ABHW
Advancing Health Care Policy
for Mental Health and Addiction

July 3, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
P.O. Box 8016, Baltimore, MD 21244-8016

Re: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, CMS–2439–P

Dear Administrator Brooks-LaSure:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rulemaking (NPRM or proposed rule) for the Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality.

ABHW is the national voice for payers managing 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 MH and SUD services in this country and are committed to promoting health equity in the healthcare system. ABHW recommends the adoption of flexible network adequacy standards rather than a one-size fits all approach. Below, please find our comments on the specific provisions of the proposed rule.

I. Access Standards

The U.S. does not have enough mental health professionals to meet the demand of the current mental health crisis. According to the Health Resources and Services Administration (HRSA), as of March 2023, 163 million Americans live in mental health professional shortage areas (HPSAs), with over 8,000 more professionals needed to ensure an adequate supply. For example, while nearly one-third of the U.S. population is Black or Hispanic, only about a tenth of practicing psychiatrists come from these communities.[i]

Moreover, there is a significant lack of access to specialty mental health care in rural areas, likely contributing to disparities in care. As many as 60% of rural Americans are estimated to live in designated mental health professional shortage areas.[ii]

- Behavioral Health Wait Times for Routine Services

ABHW supports the concept of making sure beneficiaries avoid long wait times for behavioral health services. Nonetheless, given that the current workforce shortages are already taxing the system, CMS's proposed behavioral health wait time of 10 days for routine appointments will be almost impossible to achieve**.** We urge CMS to adopt a flexible approach to behavioral health wait time standards that doesn't increase the burden on already strained practitioners.

Numerous external factors beyond a health plan's control determine the ability to meet wait-time standards, such as the patient's clinical needs, preferences, and geography. For example, an enrollee might be awaiting the results of diagnostic tests performed by third parties before an appointment can occur, or the enrollee might prefer to see a specific mental health practitioner that is temporarily unavailable. Geographic differences also influence wait times, especially for patients living in rural areas or other HPSAs where providers are more dispersed and transportation support is limited. Weather and time of year also need to be considered. For instance, winter storms might affect cancellations. While we appreciate CMS' intent to improve access, we are concerned that the standards presented are unduly inflexible and will fail to address or account for the severe workforce shortages in behavioral health.

ABHW recommends that the behavioral health appointment wait time standards should <u>not</u> be more stringent than primary care standards. At the very least, we recommend a phased-in approach to these wait-time provisions to decrease the overall burden on providers, encourage provider participation, and account for the significant behavioral workforce shortages. A rushed implementation will add confusion and costs, especially with outstanding implementation challenges with data and provider engagement and collaboration. For example, interoperability standards, technology for electronic health records, and provider scheduling systems need to be more widely adopted to ease scheduling functionality sharing between behavioral health providers and health plans. In addition, CMS should develop clearly defined guidance on assessment and wait times compliance.

Furthermore, ABHW believes a standardized definition is needed for "routine" behavioral health services. ABHW is concerned that CMS is leaving it up to states to define "routine,"

and as a result, there will be significant variability across states. What is defined as "routine" in one state may not be defined in another, leading to a patchwork of requirements that burden the system with increased complexity. **We encourage CMS to standardize the definition of "routine" rather than allow each state to determine what services are subject to the standard.** A universal definition of "routine" will afford beneficiaries across states equal access.

Generally speaking, we encourage CMS to defer to clinical expertise and recognize professional standards in establishing definitions and standards. Not all behavioral health patients need the same level of intervention, and some can have different intervals between appointments for "routine" care. For example, if a patient is maintaining or tapering off therapy, waiting longer between routine mental health appointments is beneficial. **We urge the adoption of language used in other states, such as Washington, that permits scheduling mental health services consistent "with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice."**[1]

According to this NPRM, Managed Care Organizations (MCOs) must ensure 90% compliance with these new behavioral health wait time requirements by the first rating period or after three years of the final rule's effective date. Workforce shortages are impacting all delivery systems and will complicate meeting these standards. **ABHW also recommends a phased-in approach that gradually builds up to a 90% compliance standard over five years, with an initial compliance threshold of 70% for the first rating period beginning on or after three years after the final rule's effective date, 80% after four years, and 90% by the fifth year.**

Lastly, ABHW recommends that CMS develop more flexible standards for geographic mental health deserts, such as reducing compliance thresholds in HRSA's HPSAs.

- Secret Shopper Surveys

This NPRM requires states to use an independent entity to conduct annual secret shopper surveys to validate managed care plans' compliance with appointment wait time standards and the accuracy of provider directories. The results of secret shopper surveys must be submitted to CMS annually and posted to the state's website within 30 calendar days of submission to CMS.

These mandated secret shopper survey provisions will add administrative burden for states and cause provider abrasion. This burden will be particularly apparent for behavioral health providers, who often operate small businesses independently without staffing support. **ABHW encourages CMS to build more flexibility into the provider**

[1] Washington State Law, Network Adequacy General Standard, WAC 284-170-200, 13(d) available at https://apps.leg.wa.gov/wac/default.aspx?cite=284-170-200

directory verification process by allowing providers to confirm the accuracy of directories through different means.

Independent secret shopper survey results can be helpful tools in improving the quality of care if the survey methodology is standardized, transparent, and applied consistently. These surveys and the results derived from such surveys can be skewed or inaccurate based on how questions are framed, how the sample is selected, and how rigorously answers are scored. However, this proposed rule suggests a survey requirement without first defining the survey methodology or the survey administration protocol. As a result, the surveys, administered by various third-party entities with no standard requirements established, will produce disparate methods, sample sizes, and results that do not reflect the realities of the directory information or access. **ABHW recommends a delay in adopting the secret shopper surveys until a methodology, guidelines for administration, and a standardized tool for administration, are developed. Furthermore, when CMS identifies a secret shopper methodology, we request at least a 60-day comment period to allow stakeholders to provide feedback on the proposed guidelines and measurement tools for these surveys. For example, the methodology should list the metrics for the sample size and include guidance on assessing the accuracy of responses. It should be designed to capture accurate data efficiently from disparate behavioral health practices, ranging from small behavioral health practitioners to large integrated health systems.**

- Telehealth

Currently, states with MCO contracts must consider the availability and use of telemedicine, e-visits, and other evolving and innovative technological solutions as an element in their network adequacy standards.

Telehealth has expanded access to behavioral health services in numerous ways. It has mitigated the impact of behavioral health provider shortages by expanding provider flexibilities in delivering care and allowing easier access for patients. Providers can schedule more appointments, and patients can access providers in other geographical areas. The convenience of telehealth has also increased access to culturally competent providers for marginalized and underserved individuals. Telehealth's ability to address mobility, transportation, and geographic barriers has begun transforming how individuals pursue behavioral health.

Given the efficacy of delivering behavioral health services via telehealth, ABHW encourages CMS to allow telehealth to be used to meet behavioral health time and distance standards. For example, Medicare Advantage allows a 10% telehealth credit toward meeting network adequacy requirements. **We urge CMS to develop a methodology that accounts for all the factors that impact network adequacy, including the availability of 24/7 care via telemedicine and geographic health deserts, including HPSA-designated shortage areas.**

II. In Lieu-of Services (ILOS) & Institutions for Mental Diseases (IMD)

This proposed rule codifies existing guidance for some In Lieu of Services (ILOS). However, it does not offer changes regarding the coverage of short-term stays in Institutions for Mental Diseases (IMD) as an ILOS or payments to MCOs for enrollees who are patients in an IMD. While Medicaid generally prohibits payments for services provided to beneficiaries in IMDs, the 2016 managed care rule clarified that states could use federal financial participation to make capitation payments to MCOs on behalf of non-elderly adults in IMDs in lieu of covered Medicaid services when certain conditions are met.

ABHW appreciates CMS's efforts to allow states to utilize ILOS for IMDs in the 2016 managed care rule. **We encourage CMS to work with Congress to eliminate the IMD exclusion permanently.** People with mental illness and SUDs should have access to a full range of treatment options, and inpatient psychiatric care may be an essential component of their treatment. **ABHW also encourages exempting Qualified Residential Treatment Programs (QRTPs) from the IMD exclusion.** These supports and services are necessary for some children and youth in the foster care system and were not intended to be considered IMDs. These restrictions limit access of Medicaid beneficiaries to inpatient care unnecessarily.

Finally, ABHW urges CMS to eliminate the proposal to impose a 5% cap on ILOS. While we are grateful that the cap will not impact IMDs, it will inadvertently limit the development of evidence-based models to help meet unmet behavioral healthcare needs. This proposal will limit flexibility for health plans and providers to propose an ILOS that is appropriate for certain enrollees or populations.

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

Pamela Greenberg, MPP
President and CEO

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[i] https://data.hrsa.gov/topics/health-workforce/shortage-areas

[ii] Kepley HO, Streeter RA. Closing behavioral health workforce gaps: a HRSA program expanding direct mental health service access in underserved areas. *American Journal of Preventive Medicine* 2018; 54(6 suppl 3): S190–S191. doi: 10.1016/j.amepre.2018.03.0066