February 13, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMS-4201-P 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

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to provide comment on these important proposed rules. MHA greatly appreciates the efforts to advance health equity and improve access to behavioral healthcare and commends CMS for its focus on these issues.

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 150 affiliate organizations in 37 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 have the following recommendations:

MHA strongly supports the provisions in the rule to improve equitable access to healthcare, including mental healthcare.

Mental Health America strongly supports fair and equitable access to healthcare as a priority policy goal. MHA applauds CMS for the proposal in Section 422.112(a)(8) to re-define the heading of this section by specifically referencing equity and to amend the list of populations for whom MA plans must provide equitable access to care to include people (1) with limited English proficiency or reading skills; (2) of ethnic, cultural, racial, or religious minorities; (3) with disabilities; (4) who identify as lesbian, gay, bisexual, or other diverse sexual orientations; (5) who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; 6) who live in rural areas and other areas with high levels of deprivation; and (7) otherwise adversely affected by persistent poverty or inequality.

MHA also strongly supports the additional health equity proposal in Section 422.111(b)(3)(i) to require MA organizations to include providers' cultural and linguistic

capabilities (including ASL) in their provider directories and to identify the providers who are waived to treat patients with medications for opioid use disorder (MOUD) in their provider directories. Given the removal of the waiver requirement under the 2023 Consolidated Appropriations Act, we recommend CMS retain the intent of this proposal and still require provider directories to identify those providers who have training to provide MOUD and administer, dispense, or prescribe the MOUD. The Office of the Inspector General has identified the low rate at which Medicare beneficiaries are accessing MOUD (fewer than one in five) and recommended that CMS take steps to improve access to MOUD and other support services. We concur with CMS that this new proposed MA provider directory data element is necessary for ensuring access to substance use disorder services for MA enrollees and will help them find providers who deliver evidence-based care.

MHA thanks CMS for recognizing the importance of digital health education to enrollees and requiring MA organizations to identify and offer digital health education to improve equitable access to telehealth in Section 422.112(b)(9). Digital literacy is especially important for individuals with substance use disorders and mental health conditions, who continue to use telehealth at higher rates than individuals with other medical conditions after the pandemic peak. Our affiliates have found that individuals need digital education, and such assistance is often not reimbursed by plans. This proposal is a strong step in ensuring equitable access to telehealth, and we encourage CMS to continue to work with other federal and state agencies to address additional aspects of the digital divide, including access to technological devices, data plans, and broadband.

MHA also supports the proposal in Section 422.152(a) requiring MA plans to incorporate one or more activities into their overall QI program to reduce disparities. We recommend that CMS engage with plans and beneficiaries from underserved communities to regularly review and analyze the outcomes of these activities to assure that the activities being reported and credited to the plans are the most effective choices.

MHA is grateful to CMS for recognizing the need to require MA plans to provide *standing* orders with respect to disability and linguistic accessibility, so the beneficiary does not have to continue to request accessible materials (Sec. 422.2267(a)(2) and 423.2267(a)(2)). Requiring a person to repeatedly ask for materials in an accessible format or language is burdensome and it is the responsibility of the MA plan to ensure the beneficiary has continuous access to information in the appropriate format and language.

MHA requests that CMS also consider revisiting the translation regulation for Medicare Advantage and Part D plans. Currently, plans are only required to translate into a language spoken by 5% of the population served which, with a few small exceptions, means that there is no requirement beyond Spanish. A more equitable approach would be to have a percent or numerical minimum, whichever is lower. Using percents alone, particularly in heavily populated areas, excludes large numbers of individuals from access to plan information.

MHA strongly supports the behavioral health provisions in the proposed rule. MHA recommends that CMS clarify that the one-week standard for appointments for conditions requiring medical attention includes behavioral health conditions that need attention. MHA strongly urges CMS to address the inaccuracy of provider information submitted by plans.

Mental Health America is especially grateful to CMS for the many provisions related to improving access to behavioral health. MHA strongly supports Section 422.112 (a)(1)(i) amending general access standards to expressly include behavioral health.

MHA applauds Sections 422.112 and 422.116, which expand the behavioral health specialty types for which MA plans must demonstrate network adequacy to include Clinical Psychology, Clinical Social Work, and Prescribers of MOUD. Given the removal of the waiver requirement under the 2023 Consolidated Appropriations Act, we recommend CMS retain the intent of this proposal and still require MA plans to have adequate networks of prescribers of MOUD. With respect to the proposed travel time and distance standards for the new provider categories, MHA recommends that CMS shorten the travel time and distance requirements to be comparable to those used for primary care physicians because of the increase in behavioral health needs in the country such that these conditions are increasingly common and are comparable to primary care needs.

MHA supports codifying standards for wait times for behavioral health and primary care in Section 422.112(a)(6)(i). CMS seeks comment on whether the rule should align primary care and behavioral health times or follow the requirements for qualified health plans (QHPs), which have 10-day requirements for behavioral health and 15 days for primary care for non-urgent visits. MHA urges CMS to continue to align primary and behavioral healthcare, but to make it very clear in Section 422.112(a)(6)(i)(B) that this category of 7 days includes behavioral health. The language should be amended to read: “Services that are not emergency or urgently needed, but the enrollee requires medical **and/or behavioral health** attention—within 1 week.”

We further urge that CMS describe when an enrollee needs behavioral health attention and include examples such as first experiencing symptoms of a behavioral health condition or addressing new or increased symptoms that are not urgent but need attention. In our experience, timely care can prevent crisis and avoid the need for urgent care. The proposed rule timeline of 30 days for routine and preventive care is very long for a first appointment, which is often an evaluation, so it is important to clarify that the one-week timeline applies to behavioral health needs. If CMS is not going to clarify that the one week timeline applies to behavioral health, then we strongly recommend using QHP standards because 30 days is too long to wait for needed behavioral health care.

We strongly urge CMS to separate out mental health and substance use disorder services (§ 422.112) to ensure timely access for both, so that any differences in timely

access between the two are not obscured by the combination of data. We support the 95% metric that MA plans would need to be required to achieve for appointment wait time for each service type.

We are very grateful to CMS for clarifying that behavioral health services can qualify as emergency services, so they are not subject to prior authorization. We fully support this provision and urge CMS to specify that this includes, but is not limited to, the new crisis psychotherapy service authorized in the 2023 Consolidated Appropriations Act. We further urge CMS to specifically identify substance use disorder-related emergencies, such as alcohol and drug poisoning or opioid overdose, which could similarly reasonably be expected to cause serious injury or death in the final rule. This will ensure that beneficiaries can access emergency services for their substance use disorder without regard to prior authorization or the provider's contractual relationship with the MA organization. With the implementation of 988 for mental health and substance use crisis, it is critical that MA plans pay their fair share of emergency behavioral health services.

MHA applauds the provisions in Section 422.112(b)(3) extending current requirements to coordinate with community services to include behavioral health. We are grateful to CMS for recognizing the need to close the equity gap between mental and physical healthcare and integrate care for Medicare Advantage beneficiaries.

We further support Section 422.111(e)(1) specifying more stringent enrollee notification requirements when primary care and behavioral health provider contract terminations occur. In our experience, it will be impactful to be notified both telephonically and in writing because some individuals with mental health and substance use conditions may lack stable housing so phone contact would improve the ability to notify them of these important changes.

Given the acute shortages of mental health and substance use providers, MHA strongly supports Section 422.112(a)(1), which requires that care coordination plans arrange for out-of-network care at in-network cost sharing when an in-network provider is not available or is inadequate.

There are two areas that MHA recommends CMS consider for future rules to promote accessible behavioral health services in MA plans. First, MHA urges CMS to define peer support specialists for the Medicare Advantage program and require MA plans to allow use of peer support specialists as auxiliary personnel in integrated care settings and as part of new crisis psychotherapy services. These are new provisions from the fee-for-service Medicare program and should be carried over to Medicare Advantage.

Second, MHA strongly urges CMS to address inaccurate information provided by plans. Inaccurate provider directories have been a longstanding problem with Medicare Advantage plans. CMS has previously audited plan provider directories and found that approximately half of provider locations listed had at least one inaccuracy. If provider directories are inaccurate, then information submitted for provider network adequacy

requirements will be flawed. For these provisions on network adequacy and provider directories to be meaningful, CMS must add protections such as requiring an independent audit of information provided on network adequacy or only allowing MA organizations to submit providers for network adequacy reviews if they have billed claims for a specified number of unique beneficiaries. This was the standard used by researchers to evaluate Medicaid plans and they concluded that over half of the providers listed in the directory had not actually billed the program for 5 unique beneficiaries. In addition, the percent of inaccurate listings specified for behavioral health should be part of the STAR ratings system and transparent so consumers can use the information to choose a plan and plans are financially rewarded for accurate information.

MHA strongly supports provisions expanding access to medication management therapy

Mental Health America thanks CMS for provisions in the proposed rule to make medication management therapy (MTM) more widely available. Many individuals with mental health and substance use conditions take multiple medications and have several chronic conditions. MTM is an important service to promote wellness and avoid problematic drug interactions. MHA specifically supports Section 423.153(d)(2)(i)(a) defining MTM eligibility criteria and ensuring all required chronic diseases must be considered and Section 423.153(d)(2)(i)(B) decreasing the number of medications required for eligibility from 8 to 5 medications.

MHA strongly supports expanding the definition of severe or disabling chronic conditions to add mental health and substance use conditions and defining C-SNPs and plan types to allow mental health and substance use to be combined in plans.

MHA strongly supports CMS's proposal to codify "chronic alcohol use disorder and other substance use disorders" as one of the chronic conditions that meets the definition of a severe and disabling chronic condition at Section 422.2. We commend CMS for its use of non-stigmatizing language throughout the proposed regulation, including here. Given the high rate of comorbidity between substance use disorders and mental health conditions among Medicare beneficiaries, we also support the grouping of these conditions for a C-SNP so that MA plans can either target substance use disorders as a single chronic condition or may target both together. Table D-A 1 demonstrated that only one C-SNP focused on substance use disorders between 2007-2022, and we recommend CMS work with stakeholders to identify recommendations and guidelines that would make it easier for other MA organizations to develop and deliver such plans.

MHA is also grateful to CMS for adding post-traumatic stress disorder, eating disorders and anxiety disorders to the list of chronic conditions in Section 422.2. These behavioral health conditions are very common and have very serious consequences so

adding these to the list will ensure Medicare Advantage beneficiaries with behavioral health conditions are well-served by the program.

MHA strongly supports the proposal to include a health equity index in the STAR rating program to incentivize plans to improve care for those with social risk factors. MHA urges CMS to retain its emphasis on patient experience and consider stratifying it to demographic factors such as behavioral health. MHA also strongly recommends that CMS add more behavioral health outcomes to the STAR rating system, including accuracy of provider networks and directories.

Mental Health America recognizes the profound effect of social risk factors on health outcomes, including behavioral health outcomes. We are grateful for CMS's focus on gathering data regarding these social needs and ensuring that plans work to address them to promote the overall health of plan beneficiaries. Accordingly, MHA strongly supports the provisions at Sections 422.162 and 422.166 to create a health equity index and hold plans accountable to improving care for those with social needs.

MHA is concerned, however, about the proposal in Section 422.166 to reduce reliance on patient experience substantially from a weight of 4 to a weigh of 2. This is a very large decrease that could disincentivize plans to improve patient experience. MHA was founded by Clifford Beers, an individual who used his lived experience of abuse in psychiatric treatment to advocate for improving patient experience and putting the person at the center of public policy. We continue our history of advocating for the importance of lived experience in policy development and are concerned about this reduction in focus on patient experience.

Reducing the reliance on patient experience measures is inconsistent with the other provisions in the rule regarding wait times and network adequacy. Data for these other measures is not always accurate as provided by the plans so it is important to also have beneficiaries' experience. MHA would strongly urge CMS to stratify the patient experience data by individuals with behavioral health conditions because many of the factors measured such as getting needed care and getting appointments quickly are particularly problematic for individuals seeking behavioral healthcare.

Moreover, MHA notes that the current STAR rating system does not assist individuals with behavioral health conditions in making choices between plans. MHA would urge the inclusion of more quality measures specific to behavioral health and more transparency and incentives for accurate provider directories and network submissions. In CMS's audits, the agency was able to determine a percentage of inaccuracies in MA plan provider directories. Having that information specifically for behavioral health would be very impactful for people choosing plans and plans should be rewarded for reducing that percentage for both directories and network adequacy submissions.

Mental Health America strongly supports additional requirements for prior authorization and utilization management and urges CMS to clarify the language

to ensure that medical necessity criteria are consistent with general medical standards.

The rule proposes to increase the transparency of MA plans' utilization management and prior authorization policies and to strengthen criteria and processes. Specifically, MHA supports provisions:

- Requiring the inclusion of current evidence in widely used treatment guidelines or clinical literature made publicly available to CMS, enrollees, and providers when creating internal clinical coverage criteria in Section 422.101 with the changes to subsection (b)(6) noted below to specify consistency and transparency.
- Streamlining prior authorization requirements, including adding continuity of care requirements in ongoing care for beneficiaries such that they have a 90-day transition period for active courses of treatment in Section 422.122.
- Requiring all MA plans to establish a Utilization Management Committee to review policies annually and ensure consistency with Traditional Medicare's national and local coverage decisions and guidelines. MHA strongly supports requiring that such a committee have representation from various specialties and the specific inclusion of behavioral health as an example of one of these specialties in Section 422.137(c)(4).

MHA strongly supports CMS's proposal to codify standards at § 422.101(b) and (c) for coverage criteria in medical necessity reviews to ensure that basic benefits coverage for MA enrollees is no more restrictive than Traditional Medicare. We strongly support the requirement that MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare statutes and regulations as interpreted by CMS. We recommend that CMS continue to review its statues, regulations, NCDs, and LCDs and ensure that they are consistent with clinical criteria developed by nonprofit professional associations for the relevant clinical practices. For behavioral healthcare, foundational criteria include The ASAM Criteria by the American Society of Addiction Medicine for substance use disorders and the Level of Care Utilization System (LOCUS) by the American Association of Community Psychiatrists for mental health conditions. We appreciate CMS referencing the ASAM criteria in its discussion of the proposed regulation as a generally accepted medical standard.

We are very grateful to CMS for recognizing that insurance plans have designed and used unfair medical necessity criteria to deny coverage of services and for specifying that, when there is not national guidance on those criteria, they must use generally accepted medical standards. Based on our extensive experience with denials for behavioral health coverage, we urge some changes in regulatory language to best effectuate the policies.

Plans have often used criteria designed for financial gain to deny coverage of behavioral health services. A district court in the *Wit* case issued extensive findings of

how the defendant plan developed criteria specifically for financial reasons and how such criteria were not consistent with generally accepted standards of care. The court also issued a final judgment stating that the insurers standards were not "consistent with" generally accepted standards of care and noted that several states require criteria that are "consistent with" such standards.[1] Accordingly, we urge CMS to use the same language of requiring "consistency" with "generally accepted standards of care". We are concerned that the current language would allow plans to "base" their decision on generally accepted standards of care, but add other factors designed to deny care. We urge CMS to make the following changes to § 422.101(b)(6) to ensure that the final criteria are consistent with those generally accepted standards and to be clear that level of care determinations are considered consistent if they yield the same result as the treatment guidelines. Furthermore, we urge CMS to require plans to publish the criteria themselves to ensure transparency and accountability:

> (6) When coverage criteria are not fully established in applicable Medicare statute, regulation, NCD or LCD, MA organizations may **utilize other** ~~**create internal**~~ coverage criteria ~~**that are based on**~~ **only if such criteria are consistent with current generally accepted standards of care and with** current evidence in widely used treatment guidelines or clinical literature that is made publicly available. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refer to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question. **For level of care determinations for mental health or substance use disorders, coverage criteria are consistent with widely-used treatment guidelines only if they result in a level of care determination that is consistent with the determination that would have been made using the relevant widely-used treatment guidelines.** For internal coverage policies, the MA organization must provide:
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> (i) **All coverage criteria**;
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> **(ii)** A publicly accessible summary of evidence that was considered during the development of the internal coverage criteria used to make medical necessity determinations;
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> **(iii)** A list of the sources of such evidence; and

[1] The 9th Circuit recently issued a decision acknowledged that the plan had a financial conflict of interest in developing its criteria but reversed the decision under ERISA by noting that the plan had discretion to apply these criteria. This decision underscores the importance of being clear that they can only use coverage criteria that is consistent with generally accepted standards of care.

(iv) Include an explanation of the rationale that supports the adoption of the coverage criteria used to make a medical necessity determination.

These changes, including requiring MA plans to provide their internal coverage criteria, are essential to protecting MA plan members and realizing the stated intent of CMS's proposal. Requiring the plan criteria to be consistent with general medical standards will promote access to critical behavioral health and other health services.

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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