May 29, 2024

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 Program; Request for Information on Medicare Advantage Data; CMS–4207–NC.

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) Request for Information (RFI) on Medicare Advantage (MA) data.

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.

MA provides access to critical MH and SUD care for over 32 million older adults. Over half of its beneficiaries live on annual incomes less than $24,500, and 27% of its enrollees are from Black, Latino, and Asian populations.[1] Nearly one-quarter of Medicare beneficiaries reported delaying care during the COVID-19 pandemic.[2] Now, many are seeking the behavioral health care they need. Moreover, MH conditions among older adults continue to increase steadily due to the ramifications of the social isolation that occurred because of the pandemic. During this time of increased behavioral health demand, we appreciate that CMS is asking questions to improve existing data capabilities to ensure

[1] https://bettermedicarealliance.org/publication/medicare-advantage-beneficiary-demographics/
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10806608/

efficiency in key aspects of MA, such as provider directories, prior authorization, and supplemental benefits. Please see our detailed feedback below.

I. Avoid Duplicative Reporting Obligations.

CMS already has access to a wide range of data, much of which the agency publishes publicly. Before adding new data requirements, **ABHW encourages CMS first to improve the usability and accessibility of the significant amount of data already submitted by MA plans and consider standardizing data terminology to promote alignment within Medicare, Medicaid, and other federal health programs.** For example, a recent CMS white paper highlights that Medicare and Medicaid use different categories when collecting enrollment data on race and ethnicity; Medicaid includes a category for 'multiracial' that does not exist in Medicare. This misalignment of categories can limit the ability to evaluate the impact on health outcomes and target interventions.

Any new data collection and reporting requirements should be designed to minimize the administrative burden on MA plans, providers, vendors, and other stakeholders. These requirements should not be redundant with existing requirements, be flexible enough to accommodate variation in the current MA plans, and not restrict future innovation in plan benefit design. **ABHW recommends that CMS engage with stakeholders on new data reporting requirements before they are proposed. A new proposal should follow the formal rulemaking process, with a notice and comment period.**

II. Clarify Supplemental Benefit Requirements.

The MA model enables providers to have more comprehensive, frequent patient visits and offers extensive supplemental benefits not covered under original Medicare. These supplemental benefits can include behavioral health services such as support groups and non-medical benefits such as housing, food, and caregiver respite. A 2022 Government Accountability Office (GAO) study analyzed nearly 3,900 MA plans and found that all but one offered supplemental benefits.[3]

The GAO notes that current guidance does not outline the process for health plans to submit data for supplemental benefits, and there are no applicable procedure codes for newer supplemental benefits.[4] **We encourage CMS to clarify the current reporting requirements for supplemental benefits, especially for new and innovative benefits.** If CMS is not receiving the supplemental benefits data from health plans it anticipated, it may be due to varying interpretations of current requirements. **ABHW recommends that CMS establish a monthly technical assistance call on the new data reporting requirements for vendors, providers, and health plans to answer these types of questions in a more formal way with open dialogue. At a minimum, we encourage CMS to release a Frequently Asked Questions (FAQ) document so that MA plans have a better understanding of current reporting requirements.**

ABHW also recommends that CMS clarify what supplemental benefits "utilization" means for reporting purposes. For example, does CMS define utilizing a behavioral health support group when a

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[3] https://www.gao.gov/products/gao-23-105527

[4] GAO. Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization. January 2023. Available here.

member checks in for the session or only when they complete it? For digital therapeutic application-based supports such as Calm and Ginger, does utilization happen when a member downloads the application, or does CMS need proof of use for each session? More clarity from CMS on these reporting requirements will allow health plans to build the data infrastructure necessary to capture this information and ensure consistent reporting across health plans.

III. Provider Directories & Network Adequacy – Shared Responsibility of Health Plans & Providers.

Provider Directory Requirements:

ABHW members agree that up-to-date provider directories are essential for patient care and have heavily invested in ensuring complete and accurate directories of available in-network provider resources. We also believe that discrepancies in provider directories can frustrate consumers and directly impact access to care.

Existing health provider directories have persistent information gaps and challenges maintaining accuracy. Updating databases for the behavioral health workforce also presents obstacles. Behavioral health providers 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. **ABHW strongly believes that maintaining up-to-date, robust provider directories should be a shared responsibility of providers and health plans**. Without providers actively verifying and updating their information, health plan directory data will be inaccurate and incomplete**.**

Network Adequacy Requirements:

To adequately measure network adequacy, CMS should collect data that accounts for provider supply and distribution differences. **CMS should allow health plans to document the providers they could not contract with when they submit network adequacy reporting.** This reporting could contain descriptions of health plans' efforts to contract with the provider or group to show that all reasonable efforts were taken. CMS has set a precedent for this network adequacy allowance with Institutional Special Needs Plans (I-SNP) and should expand it to MA plans since a lack of willing providers impacts all health plan networks.

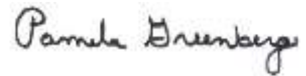
IV. Prior Authorization Data – Implement Recent Regulatory Activities.

We encourage CMS not to impose any new prior authorization or utilization management data reporting requirements on MA plans until its recent regulatory requirements go into effect. For example, the recent CMS Advancing Interoperability and Improving Prior Authorization Processes for MA Organizations and Medicaid Managed Care Plans rule requires health plans to post prior authorization data on their websites starting in 2026. Additionally, the 2025 MA and Part D Technical rule obligates MA plans to conduct a health equity analysis of utilization management policies and post them on their websites starting in 2025.

Conclusion

ABHW is committed to engaging with CMS to improve behavioral health access within MA. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,



Pamela Greenberg, MPP
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