March 7, 2022

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Part D Proposed Rule; Request for Information: Building Behavioral Health Specialties Within MA Networks

Dear Director Brooks-LaSure,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule related to CY 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefits Programs (proposed rule). Our comments are outlined below and focus solely on the embedded request for information (RFI) on building behavioral health specialties within Medicare Advantage (MA) networks.

ABHW serves as the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat mental health (MH) and substance use disorders (SUDs), and other behaviors that impact health and wellness.

Overarchingly, our organization's goals aim to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes. Furthermore, through our policy work, we strive to promote equal access to quality treatment. We are deeply concerned about health disparities in this country in the areas of MH and SUD services and are committed to promoting health equity in the health care system.

With regard to the RFI, we appreciate CMS seeking information to build better behavioral health networks. As you consider policy changes on this critical issue, we submit the following for your consideration.

Challenges related to lack of behavioral health provider supply in certain geographic regions for beneficiaries, health plans and other stakeholders.

Benefits of Managed Care.

We applaud CMS's goal to ensure greater access and believe that strongly focusing on addressing the underlying workforce shortage is a key part of the strategy. COVID-19 has not only exacerbated the longstanding behavioral health workforce shortage, but also increased the need for behavioral health providers.[1] Challenges with provider networks have been on-going. For example, due to the demand, psychiatric practices fill up very quickly, even if the provider is only seeing private-pay patients, so providers do not immediately see the added value of managed care organizations to their practices. In reality, managed care can add significant value to both providers and patients, as it allows the health plans to help coordinate with the providers to enhance patient care and more importantly, allows providers to collaborate with one another to better patient outcomes. Furthermore, managed care organizations offer benefits to providers with continuing medical education and access to data they may not otherwise be able to access.

Provider Challenges.

Administrative burdens.

Health plans recognize that pain points exist for physicians related to being a part of a network. For example, regarding the pharmacy benefit for Medicare Part D, it can be difficult for providers to be reimbursed for prescribing medication to this population since each Medicare Advantage plan has its own formulary. To identify and address these pain points, we urge CMS to consider working with Congress on a legislative solution as well as requesting that the Center for Medicare and Medicaid Innovation put forth a demonstration on this issue.

Furthermore, for each network that a provider belongs to, he/she must currently attest their qualifications quarterly. Such an administrative burden may discourage providers from joining networks. We recommend CMS consider establishing a common location where providers can attest for all of their networks simultaneously. Potentially, the Council for Affordable Quality Healthcare's

[1] Barna, Mark, Mental health workforce taxed during COVID-19 pandemic: Worker shortage hinders access, *The Nation's Health*, 51(10) 1-14; January 2022.

credentialing system can be expanded to allow providers to also attest their qualifications.

Appropriately utilizing telehealth services.

Additionally, telehealth providers have been an important resource in the nation's response to COVID-19 and will continue to provide much-needed services and fill in the gaps in care after the pandemic ends. CMS should engage with stakeholders and consider methods other government programs use to include telehealth providers in network adequacy standards.

Allowing providers to practice at the top of their license.

1. <u>Coverage for marriage and family therapists, mental health counselors, and peers</u>.

We advocate for solutions to expand access to care and address ongoing workforce shortages across the country to help ensure people who need MH/SUD treatment get the care they need. As one first step, CMS should consider working with Congress to expand eligible Medicare providers to include marriage and family therapists (MFTs), mental health counselors (MHCs), and certified peer support specialists.

- ***Medicare coverage of mental health counselors and marriage and family therapists***. Recognition of MHCs and MFTs as Medicare providers would increase the pool of eligible mental health professionals by over 200,000 licensed practitioners. Studies have shown that these providers have the highest success and lowest recidivism rates with their patients as well as being the most cost effective.[2] We ask that CMS urge Congress to pass the Mental Health Access Improvement Act (S. 828, H.R. 432), which recognizes MHCs and MFTs as covered Medicare providers, helps address the critical gaps in care, and ensures access to needed services.

- ***Medicare coverage of peer support services***. Certified peer support specialists can be vital in providing support to people living with mental health conditions and SUDs. These paraprofessionals are individuals with

[2] D. Russell Crane and Scott H. Payne, Individual Versus Family Psychotherapy in Managed Care: Comparing the Costs of Treatment by the Mental Health Professions, Journal of Marital & Family Therapy 37, no. 3 (2011): 273- 289.

lived experience of recovery from a MH disorder or SUD. This evidence-based practice helps individuals navigate the often-confusing health care system, get the most out of treatment, identify community resources, and develop resiliency. Due to the COVID-19 pandemic, engagement with treatment and care has been disrupted, but finding and utilizing support, such as peer services, in a timely manner can help mitigate negative health outcomes of the disruption. To that end, we urge CMS to work with Congress to pass the Promoting Effective and Empowering Recovery Services in Medicare (PEERS) Act of 2021 (S. 2144, H.R. 2767), which recognizes the unique role of peer support specialists in helping individuals better engage in services, manage physical and mental health conditions, build support systems, and, ultimately, live self-directed lives in their communities.

Adding MHCs and MFTs to the list of covered providers would not only expand the behavioral health workforce but would allow the providers currently covered by Medicare to practice at the top of their licenses.

2. Collaborative Care Model.

Several years ago, CMS approved the Collaborative Care Model (CoCM), which provides specific billing codes for an evidence-based mode of care to deliver mental health and SUD services in primary care. The CoCM provides for patients to be treated by their primary care physician in conjunction with a behavioral health care manager and a consultant psychiatrist. It has been proven to be an effective model that integrates care, expands access, and improves outcomes.

ABHW believes the CoCM is an important model not only because of its ability to provide integrated care, but because it makes primary care providers more comfortable with talking about behavioral health issues with their patients, thus creating a larger workforce capable of treating SUDs and mental health disorders. It also allows behavioral health providers to see more patients by practicing at the top of their license. We continue to support CMS in its efforts to expand the use of CoCM and welcome the opportunity to partner with CMS to advance this important initiative.

Challenges related to accessing behavioral health providers for enrollees in MA health plans, including appointment wait times.

ABHW recognizes the importance of having network adequacy and supports policies that will bolster the behavioral health workforce. However, we caution CMS in considering provisions to evaluate network adequacy based not only on time and distance standards, but also using appointment wait-times for services. We believe that, particularly for behavioral health services, this proposal will only exacerbate an already overburdened system by creating additional administrative burdens.

Furthermore, if wait times are used as a barometer for network adequacy, there must be clear guidance on how health plans can assess appointment wait times consistently, and how CMS may replicate that process consistently. Any standards related to appointment wait times should be based on a verified, data-driven assessment of plan networks, and should be considered as a component of the overall workforce.

Opportunities to expand access for substance use disorders (SUDs).

Medication-Assisted Treatment (MAT).

ABHW strongly supports any opportunities to expand access for OUD and SUD treatments. Specifically, we believe the biggest opportunity expanding access to SUDs is through increasing access to MAT. First, we urge CMS to work with Congress to eliminate the in-person evaluation requirement currently mandated by the Ryan Haight Act before a provider can utilize MAT. This requirement is difficult for many individuals with SUDs due to a physical inability to leave the house or to a lack of provider in their geographic area.

Second, we ask CMS to work with the Drug Enforcement Administration (DEA) to promulgate the long overdue rule for the telemedicine special registration process, and to urge DEA to ensure that the rule allows providers to prescribe MAT to SUD patients by employing telemedicine.

Lastly, we also advocate for removing the DEA X-waiver requirement for practitioners before prescribing buprenorphine. We appreciate the practice

guidelines[3] that the U.S. Department of Health and Human Services published last year to alleviate some of the administrative burden around the X-waiver but we do not believe the practice guidelines go far enough. As such, we urge CMS to work with Congress to pass the Mainstreaming Addiction Treatment Act of 2021, which would eliminate the X-waiver and increase the workforce of providers prescribing MAT.

Contingency Management.

While ABHW does not support mandating specific treatments and services, we do support removing barriers to clinically appropriate treatment for substance use disorders, such as contingency management. Specific to contingency management, we support seeking a blanket waiver from CMS for anti-kickback violations, supporting the creation of appropriate billing codes, as well as educating regulators and the public on the benefits of contingency management.

<u>Other Considerations</u>.

Concerns with Fraud, Waste, and Abuse.

In conjunction with policies to expand access to SUDs, it is prudent to acknowledge that more work needs to be done to curb fraud, waste, and abuse in SUD treatment. Payers often struggle with unlicensed or unregulated providers, while they may be technically expanding the workforce by adding numbers, they are also causing potential harm to patients. To verify a provider, managed care organizations need to conduct burdensome investigations to ensure vulnerable patients are not harmed, which slows down the process of expanding the number of available providers. We note that the Medicare population is especially vulnerable to this type of exploitation.[4]

Additionally, the window to get someone into treatment is often small and passes quickly, and once passed, the individual may no longer want to seek treatment,

---

[3] Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder, 86 FR 22439 (April 28, 2021).
[4] Nicholas, L., Hanson, C., Segal, J., et al. Association Between Treatment by Fraud and Abuse Perpetrators and Health Outcomes Among Medicare Beneficiaries, JAMA Internal Medicine, October 28, 2019. https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder, last visited February 11, 2022.

resulting in loss of care for that patient. As such, we recommend CMS establish a national group or committee to regulate SUD providers, which will help to standardize requirements for SUD providers as well as alleviate the strain on payer resources.

Provider Contracting Decisions May Exacerbate Coverage Issues.

Providers often do not uniformly accept different insurance plans, which may lead to disparities in care. For example, if Plan A covers most services and Plan B covers only 25% of services, treating patients with Plan A will be a priority for the provider. Not all individuals need or can afford coverage under Plan A but providers in Plan B may not have the same provider access and this may ultimately lead to patient harm. Furthermore, when situations like this arise, payers have limited levers to correct the issue. Specifically, the only recourse for a payer is to terminate the contract with the provider, which only exacerbates the workforce shortage issue.

Conclusion.
Thank you for the opportunity to comment on this important proposed rule. Please feel free to contact Deepti Loharikar at loharikar@abhw.org or (202) 499-2279 with any questions.

Sincerely,

Pamela Greenberg, MPP
President and CEO