



February 13, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services
Attention: CMS-9898-NC
P.O. Box 8016, Baltimore, MD 21244-8016

RE: Medicare Advantage and Part D 2024 (MAPD): CMS-4201-P

Dear Administrator Brooks-LaSure:

The Association of Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (MAPD).

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 the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness.

Our organization aims 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 and address the stark inequities created by systemic racism. 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 healthcare system.

This proposed rule expands network adequacy and prior authorization requirements for Medicare Advantage Organizations (MAO). Below please find our comments on the specific provisions of the Notice of Proposed Rule Making (NPRM or proposed rule).

I. MA Provider Directories

ABHW recognizes and supports the need for accurate provider directories, particularly in light of the increasing demand for services and accompanying workforce shortages, straining the system's capacity overall. MAO provider directories depend on timely and accurate data submissions from providers. We recognize that this creates an administrative burden on providers, particularly behavioral health providers, who often operate small businesses independently without staffing support. They often use their personal information to operate their practices, making it difficult for health plans to monitor their availability and relay timely and accurate information about the provider to the MAO membership. As a result, tracking the input of information maintained continuously and under the providers' control in the directory is challenging.

We strongly believe that maintaining up-to-date, robust provider directories should be a shared responsibility of providers and health plans. **We encourage CMS to support providers through funding incentives, technical assistance, and training for small-scale behavioral health providers to meet their obligations to provide timely and accurate information and information updates to MAO.**

II. Network Adequacy

1. Adding Clinical Psychologists and Licensed Clinical Social Workers

ABHW supports CMS's concept to add Clinical Psychologists and Licensed Clinical Social Workers to the network adequacy standards as these categories of providers provide material services for behavioral health and are in significant demand. However, developing these mandated network adequacy requirements will not solve the mental health workforce shortage, as confirmed by the recent GAO report.¹

We recommend CMS delay this proposal to 2025, given the challenges to MAO establishing adequate provider networks for these new provider types by Plan Year 2024. If this proposal is finalized, we request that CMS issue sub-regulatory guidance providing flexibility in circumstances where there are not enough providers and continue to work with stakeholders to expand the supply of providers. We also urge CMS not to dictate which types of practitioners must be used to meet enrollees' behavioral health needs but instead allow MAO to tailor their network of behavioral health professionals to meet the needs of their patient population.

¹ GAO, Behavioral Health: Available Workforce Information and Federal Actions to Help Recruit and Retain Providers, October 2022, available at <https://www.gao.gov/products/gao-23-105250>

2. Adding Prescribers of Medications for Opioid Use Disorder (MOUD)

We request that CMS withdraw the proposal to add prescribers of MOUD as a specialty type to network adequacy requirements. There are numerous pending regulations expected between now and 2024 that will alter the scope of providers qualified and permitted to prescribe MOUD treatment. The current environment is in flux regarding the need for MOUD waivers - even since the publication of this proposed rule - with the passage of the Mainstreaming Addiction Treatment Act (MAT) and the Medication Access and Training Expansion (MATE) Act in the Consolidated Appropriations Act of 2023 (CAA). Additionally, there is pending rulemaking from the Drug Enforcement Agency (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) expanding flexibilities for Opioid Treatment Program (OTP) qualifications and treatment, which significantly impact MOUD providers and services. Furthermore, we are also awaiting the special registration for the practice of telemedicine and waiver rules for providers who treat opioid use disorders (OUDs) and proposed regulations that allow providers to continue prescribing controlled substances by telemedicine. All these changes will impact providers who may or may not qualify for inclusion in the proposed MOUD category. It will add unnecessary confusion and burden if health plans identify MOUD providers in current directories that will be outdated once other planned rulemaking and guidance are released. This lack of clarity and the frequency of additions and subtractions of MOUD providers from provider directories will confuse consumers and mislead them about which providers can provide the care and treatment they seek. **At a minimum, we urge CMS to delay adding these additional MOUD regulations until CY 2025, after these other expected changes are rolled out and the qualifications of this category are clearer. We encourage future guidance on how MOUD providers should be identified within this category.**

3. Extending Telehealth Credits to Behavioral Health Specialists above 10%

ABHW members strongly endorse the proposal that Medicare Advantage plans would be able to obtain the benefit of the existing ten percentage points credit toward meeting the time and distance standards of these new specialty providers within their network adequacy standards. Telehealth has proven to be an effective way to expand access to high-quality care – particularly in behavioral health. The United States Department of Health and Human Services (HHS) and CMS have acknowledged the benefits of telehealth and should continue to evaluate ways to improve access, particularly in rural areas or areas with significant provider shortages. **Given the acute workforce challenges limiting the supply of behavioral health providers and the efficacy of delivering behavioral health services via telehealth, we request that CMS consider increasing the telehealth credit above 10%.**

III. Enrollee Notification Requirements for MAO, Provider Contract Terminations

CMS proposes to add new specific enrollee notification requirements provisions to address provider contract terminations that involve behavioral health providers. CMS does not

provide sufficient analysis to explain why behavioral health providers should be treated differently, from a contract termination perspective, from other specialties that beneficiaries consider very important.

ABHW believes CMS's proposal to create special behavioral health termination notice requirements is unnecessarily burdensome and inconsistent with industry standards on notification practices. This proposal will not meaningfully improve transparency or access for MAO members needing behavioral health services. CMS's requirements would require issuing a termination notice to all enrollees who have been the terminated provider's patient. As written, the proposal puts no timeframe or other qualifying conditions on this requirement which means, for example, that notice would have to be provided to any patient of that provider, including, for example, a patient who last had treatment with the provider several years prior. These changes to existing plan provider termination notifications processes and procedures would require significant expense and staff time and inevitably drive higher administrative costs without material benefit to members. Former patients who receive termination notices from treatment that ended years earlier will be confused. **We urge CMS to withdraw this specialized proposal for behavioral health provider terminations or, in the alternative, create a definitive cut-off period based on the last appointment between a provider and a patient of no greater than one year.**

In addition, this rule proposes that MAO notify enrollees at least 45 calendar days before the termination effective date for contract terminations that involve a primary care or behavioral health provider instead of 30 calendar days for other provider types. Some providers terminate their contract in less than 45 days (as is often their right under their contract), and the industry standard is 30 days for terminations without cause. **We encourage CMS to maintain the existing requirements that plans issue notice to enrollees within a defined period from receipt of the provider notice, which should be no less than 30 days.**

We also oppose the proposal to require telephonic notification as unnecessarily duplicative and administratively burdensome without significant demonstrated benefit. Furthermore, our members find that telephonic outreach is often not well received by beneficiaries. **We strongly believe written notice is sufficient and request CMS withdraw this proposal.**

IV. MAO Access to Services: Appointment Wait Time Standards

CMS proposes to codify appointment wait times as standards for primary care services that are the same as those described in the Medicare Managed Care Manual and to extend those standards to behavioral health services. CMS also seeks comments on alternative specific appointment wait times standards to apply to MAO.

ABHW supports the concept of making sure beneficiaries avoid long wait times for services. However, given that the current behavioral health workforce shortages are already taxing the system, CMS's proposed behavioral health wait time of 10 days will be almost impossible to operationalize. We urge CMS to adopt a flexible approach to wait time

standards, particularly for behavioral health, that doesn't increase the burden on the already strained behavioral health workforce. Numerous external factors beyond a health plan's control determine the ability to meet wait time standards, including an enrollee's clinical condition, geography, weather, time of year, and a provider's capacity.

We request that CMS align wait times for behavioral health services with existing standards already applied in the industry – such as the National Committee for Quality Assurance (NCQA) standards, which are already standardized across provider types and will eliminate confusion among stakeholders – plans, providers, and patients. Additionally, at a minimum, CMS should implement a different timeframe for non-emergency behavioral health services to be fourteen days versus the proposed one week. Given that emergency or urgent care is generally made available across the industry within “72 hours,” there should be a more differentiated standard for non-urgent care. This seems warranted for non-emergency behavioral health, with the unprecedented demand for services and limitations in the system and workforce today.

V. Expanding Emergency Services

CMS proposes modifications and revisions to the regulations governing when and how MAO develop and use coverage criteria and utilization management policies to ensure that MAO enrollees receive the same access to medically necessary care they would receive in traditional Medicare.

1. Behavioral Health to Continuity of Care & Integration

The proposed rule would add behavioral health services to the list of services for which MAO must have programs for continuity of care and integration of services. **Before making changes, we request that CMS share the list of specific behavioral health services that will be added for continuity of care and integration of services purposes.**

2. Clarifying Emergency Medical Condition

CMS proposes to clarify the definition of “emergency medical conditions” to include both physical and mental health conditions and codify section 1852(d)(3)(B) of the Social Security Act. The MAO would be required to reimburse a provider for emergency services without prior authorization, or the emergency care provider must have a contractual relationship with the MAO.

ABHW agrees that behavioral health events can constitute an emergency medical condition. Therefore, we support clarifying that emergency medical conditions can arise from a MH or SUD diagnosis. However, defining emergency medical conditions as “conditions for which an enrollee may receive behavioral health crisis services” is not helpful because there is no universal definition of crisis services. We would suggest that “services for an emergency medical condition” and “behavioral health crisis services” are not always congruent terms. **We recommend that CMS work with the Substance Abuse and Mental Health Services**

Administration (SAMHSA) to define crisis services more clearly and establish care standards for these services in an emergency medical condition. ABHW welcomes the opportunity, as the 988 system and the crisis services continuum continue to be implemented and evolve, to engage with CMS on the need for clear definitions and standards to ensure a comprehensive emergency behavioral health response and crisis services system.

3. Prior Authorizations

Our members continue to develop and offer solutions to streamline prior authorization processes for providers with technology, most notably with Electronic Medical Record (EMR) integration. However, behavioral health providers have much lower adoption and utilization of EMRs and technology options than providers in other specialties.

Notably, there are far fewer mental health services offered by our member organizations subject to prior authorization than in the past. Further, although not applicable to Medicare, the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements have also impacted prior authorization requirements. Over the years, numerous members have removed or decreased the application of prior authorization and other medical management reviews from most in-network outpatient and telehealth-delivered services.

The real challenge to improving access and streamlining prior authorizations is access to technology. Behavioral health providers have been excluded from federal funding to adopt EMRs. **ABHW urges the Center for Medicare and Medicaid Innovation (CMMI) to develop a demonstration program to incentivize behavioral health providers to adopt EMRs and technology to comply with and leverage forthcoming interoperability guidelines. This would advance clinic integration and achieve cost savings for all stakeholders.**

Prior authorization is a critical element of care coordination, helping to ensure patient treatment is safe, medically necessary, high value, and appropriate. **We urge CMS to keep prior authorizations linked to services and not extend them to all subsequent treatments “over the course of treatment.”** It is clinically appropriate to undergo additional prior authorization analysis between stages of treatment. For example, for an individual diagnosed with OUD, a prior authorization would determine their first stage of treatment in an acute care detoxification facility but would not extend to all further residential rehabilitation and other services that may be required in their recovery journey. One of the essential elements of medical policy is ensuring that a service is provided at the correct point in the process. Prohibiting such medical policy would result in worse healthcare outcomes for beneficiaries and higher costs that would be passed on to beneficiaries in the form of higher premiums and fewer supplemental benefits.

4. Utilization Management (UM) Committee


ABHW supports ensuring UM policies are reviewed regularly by health plans with diverse clinical experience and expertise. This review must be applied in a productive manner that

minimizes duplication and administrative costs. NCQA accreditation already requires accredited plans to have qualified medical personnel review UM criteria and decisions. **We encourage CMS to consider eliminating repetitive actions and allow MAO to be deemed to have satisfied this requirement if they are NCQA accredited.**

Conclusion

Thank you for the opportunity to provide feedback on this proposed rule. We are committed to engaging with CMS and other partners on opportunities to improve behavioral health access. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,



Pamela Greenberg, MPP
President and CEO