National Alliance on Mental Illness

February 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

Re: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4201-P)

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the proposed rule, "Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4201-P)." NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization, providing education, support and advocacy in communities around the country. We are dedicated to building better lives for people affected by mental illness, including the millions of people with mental illness who rely on Medicare for mental health treatment. Medicare is a lifeline for both older adults who live with mental health conditions as well as younger adults who are eligible because of a disabling mental health condition. We have a unique perspective on how Medicare can support people with mental illness and ways in which the program can be improved. We hope our expertise can be helpful as you consider ways to increase access to mental health treatments and medications in Medicare Advantage (MA) and Part D. We offer the following detailed comments.

**Behavioral Health in Medicare Advantage (MA) (§§ 422.112, 422.113 and 422.116)**
NAMI greatly appreciates CMS' commitment to removing barriers to mental health and substance use disorder (MH/SUD) care and services as part of CMS's Behavioral Health Strategy. We see proposed changes in this rule as an important first step to increasing access to behavioral health services and improving outcomes for beneficiaries with behavioral health care needs. Specifically, NAMI strongly supports regulatory changes that will strengthen network adequacy requirements and reaffirm MA organizations' responsibilities to provide behavioral health services. Specifically, we support:

1. Adding Clinical Psychologists, Licensed Clinical Social Workers, and Prescribers of Medication for Opioid Use Disorder as specialty types to be subject to network adequacy evaluation,
2. Amending general access to services standards to explicitly include behavioral health services,
3. Codifying standards for appointment wait times for both primary care and behavioral health services,
4. Clarifying that emergency medical services that must not be subject to prior authorization include behavioral health services to evaluate and stabilize an emergency medical condition,

5. Requiring that MA organizations notify enrollees when the enrollee's behavioral health or primary care provider(s) are dropped midyear from networks, and
6. Requiring that MA organizations establish care coordination programs, including coordination of community, social, and behavioral health services to help move towards parity between behavioral health and physical health services and advance whole-person care.

We are grateful for CMS' efforts to improve network adequacy in MA. NAMI runs a nationwide toll-free Helpline, and we consistently hear from callers who have difficulty finding a mental health provider and long wait times once a provider is identified. Research consistently shows that provider networks for MH/SUD are often less robust than networks for physical health. Additionally, beneficiaries covered by MA more frequently go out of network for mental health services than other health care services, increasing their average cost-sharing payments.[i] Strengthening network requirements and enhancing service coordination will provide greater support for people to tend to all their health needs.

Specifically, NAMI supports codifying standards for wait times for behavioral health and primary care in Section 422.112(a)(6)(i). CMS has proposed to align standards for primary care and behavioral health, as follows:

> "(A) Urgently needed services or emergency—immediately;
> (B) Services that are not emergency or urgently needed, but the enrollee requires medical attention—within 1 week; and
> (C) Routine and preventive care—within 30 days."

However, CMS seeks comment "on alternative specific appointment wait times standards to apply to MA organizations" and that CMS is considering establishing appointment wait time standards that align with those established for qualified health plans, (QHPs) as outlined by CMS in the "2023 Final Letter to Issuers in the Federally-facilitated Exchanges." The appointment wait time standards for QHPs require that behavioral health appointments must be available within 10 business days, and does not break things out into three categories that CMS has proposed. While there is no national consensus on what an acceptable length of time to wait for a medical appointment,[ii] we believe that a 30-day standard is far from an appropriate time to wait for an appointment. Therefore, while the 7 days standard for the B category is better than a 10-day standard, we fear that MH/SUD appointments could be considered routine care, and thus be lumped into the C category of 30 days. Therefore, NAMI encourages CMS to adopt wait-time standards that are consistent with those established for QHPs to ensure that beneficiaries can access care more quickly than within 30 days.

NAMI supports CMS's proposal to require MA organizations to reimburse a provider for emergency services for physical and mental conditions without regard to prior authorization or the emergency care provider's contractual relationship with the MA organization. We appreciate CMS's examples of mental health emergencies including when "one could reasonably be expected to cause serious injury (or death) to oneself if one's behavioral health condition results in a suicide plan, attempt, other suicidal behavior, or other forms of serious self-harm." However, CMS has not identified 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 its final rule, we recommend that CMS clarify that substance use disorder-related emergencies should also fall under one or both of these categories,

to 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.

**Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, 422.138, and 422.202)**

NAMI supports regulatory changes that ensure timely access to care. Specifically, we support:

1) Require 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.
2) Require that the physician or other health care professional used by the MA plan have expertise in the field of medicine that is appropriate for the service be involved before the MA plan can deny coverage.
3) Streamline prior authorization requirements, including adding continuity of care requirements in ongoing care for beneficiaries (requiring that when an enrollee is granted prior authorization approval it will remain valid for the full course of treatment), and
4) 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.

Many health insurance companies use utilization management techniques and policies to evaluate the necessity of medical treatments and services. While utilization management tools may be "effective" for plans seeking to control costs and utilization of services, they can inhibit access to medically necessary care and can harm individuals with mental health conditions. Specifically, prior authorization policies have been associated with increased medication discontinuation, reductions in mental health visits, and increases in emergency room visits.[iii] There is also evidence that utilization management decisions are not made consistent with clinical best practices. For example, a recent class action suit, Wit v. United Behavioral Health (UBH), found that UBH created flawed medical necessity criteria for determining whether to cover mental health and addiction treatment that were based on its own financial interests rather than accepted clinical standards. Additionally, the development of utilization management techniques is typically done without much or any patient input, and the rationale for such decisions is not typically made public. Since 99% of Medicare Advantage enrollees were enrolled in a plan that required prior authorization for some services in 2022,[iv] we believe the changes suggested by CMS are critical to helping beneficiaries access critical health care services and encourage CMS to finalize these changes.

While we are supportive of the overall changes, we encourage CMS to consider adding an explicit requirement that if creating internal clinical coverage criteria, MA and Part D plans must use generally accepted standards of care. Therefore, we call upon CMS to make the following changes to § 422.101(b)(6):

> (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.

**Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (§§ 422.162, 422.164, 422.166, 422.260, 423.182, 423.184, and 423.186)**

NAMI supports regulatory changes that advance health equity. Specifically, we support:

1. Adding a health equity index (HEI) reward for the 2027 Star Ratings to further incentivize Parts C and D plans to focus on improving care for enrollees with social risk factors (SRFs).

Many social risk factors are disproportionately experienced by people with behavioral health conditions, including income,[v] food[vi] and housing insecurity,[vii] which can in turn affect enrollees' health outcomes. We share the Administration's commitment to advancing equity throughout the health care system, and we support your efforts to add a health equity index reward to the Star Ratings Program to focus on improving care for beneficiaries with social risk factors.

However, we are concerned that this proposal would reduce the weight of patient experience/ complaints and access measures, proposed to "further align efforts with other CMS quality programs and the current CMS Quality Strategy." Individuals with mental health conditions are not afforded the same opportunities to share their patient experience of care in the Medicare program, so having their voice further reduced in the process would cause a greater disadvantage to our population. We believe it's important to provide beneficiaries with transparent, clear information about the quality of health insurance plans, which includes how beneficiaries view their experience of care. NAMI recommends that CMS not move forward with the proposal to reduce the weight of patient experience/complaints.

**Amending the Definition of Severe or Disabling Chronic Condition; Defining C-SNPs and Plan Types; and Codifying List of Chronic Conditions (§ 422.2)**

NAMI supports regulatory changes that strengthen MA and Part D program policies through the inclusion of mental health and substance use disorder in specialized plans. Specifically, we support:

1. Amending the Definition of Severe or Disabling Chronic Condition, and
2. Chronic Condition Special Needs Plan Definition, Scope and Eligibility (§§ 422.2, 422.4, and 422.52)

Chronic Condition Special Needs Plans (C-SNPs) are special needs plans (SNPs) that restrict enrollment to individuals with specific severe or disabling chronic conditions. We appreciate CMS seeking comment on the proposed list of chronic conditions for C-SNPs. We appreciate that CMS is adding (1) anxiety associated with COPD and (2) SUD and chronic and disabling mental health conditions to the list. NAMI supports these proposals.

**Health Equity in Medicare Advantage (MA) (§§ 422.111 and 422.112)**

NAMI appreciates and supports CMS's proposal to advance health equity across Medicare and pursue a comprehensive approach to advancing health equity for all, including those who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Specifically, we support:

1. Amending 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,
2. Requiring MA organizations to include providers' cultural and linguistic capabilities in provider directories, and
3. Clarifying that MA organizations must provide all enrollees, without exception, accommodations to equitably access services according to applicable statutory, regulatory, and other guidance.

NAMI supports public policies that can reduce mental health inequities and advance health equity and encourages CMS to finalize these policies.

**Medication Therapy Management (MTM) Program (§ 423.153)**

NAMI supports regulatory changes that enhance the MTM program and increase the number of beneficiaries receiving these services. Specifically, we support:

1. Requiring plan sponsors to include all core chronic diseases previously identified by CMS in their targeting criteria,
2. Lowering the maximum number of covered Part D drugs a sponsor may require from 8 to 5 drugs and requiring sponsors to include all Part D maintenance drugs in their targeting criteria, and
3. Revising the methodology for calculating the cost threshold to be commensurate with the average annual cost of 5 generic drugs.

People with behavioral health conditions commonly have co-occurring physical health conditions, yet management of these conditions and medication treatment often occurs in separate silos. We commend CMS for proposing to require that plans include all 10 core chronic diseases, including mental health, identified by CMS in the MTM targeting criteria. As CMS identifies in the proposal, we believe this change will expand the number of eligible enrollees and support those with behavioral health conditions to access important MTM services.

**Expanding Eligibility for Low-Income Subsidies (LIS) Under Part D of the Medicare Program (§§ 423.773 and 423.780)**

NAMI supports implementation of certain provisions of the Consolidated Appropriations Act of 2021 and the Inflation Reduction Act (IRA) of 2022 that increase access to affordable prescription drug coverage. Specifically, we support:

1. Implementation of the IRA's provision and CMS' proposal to expand eligibility under the LIS program to individuals with incomes between 135% and 150% of the FPL, effective January 1, 2024.

Currently, an individual qualifies for the full LIS benefit if their income is below 135% of the federal poverty level (FPL) and qualifies for a partial LIS benefit if their income is between 135% and 150% of the

FPL. CMS is proposing to implement the expansion of eligibility for the full LIS benefit to individuals with incomes between 135% and 150% of the FPL. The LIS program helps millions of Medicare beneficiaries with low incomes and behavioral health conditions afford needed medications. By expanding eligibility of the LIS program, more individuals who struggle with the cost of their mental health and substance use disorder medications.

While NAMI fully supports implementation of this provision, we are concerned that beneficiaries between 135% and 150% of the FPL are not auto-enrolled into a LIS-eligible plan, and therefore, may not know they may be eligible for the full benefit. NAMI encourages CMS to explore opportunities to educate beneficiaries potentially eligible for the full LIS benefit and to consider a mechanism for auto-enrollment so that all eligible beneficiaries can benefit from the LIS.

**Conclusion**

NAMI is grateful for the many proposals within this rule to strengthen coverage and care for people with mental health and substance use disorder conditions covered by MA and Medicare Part D. Thank you for the opportunity to comment. For questions or further information, please contact Jennifer Snow, National Director of Government Relations and Policy at jsnow@nami.org.

Sincerely,

Hannah Wesolowski
Chief Advocacy Officer
National Alliance on Mental Illness

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[i] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05226
[ii] https://www.ncbi.nlm.nih.gov/books/NBK499495/
[iii] https://ps.psychiatryonline.org/doi/full/10.1176/ps.62.2.pss6202_0186
[iv] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/
[v] https://www.nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Supplemental-Security-Income-(SSI)-and-Social-Security-Disability-Insurance-(SSDI)
[vi] https://www.nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Social-Determinants-of-Health-Food-Security
[vii] https://www.nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Social-Determinants-of-Health-Housing