

National Association for Behavioral Healthcare



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13 March 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically

Re: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program. CMS-0057-P.

Dear Administrator Brooks-LaSure:

The National Association for Behavioral Healthcare (NABH) appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on its proposed rule pertaining to electronic prior authorization. NABH represents behavioral healthcare systems that provide the full continuum of mental health services and substance use disorder (SUD) treatment, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility-based outpatient programs, and medication assisted treatment centers. Our membership includes behavioral healthcare providers in 49 states and Washington, D.C.

In general, NABH supports the overall direction of this rule as an electronic process would help bring standardization to this administratively demanding process. In addition, a more systematized process would raise the transparency of the prior authorization practices of health plans, including the tracking of key patterns related to the timeliness of initial prior authorization responses, as well as the basis for, volume, rate, and timing of subsequent denials and appeals. In particular, our comments focus on the following behavioral health-related requests for information (RFI), as well as address several related topics.

RFI #1: How should CMS advance electronic data exchange among behavioral health and other providers?

Given current information system limitations across the behavioral health sector, without a federal investment in compliant information technology to enable behavioral health connectivity, most providers in this sector will remain shut out of 1) the interoperable exchange of patient health information; and 2) the electronic prior authorization processes proposed by this rule. In fact, several foundational positions in the proposed rule are wholly misaligned with the current information technology limitations facing the behavioral health sector. For example, the rule states,

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“We believe that covered entities have already largely invested in the hardware, software, and connectivity necessary to implement the proposed new and modified standards.” Yet, this status does not apply to the vast majority of mental health and substance use disorder treatment providers. Rather, the opposite is true. In fact, to illustrate current capacity limitations, most inpatient psychiatric hospitals have the ability to electronically bill payers, and some have a form of electronic prescription management. But most lack the ability to send or receive interoperable data because, for even those that have an electronic health record, their systems are outdated and do not meet the Health and Human Services 2015 minimum standards for interoperability and meaningful use.

The rule also notes that while “The vast majority of physicians and other practices will need to make relatively small changes in their systems and processes, with additional fees from their vendors for additional functionality,” “Some of the smallest provider entities may elect to continue their current manual processes.” In the case of most behavioral health providers, the overriding majority are in the latter category with their reliance on outdated communication methods including faxes, emails, and phone calls.

RFI #2: Should CMS prohibit payers from denying claims for which prior authorization has been approved?

NABH strongly supports modifying existing regulation to treat prior authorization approvals as a promise of payment that cannot be retracted, in addition to a determination of whether an item or service is medically necessary. This new interpretation should explicitly protect payment for all approved prior authorization requests, when the beneficiary has active coverage and no fraud exists. In addition, it would be appropriate for CMS to exempt any prior authorization requests for which a technical error applies, such as a duplicate claim or other fixable error in the claim. Adequate time to implement such technical corrections should be included in the policy. We note that this broader approach already has been implemented for commercial insurers by California and other states. In addition, we fully support the application of this prior authorization approach to all payers.

RFI #3: Should the prior authorization process be used to collect any risk factor data on behavioral health patients?

The feasibility of using the prior authorization process to collect patient-level risk factor data warrants thoughtful consideration, in advance, in close partnership with behavioral health stakeholders, including providers. For example, we recognize that the quality reporting program associated with the inpatient psychiatric facility prospective payment system is currently being expanded, with two additional quality measures recently approved by Congress. Any effort to expand quality data collection beyond the existing plan, whether through additional social determinants or other metrics, should begin with an assessment of the effectiveness of the rollout of existing quality reporting program, including the 2023 expansion – as a whole and per metric. In the short run, without adding further data collection burden, CMS could utilize existing claims data on beneficiaries’ Medicare/Medicaid dual-status as a broad proxy for other more-complex social determinants, to study its impact on service utilization, process measures, and clinical outcomes, as well as model how this and similar metrics would affect payments under various risk-adjustment approaches.



Use the Electronic Platform to Help Eliminate Erroneous Prior Authorization Denials

While somewhat outside the scope of this proposed rule, we share our ongoing concern that the Medicare Advantage (MA) prior authorization process has been fraught with erroneous denials by plans, as confirmed by the Office of the Inspector General in its April 2022 report.¹ As such, NABH strongly supported CMS' clarification in its contract year 2024 MA proposed rule's that MA insurers must at least meet Original Medicare's coverage standards, which apply to fee-for-service Medicare. Given the plans' damaging MA history, it is essential that the process enhancements implemented through a new electronic process include protections to ensure that this pattern of errors is not inadvertently perpetuated. In fact, the MA rule cautions that "MA organizations' flexibility to deliver care using cost-effective approaches should not be construed to mean that Medicare coverage policies do not apply to the MA program." It remains true that MA plans may cover benefits beyond those that Original Medicare covers by offering supplemental benefits. **With specific regard to behavioral health access to care, as curtailed by erroneous MA denials, the proposed electronic process should exempt all emergency behavioral health and substance use disorder treatments, including emergency department and life-saving intensive and outpatient opioid treatment programs.**

The medical necessity criteria used in the proposed electronic process – especially if ultimately standardized across plans – must prohibit coverage denials based on MA insurers' internal, proprietary, or external clinical criteria not found in Original Medicare coverage policies. Further, when there are no applicable behavioral health coverage criteria in Medicare statute, regulation, or national or local coverage determinations, any internal or licensed coverage criteria that MA insurers rely on must be entirely consistent with generally accepted standards of care established by non-profit clinical specialty associations, such as those that the American Society of Addiction Medicine or the American Psychiatric Association have developed and made publicly available to CMS, enrollees, and providers. This is critical given that health plans historically have used substandard mental health and substance use treatment criteria to deny medically necessary care, as the *Wit v. United Behavioral Health* case highlighted and is stated in published clinical literature.²

In addition, in alignment with CMS' MA proposed rule, the electronic process should prohibit any denials prior to case-level evaluations by a physician or other health care professionals with medical expertise that aligns with the pertinent clinical service, as already required of Medicaid managed care plans. The definition of "relevant expertise" must ensure a meaningful level of expertise is achieved – especially, for example, for specialty services typically provided by psychiatrists and psychologists in combination with multi-disciplinary clinical teams.

To evaluate the accuracy of prior authorization denials, we also support the comparison of MA data collected through the electronic process with comparable results under Original Medicare and for commercial health plans. As with the OIG study, such an accuracy assessment should be based on clinician examination of medical records with, if feasible, the comparison of accuracy rates by

¹ ["Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care".](#)

² Goldman RL, Weir CR, Turner CW, Smith CB. Validity of utilization management criteria for psychiatry. *Am J Psychiatry.* 1997 Mar;154(3):349-54. doi: 10.1176/ajp.154.3.349. PMID: 9054782.

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payer. Such comparisons would yield insightful feedback that could be used to improve existing admissions and quality reporting protocols, and to benchmark and improve prior authorization practices by payer, as well as relative to local and national patterns.

Thank you for considering our comments. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100.

Sincerely,

A handwritten signature in black ink, appearing to read 'Shawn Coughlin'. The signature is fluid and cursive, with the first name 'Shawn' and last name 'Coughlin' clearly distinguishable.

Shawn Coughlin
President and CEO

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