January 05, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

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:

Thank you for the opportunity to comment on the proposed rule CMS-4205-P that includes changes to the Medicare Advantage (MA) Program, specifically the proposed network adequacy requirements for the new outpatient behavioral health specialty type.

Mental Health America (MHA) – founded in 1909 – is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the mental health of all. With nearly 200 affiliate organizations in 41 states, our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services, early identification, integrated care, behavioral health services, and supports.

We strongly support the proposed addition of an outpatient behavioral health specialty type at 42 CFR 422.116(b)(2) as well as the accompanying time and distance standards for this facility type added to 42 CFR 422.116(d)(2), but with **two modifications** to strengthen these provisions. And, we suggest an **additional modification** to 42 CFR 422.116(a)(3)(i) to improve access to care and ensure that behavioral health networks are accurate and adequate.

We support, without modifications, the proposed addition of the new outpatient behavioral health specialty to the list at 42 CFR 422.116(d)(5) of specialty types for which MA plans receive a 10-percentage point credit towards the percentage of beneficiaries that reside within published time and distance standards when the plan includes one or more telehealth providers of that specialty type that provide additional telehealth benefits. Over the past four years telehealth has become a critical component of the behavioral health treatment landscape and comprises a significant portion of service delivery. While we do not think telehealth should be offered in lieu of in-person care, we do believe it is an appropriate means of supplementing a provider network and therefore support the addition of the outpatient behavioral health specialty type to paragraph (d)(5). This is especially the case because psychiatry, clinical psychology, and clinical social work are already included in paragraph (d)(5).

We also support, without modifications, the proposed additions to 42 CFR 422.137 that would require MA plans to have at least one member with expertise in health equity on their utilization management committees, require MA plans to conduct an annual health equity analysis on the use of prior authorization, and require that the results of these analyses be posted on MA plans' websites. It is critical that MA plans seek to achieve health equity, particularly in their utilization management practices. The analysis required in the proposed 422.137(d)(6) will elucidate whether prior authorization is being

deployed in an equitable fashion for those receiving low-income subsidies, those who are dually eligible for Medicare and Medicaid, and those who have a disability. A significant number of Americans with serious mental illnesses are enrolled in Medicare due to disability status and they are not afforded the protections of the Mental Health Parity and Addiction Equity Act (MHPAEA) due to the law's inapplicability to any parts of Medicare. Given the continued noncompliance seen by plans and insurers who are subject to MHPAEA, particularly in terms of utilization review, it would not be surprising if MA plans are engaging in discriminatory prior authorization practices for those with serious mental illness. This analysis and the public posting should reveal whether that is the case or not.

As noted above, we have three recommendations that would make these proposed changes stronger and ensure that MA beneficiaries have sufficient access to both mental health and substance use disorder outpatient care:

- The proposed base time and distance standards for the outpatient behavioral health specialty type should match the time and distance standards established for the Outpatient Clinical Behavioral Health specialty type for Qualified Health Plans (QHPs).
- The outpatient behavioral health specialty type should be broken out into an outpatient mental health specialty type and an outpatient substance use disorder specialty type.
- Providers who have not billed an MA plan in the previous plan year should not count towards meeting the network adequacy standards for that plan.

Time and Distance Standards Should Match the Standards for Qualified Health Plans

The proposed outpatient behavioral health specialty type at 422.116(b)(2) aligns neatly with the outpatient clinical behavioral health specialty type established under the QHP standards. However, the proposed maximum time and distance standards for the new outpatient behavioral health specialty type at 422.116(d)(2) are quite different than the maximum time and distance standards found in the QHP standards (page 13). For each of the five county designations the maximum time and distance standards proposed for the MA outpatient behavioral health specialty type are significantly greater than those established for the QHP outpatient clinical behavioral health specialty type. In some instances, the difference is twofold or more (large metro and metro).

This is not the case with psychiatry and inpatient psychiatric facility services. The maximum time and distance standards under 422.116(d)(2) for these specialty types are identical to the QHP standards for psychiatry and inpatient or residential behavioral health facility services, respectively.

Further, for virtually every other specialty type, the standards established by 422.116(d)(2) are exactly the same as those in place for QHPs. In other words, outpatient behavioral health is essentially the only specialty type for which MA has different maximum time and distance standards than those for QHPs, and they are much worse. Given that Medicare beneficiaries are age 65 and above or are enrolled in Medicare due to disability status—particularly those with serious mental illnesses—the time and distance standards for MA plans should be at least equal to or even more stringent than those for the Qualified Health Plans serving younger, healthier individuals. However, the proposed rules provide less access for those with greater needs and must be modified to create consistent standards across plans and populations. We understand that there was a methodology used from the February 2020 proposed rule (85 FR 9002) with updated data from 2021 and 2022 Part B claims. However, MA beneficiaries continue to experience challenges accessing care and aligning standards with the QHP standards will enhance consistency across insurance products.

Separate Specialty Types for Mental Health and Substance Use Disorder

CMS' stated rationale (88 FR 78484) for why it has created a combined outpatient behavioral health specialty type inclusive of multiple providers instead of one for opioid treatment programs (OTPs) alone is because it believes this approach will still yield a "meaningful access standard for the OTP specialty type." We find this reasoning to be problematic and unlikely to create an accurate picture of the availability of SUD treatment within an MA plan's network.

We are concerned that the multiple different provider types included within the outpatient behavioral health specialty contains many who only provide either mental health care or substance use disorder care or providers who provide treatment predominantly for one and very minimal service delivery for the other, such as mere screening or referral.

Also, community mental health centers (CMHCs) are one of the provider types that many MA plans will indeed have in a capacity that meets the time and distance standards for the proposed outpatient behavioral health specialty type. Ostensibly, CMHCs could be pointed to as offering mental health and substance use disorder services. But, CMHCs often only provide substance use disorder care for individuals who are receiving primary treatment for a co-morbid mental health condition, if they provide substance use disorder treatment at all.

In fact, CMHCs primarily exist for the purpose of providing mental health treatment and not necessarily providing substance use disorder treatment. This is made plainly obvious by reading how CMHCs are defined at 42 CFR 410.2 and then by reading the conditions of participation for CMHCs found at 42 CFR 485.900 through 485.920. The term "substance use disorder" appears zero times and "substance abuse" appears once in a very tangential fashion within the definition of "mental health counselor" at 42 CFR 485.904(b)(5). The conditions of participation are quite lengthy and detailed, and it is very clear that they are structured for mental health treatment and not substance use disorder treatment. There are no requirements for CMHCs to provide medications for opioid use disorder (MOUD) nor are there any requirements that they can provide the services necessary for levels 2.1, 2.5, or 2.7 of the ASAM Criteria Continuum of Care.

There is a very real possibility that by creating this outpatient behavioral health specialty type that is inclusive of both mental health and substance use disorder provider types there will be many MA plans that actually have zero providers within the time and distance specifications that provide evidence-based substance use disorder treatment, especially MOUD. Under the current proposed structure, even if an MA plan meets the time and distance standards for the new outpatient behavioral health specialty type, it will be impossible to know if the plan has real access to OTPs, MOUD, and other outpatient substance use disorder care. Splitting this new specialty type into outpatient mental health and outpatient substance use disorder should alleviate this issue and ensure adequate access to care for MA enrollees.

Providers Who Have Not Billed in the Previous Year Should Not Count

This recommendation is very simple. Providers who have not billed an MA plan during the most recent plan year are not really in the network and should not count towards meeting the network adequacy standards for that plan. Providers as such are what contribute to "ghost networks" and this is more prevalent in behavioral health provider networks. This could be addressed easily within 42 CFR 422.116(a)(3)(i), which reads:

> (i) The following providers and facility types do not count toward meeting network adequacy criteria:

Paragraphs (a)(3)(i)(A) through (C) then list provider circumstances that currently lead to them being disqualified from counting for meeting the network adequacy criteria. A new paragraph (a)(3)(i)(D) could be added to read:

(D) Providers who have not billed the MA plan in the previous plan year.

Future Reforms to the Medicare Advantage Quality Bonus Program

Finally, we have a recommendation for future Medicare Advantage proposed rules. We recommend that the Medicare Advantage Quality Bonus Program, specifically the star ratings measures, add measures on prior authorization, network adequacy, and provider directory accuracy. Each of these three issues can have a profound effect on not just consumer experience with their MA plans, but also their ability to access needed care and their overall health outcomes. This is especially the case for individuals with mental health conditions and substance use disorders in MA because, as noted above, they are not afforded the protections of MHPAEA, unlike several hundred million other Americans. Excessive and stringent prior authorizations can delay or outright deny lifesaving care. Inadequate networks mean that even when care is approved, it is inaccessible and not received. Inaccurate directories reveal networks that exist only on paper, deceiving consumers into thinking they have sufficient access to care when they don't. These are important aspects of MA plan performance that consumers should know about when selecting a plan and therefore should be included as future star rating measures.

Thank you for providing MHA with the opportunity to comment. For questions or further information, please contact me at mgiliberti@mhanational.org.

Sincerely,

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