted information needed to identify and address *specific* gaps in a behavioral healthcare network. In fact, only through more specific network composition details could CMS ensure that a MA plan is offering services that cross the full continuum of behavioral healthcare services.

To illustrate this dynamic, under the proposed single network category a MA plan network that includes a Community Mental Health Center (CMHC) could potentially satisfy the outpatient behavioral health network requirement, however, most CMHCs do not provide addiction services or medication assisted treatment. Therefore, we recommend that CMS separate the proposed “outpatient behavioral health category” into separate subcategories for substance use and mental health services. The details gained through this change will yield a more meaningful assessment of behavioral healthcare capabilities offered per health plan.

When tallying the services that a MA health plan network provides, to diminish the potential for “ghost networks,” CMS should *not* count:

- providers who are not licensed or appropriately credentialed to provide services in outpatient behavioral health facilities unless they are routinely providing behavioral healthcare services; or
- providers that have not been actively submitting mental health and/or SUD claims.

Opioid Treatment Programs (OTP). **To further improve the local response to the opioid epidemic including the detrimental impact of fentanyl on opioid-related deaths, we recommend that the SUD network category require plans to report whether and where OTP services are provided within the network.** Methadone is the most effective treatment for opioid addiction in combination with fentanyl. OTPs are the only setting that can provide methadone treatment, which requires compliance with multiple criteria such as specific practitioner oversight of methadone dispensing, safe drug storage, and wrap-around care. Collecting specific information on the availability of fentanyl-related treatments through methadone would advance the Biden administration’s stated priority of increasing access to *all forms of medications* for opioid use disorder. This network reporting requirement could be augmented with a waiver for MA plans in states with no OTPs. On its own, the reporting requirement may indirectly encourage states with no OPTs to add them to their fentanyl crisis response. Given the ongoing intensity of the nationwide impact of fentanyl, we also urge CMS to implement other incentives for all states to expand access to comprehensive and supervised methadone treatment.



Because methadone treatment by OTPs requires frequent visits, which can be daily or several times per week, we recommend that CMS consider *reducing* the time and distance standards for patients using OTP services. Access also could be expanded through the increased use of mobile vans.

NABH also supports the concept of incentivizing MA plans to incorporate additional BH providers in their networks by offering a 10% network adequacy compliance credit.

#### **New MA Data Collection Would Increase Transparency and Accountability**

NABH strongly supports initiatives to improve the transparency and accountability of MA plans, as discussed in our [comment letter](#) on the CY 2025 MA proposed rule. As such, we applaud this proposal to create a new process to collect detailed data from MA plans. In general, we agree with the planned data collection described in the rule, including service level data for all initial coverage decisions and plan level appeals, such as decision rationales for items, services, or diagnosis codes to have a better line of sight on utilization management and prior authorization practices, among many other issues. Such data would eventually help open the door to more MA patients with behavioral healthcare needs, which is especially crucial for those in life-threatening situations.

#### **Include Behavioral Health Data in MA Plans' Health Equity Analyses**

NABH agrees with CMS' position in the proposed rule that "prior authorization policies and procedures may have a disproportionate impact on underserved populations and may delay or deny access to certain services." We also highlight that the behavioral healthcare patient population, in particular, is disproportionately composed of underserved patients, including patients who are low-income and/or a member of a marginalized group. As such, we are particularly concerned about underserved patients with a serious mental illness and/or SUD when they face an urgent need for care which, for example, may include risk of harm to self and others. **To monitor and improve the status of this fragile population relative to MA plans' utilization management (UM) practices, the plans must be required to develop distinct UM protocols and data collection for serious mental illness and SUD patients.** Doing so would help provide the specific data needed to assess and ultimately advance the behavioral healthcare equity through health equity evaluations of each MA plan. We also support CMS' plan to assess health plans' equity status by comparing data related to prior authorization practices and outcomes for patients with and without social risk factors, with a focus on low-income patients and those with a disability.

**In addition to the proposal to require UM committees to include a member with expertise in health equity, we urge CMS to also require a committee member with relevant behavioral healthcare expertise.** We also support the proposal for annual health equity analyses to be made *readily* available to the public on the MA plans' websites, which otherwise can be complex and difficult to maneuver for MA enrollees.

#### **Modify Proposed Appeals Process Improvements to Include Behavioral Healthcare Services**

NABH supports the proposal to streamline the beneficiary appeals process used to challenge an MA plan's decision to terminate coverage for certain services, including allowing expedited appeals, in a manner that is consistent with Traditional Medicare. We also note that, as has been flagged through numerous secret shopper initiatives in 2023, behavioral healthcare patients enrolled in MA also suffer major access challenges caused by "ghost networks" that dramatically overstate the availability of available behavioral healthcare practitioners. In addition, prior authorization denials that are based on proprietary and non-transparent criteria, frequently are reversing the treating physician's referral for behavioral healthcare services. These clinically unsubstantiated denials and terminations second guess the attending physician's clinical judgment and are yet another method of reducing access to necessary behavioral healthcare services. Instead, prior authorization and termination of coverage denial by an MA

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plan should be based on generally accepted clinical standards that are publicly posted, and should include for the provider, the clinical rationale used as the basis for each denial. **Given these well-documented behavioral healthcare access problems, we encourage CMS to modify this proposal to also apply the proposed appeals rights, including expedited appeals, to MA decisions to deny and terminate behavioral healthcare services provided in all behavioral healthcare settings that Medicare covers.** Such a modification would allow first-round appeals to be reviewed by an unbiased quality improvement organization (instead of the MA plan), consistent with Traditional Medicare.

Thank you for considering NABH's recommendations for these important rules. We look forward to supporting and working with you and your staff to address this critical issue. Please contact me at 202-393-6700, ext. 100 or [shawn@nabh.org](mailto:shawn@nabh.org) if you have questions.

Sincerely,

Shawn Coughlin  
President and CEO