National Association for Behavioral Healthcare

Access. Care. Recovery.

7 March 2022

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

Re: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs (CMS 4192-P)

Dear Administrator Brooks-LaSure:

The National Association for Behavioral Healthcare (NABH) respectfully submits the following comments regarding the proposed rule on the Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs issued by the Centers for Medicare and Medicaid Services (CMS) on Jan. 12, 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 (MAT) centers. Our membership includes behavioral healthcare providers in all 50 states and Washington, D.C. We appreciate this opportunity to provide comments on 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 stays 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, "[b]eneficiaries 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 "[b]eneficiaries 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 number 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, and they often misinterpret level-of-care and/or medical necessity criteria confirmed by the attending physician/clinician. 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.

Recommendations:

Establish specific network adequacy standards for the full continuum of mental health and addiction treatment and require those standards be met prior to approval for participation in Medicare

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 approval for participation in Medicare.

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.[xvi] 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[xvii] 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, 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[xviii] and Level of Care Utilization System (LOCUS) from 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 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.[xx]

Require Medicare Advantage plans to demonstrate reimbursement rates for behavioral healthcare providers are comparable to rates for other similar healthcare services.

Individuals with behavioral healthcare needs are generally much more likely to access these services out-of-network reflecting the widespread lack of network adequacy for behavioral healthcare;[xxi] for example, people accessed inpatient behavioral health facilities out of network five times more often and used out-of-network outpatient behavioral health facilities almost six times more often than they used out-of-network medical/surgical facilities in 2017. This disparity has increased significantly in recent years.[xxii]

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.[xxiii] 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.[xxiv] 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.[xxv] We urge CMS to require plans to demonstrate that their reimbursement rates for mental health and addiction treatment are comparable with the rates for similar medical/surgical services as part of the application process for participating in MA. Furthermore, demonstration of comparable reimbursement rates should be a prerequisite for any exception to MA network adequacy requirements.

Require Medicare Advantage plans to comply with parity requirements and use generally accepted standards of care for utilization management.

A recent study disclosed that MA enrollees pay significantly more cost-sharing for mental health services provided in-network than they pay in cost-sharing for the same services from non-mental health in-network providers.[xxvi] Due to this finding and numerous indications that MA enrollees do not have adequate access to behavioral healthcare (as discussed above), we urge CMS to implement a requirement that MA

plans comply with mental health and addiction treatment parity. CMS has already used its administrative authority to require that 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."[xxvii] We urge CMS to extend this parity requirement 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".[xxviii] These new requirements for Medicare Advantage plans also should include the new parity documentation requirements enacted as part of the *Consolidated Appropriations Act, 2021*[xxix] that CMS also extended to QHPs through a recent rulemaking.[xxx]

Require MA plans to base utilization management on generally accepted standards of care.

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 as required by the federal court in *Wit v. United Behavioral Health*. [xxxi] 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.[xxxii]

Require MA plans to cover services delivered via telehealth including audio-only for mental health and addiction treatment.

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.[xxxiii] 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.[xxxiv] 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.[xxxv]

We urge CMS to use its authority to ensure continued coverage of behavioral healthcare services via telehealth by 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 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.[xxxvi] 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. [xxxvii] 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.

Increase accountability of MA plans for providing access to mental health and addiction treatment.

The Medicare Star Rating program is intended to help beneficiaries and providers compare the quality and performance of MA plans.[xxxviii] 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 addiction 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. Recently, CMS announced that even this one mental health measure will not be incorporated into the Star Rating calculations for 2022 and 2023 star ratings due to the impact of Covid-19 on data collection.[xxxix] We urge CMS to improve the measures in the MA Star Rating program to more effectively assess access to mental health and addiction treatment services among MA enrollees and require that these measures be assigned the highest weight in the calculation of MA plan Star Ratings.

Ensure MA plans reimburse Critical Access Hospital on par with traditional Medicare reimbursement.

Critical Access Hospitals (CAHs) provide a crucial source of behavioral healthcare to rural areas where access to care is generally in very short supply. CAHs may include inpatient psychiatric units and these facilities also assist in developing community-based services and recruiting mental health practitioners.[xl] These small independent institutions in remote, rural areas incur higher operating costs than their urban counterparts. Furthermore, the populations they serve are generally made up of older and sicker patients with lower incomes than individuals living in urban areas.[xli]

In recognition of this financial vulnerability and to support the availability of care in rural areas, Congress established a requirement that hospitals in these areas that qualify as CAHs receive cost-based reimbursement.[xlii] The CAH designation and cost-based reimbursement requirement were intended to prevent additional rural hospital closures at a time when roughly 150 rural hospitals closed between 1990 to 1997.[xliii]

However, this cost-based reimbursement requirement only applies to Medicare FFS coverage. CAHs must negotiate rates and contracts with MA plans, and these plans usually require CAHs to accept the same rates and terms as urban hospitals[xliv] despite their financial challenges described above. As enrollment in MA plans has increased including in rural areas, the protections established for CAHs have significantly diminished.

According to our members, low reimbursement by MA plans combined with increasing enrollment of Medicare beneficiaries in these plans are causing hospitals to close in rural areas. Currently 46% of rural hospitals operate at a loss—an increase from 40% in 2017.[xlv] It has been estimated that 21% of all rural hospitals are in danger of imminent closure.[xlvi] We urge you to require MA plans to reimburse CAHs consistent with policies that apply to traditional Medicare reimbursement to improve or at least maintain access to inpatient care including behavioral healthcare in rural areas.

Encourage MA plans to provide coverage beyond the 190-day lifetime limit

Medicare beneficiaries are limited to 190 days of inpatient care in a psychiatric hospital over the course of their entire lifetime. No other lifetime limits exist in Medicare for any other type of inpatient care. Eliminating the Medicare 190-day lifetime limit for psychiatric hospitals would expand beneficiary choice, increase access for those with more serious behavioral health conditions, improve continuity of care, create a more cost-effective Medicare program, and align Medicare with parity, the standard required for practically all other healthcare coverage programs.

According to CMS staff, although MA 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". This is not surprising as beneficiaries with serious behavioral health conditions tend to generate higher healthcare costs due to a number of factors, including the high rate of co-morbid physical health conditions among this population.[xlvii]

National Association for Behavioral Healthcare

Access. Care. Recovery.

To improve access to inpatient behavioral healthcare for Medicare beneficiaries enrolled in MA plans and increase inpatient behavioral healthcare facility enrollment in MA plans, we urge CMS to use the authority to offer supplemental benefits through MA plans and develop financial incentives to encourage availability of this level of care based on medical necessity as opposed to an arbitrary and highly discriminatory 190-day lifetime limit.

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.

---

[i] Vahratian A, Blumberg SJ, Terlizzi EP, Schiller JS: Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. MMWR Morb Mortal Wkly Rep. ePub: 26 (March 2021). Available at http://dx.doi.org/10.15585/mmwr.mm7013e2.

[ii] Czeisler MÉ , Lane RI, Petrosky E, et al: Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. Available at http://dx.doi.org/10.15585/mmwr.mm6932a1external.

[iii] Pollard MS, Tucker JS, Green HD: Changes in Adult Alcohol Use and Consequences During the COVID-19 Pandemic in the US. JAMA Network Open, 3(9):e2022942 (2020). Available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770975.

[iv] Ahmad FB, Rossen LM, Sutton P: Provisional drug overdose death counts. National Center for Health Statistics. 2022 Available at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

[v] Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. MMWR Morb Mortal Wkly Rep 2021;70:888–894. DOI: http://dx.doi.org/10.15585/mmwr.mm7024e1.

[vi] Hawryluck L, Gold WL, Susan, S: SARS Control and Psychological Effects of Quarantine, Toronto, Canada, Emerg Infect Dis 10(7): 1206–1212, July 2004; Reardon S: Ebola's mental-health wounds linger in Africa: health-care workers struggle to help people who have been traumatized by the epidemic. Nature 519 (7541): 13, 2015; Goldmann E, Galea S: Mental health consequences of disasters. Ann Rev Public Health 35: 169–83, 2014. Available at https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-032013-182435?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed.

[vii] Coe E, Collins K, Enomoto K, Ononogbu U. Insights on Utilization of Behavioral Health Services in the Context of Covid-19. McKinsey & Company. June 15, 2021. Available at https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/insights-on-utilization-of-behavioral-health-services-in-the-context-of-covid-19.

[viii] Mcginty B. Medicare's Mental Health Coverage: How Covid-19 Highlights Gaps and Opportunities for Improvement. Commonwealth Fund Issue Brief, July 2020. Available at https://www.commonwealthfund.org/sites/default/files/2020-07/McGinty_Medicare_mental_hlt_COVID_ib.pdf.

[ix] *Ibid*.

[x] Owens PL (AHRQ), Fingar KR (IBM Watson Health), McDermott KW (IBM Watson Health), Muhuri PK (AHRQ), Heslin KC (AHRQ). Inpatient Stays Involving Mental and Substance Use Disorders, 2016. HCUP Statistical Brief #249. March 2019. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb249-Mental-Substance-Use-Disorder-Hospital-Stays-2016.pdf (Data does not include psychiatric or other behavioral health focused hospitals).

[xi] Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2020, Detailed Tables, Table 5.2A, https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables.

[xii] Centers for Medicare and Medicaid Services. Access to Care among Medicare Beneficiaries With and Without Depression, Medicare Current Beneficiary Survey Data Highlight, June 2017. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Downloads/ATC_Depression_2017.pdf.

[xiii] Centers for Medicare and Medicaid Services. Access to Care among Medicare Beneficiaries With and Without Depression, Medicare Current Beneficiary Survey Data Highlight, June 2017. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Downloads/ATC_Depression_2017.pdf.

[xiv] Jacobson G. et al., Medicare Advantage: How Robust Are Plans' Physician Networks? (Oct. 5, 2017). Available at www.kff.org/medicare/report/medicare-advan - tage-how-robust-are-plans-physician-networks/.

[xv] Martino SC, Elliott MN, Haviland AM, et al. Comparing the Health Care Experiences of Medicare Beneficiaries with and without Depressive Symptoms in Medicare Managed Care versus Fee-for-Service. Health Services Research. 2016 51(3): 1002-1020. https://doi.org/10.1111/1475-6773.12359

[xvi] Centers for Medicare and Medicaid Services: Patient Protection and Affordable Care Act; HHS notice of Benefit and Payment Parameters for 2023. Proposed Rule. 87 Fed. Reg. 584. Jan. 2022.

[xvii] See 42 CFR 422.102(f)(1)(i).

[xviii] Mee-Lee D, Shulman GD, Fishman MJ, et al, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-occurring Conditions. 3rd ed. 2013.

[xix] American Association of Community Psychiatrists. (2009) LOCUS Level of Care Utilization System for Psychiatric and Addictions Services, Adult Version 2010. Retrieved from http://cchealth.org/mentalhealth/pdf/LOCUS.pdf.

[xx] Office of the Assistant Secretary for Planning and Evaluation (ASPE): Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing. November 2021.

[xxi] Melek, S., Davenport, S. & Gray, T.J., Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement (Nov. 19, 2019), https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.

[xxii] *Ibid*.

[xxiii] Melek, S., Davenport, S. & Gray, T.J., Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement (Nov. 19, 2019), https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.

[xxiv] Pelech D, Hayfor T. Medicare Advantage And Commercial Prices For Mental Health Services. Health Affairs. 2019 Feb;38(2):262-267. DOI: 10.1377/hlthaff.2018.05226.

[xxv] Mark TL, Olesiuk W, Ali MM, et al. Differential Reimbursement of Psychiatric Services by Psychiatrists and Other Medical Providers. Psych Services. 68:281-285. 2018. doi: 10.1176/appi.ps.201700271.

[xxvi] Pelech D, Hayfor T. Medicare Advantage And Commercial Prices For Mental Health Services. Health Affairs. 2019 Feb;38(2):262-267. DOI: 10.1377/hlthaff.2018.05226.

[xxvii] Centers for Medicare and Medicaid Services. Medicare Managed Care Manual, Chapter 16-B: Special Needs Plans, Rev. 123, Issued: Aug. 19, 2016. See Section 70.2, SNP-Specific Plan Benefit Packages. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf.

[xxviii] 42 CFR 422.110(a)(1).

[xxix] See Departments of Labor, Health and Human Services, and Treasury. FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45. April 2, 2021. Available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

[xxx] Centers for Medicare and Medicaid Services: Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond. 86 Fed. Reg. 53412. Nov. 26, 2021. Available at https://www.federalregister.gov/documents/2021/09/27/2021-20509/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver.

[xxxi] *Wit v. United Behavioral Health*, Case No. 14-cv-02346-JCS (N.D. Cal. Nov. 3, 2020).

[xxxii] California SB-855 https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855 ; Illinois HB2595 https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855 ; and Oregon HB 3046 https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3046/Enrolled.

[xxxiii] Mace S, Boccanelli A, Dormond M: The Use of Telehealth within Behavioral Health Settings: Utilization, Opportunities, and Challenges. Behavioral Health Workforce Research Center, University of Michigan, (March 2018) Available at https://behavioralhealthworkforce.org/wp-content/uploads/2018/05/Telehealth-Full-Paper_5.17.18-clean.pdf ; Bashshur RL, Shannon GW, Bashshur N, Yellowlees PM: The empirical evidence for telemedicine interventions in mental disorders. Telemed J E Health, 22(2): 7-113 (Jan. 2016).

[xxxiv] National Quality Forum and AHA Center for Health Innovation: Redesigning Care: a How-To Guide for Hospitals and Health Systems Seeking to Implement, Strengthen and Sustain Telebehavioral Health. (2019). Available at https://www.aha.org/system/files/media/file/2020/03/Telebehavioral-Health-Guide-FINAL-031919.pdf .

[xxxv] Lin L, Casteel D, Shigekawa E, et al.: Telemedicine-delivered treatment interventions for substance use disorders: A systematic review. Journal of Substance Abuse Treatment, 101: 38-49 (June 2019).

[xxxvi] Koma W, Cubanski J, Neuman T: Medicare and Telehealth: Coverage and Use During the Covid-19 Pandemic and Options for the Future. Kaiser Family Foundation, (May 2021). Available at https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future/.

[xxxvii] Sachs JW, Graven P, Gold JA, et al. Disparities in Telephone and Video Telehealth Engagement during the Covid-19 Pandemic. J Am Med Informatics Assn 4(3): 1-5, 2021. Available at https://academic.oup.com/jamiaopen/article/4/3/ooab056/6334258.

[xxxviii] See Centers for Medicare and Medicaid Services. 2022 Star Ratings Fact Sheet. Available at https://www.cms.gov/files/document/2022-star-ratings-fact-sheet1082021.pdf.

[xxxix] CMS, Center for Medicare Services. Memo titled Medicare Health Outcomes Survey (HOS) Outcome Measures Moved to Display for 2022 and 2023 Star Ratings. August 5, 2021. Available at https://www.cms.gov/httpseditcmsgovresearch-statistics-data-and-systemscomputer-data-and-systemshpmshpms-memos-archive/hpms-memos-wk-1-august-2-6 .

[xl] Muskie School of Public Service, Research and Policy Brief: Rural Inpatient Psychiatric Units Improve Access to Community-based Mental Health Services, but Medicare Payment Policy a Barrier. Maine Rural Health Research Center. Aug. 2007. Available at http://muskie.usm.maine.edu/Publications/rural/pb36/IPU.pdf .

[xli] Shartia R. Thomas et al., *A Comparison of Closed Rural Hospitals and Perceived Impact,* NC Rural Health Res. Program (Apr. 2015), https://www.ruralhealthresearch.org/mirror/10/1000/comparison-of-closed-rural-hospitals-and-perceived-impact.pdf.

[xlii] Balanced Budget Act of 1997 (Pub. L. 105-33).

[xliii] Pengxiang Li et al., *Converting to Critical Access Status: How Does it Affect Rural Hospitals Financial Performance?* Inquiry: The Journal of Health Care Organization Provision, and Financing 46, 46 (2009).

[xliv] *Critical Access Hospitals' Experiences with Medicare Advantage Plans*, NORC Walsh Ctr. for Rural Health Analysis & RUPRI Ctr. for Rural Health Pol'y Analysis (2008).

[xlv] Jessica Seigel, *Rural Hospital Closures Rise to Ninety-Eight*, Nat'l Rural Health Ass'n (Feb. 20, 2019), https://www.ruralhealthweb.org/blogs/ruralhealthvoices/february-2019/rural-hospital-closures-rise-to-ninety-seven.

[xlvi] David Mosley & Daniel DeBehnke, *Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents*, Navigant (Feb. 22, 2019), https://www.navigant.com/insights/healthcare/2019/rural-hospital-sustainability.

[xlvii] Figueroa, JF, Phelan J, Orav EJ, et al. Association of Mental Health Disorders with Health Care Spending in the Medicare Population. JAMA Netw Open. 2020; 3(3). Available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762948.