

National Association for Behavioral Healthcare



Access. Care. Recovery.

13 February 2023

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services

Submitted Electronically

Re: 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. [CMS-4201-P]

Dear Administrator Brooks-LaSure:

The National Association for Behavioral Healthcare (NABH) respectfully submits to the Centers for Medicare & Medicaid Services (CMS) the following comments on the Contract Year (CY) 2024 proposed rule related to Medicare Advantage (MA) program. NABH represents behavioral healthcare systems providing 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.

NABH appreciates this rule's focus on improving access to and quality of care by increasing the oversight and transparency of MA insurers. This important and positive rule includes multiple provisions that will directly assist patients requiring mental health and SUD treatments. In particular we support the proposed improvements related to prior authorization, network adequacy, and quality of care – many of which NABH and other mental health patient and provider advocates have long pursued. In addition, this letter addresses a concern related to the timeframes allowed for identifying, reporting, and refunding overpayments.

Behavioral Health-related Improvements

Responding to comments from behavioral healthcare and SUD treatment stakeholders that CMS received in 2022, CMS included these provisions in the rule to clarify and expand MA responsibilities related to services for behavioral healthcare patients, which NABH strongly supports:

- Regarding the process used to assess MA plans' level of network adequacy, expand current compliance criteria to include a specific category for clinical psychologists, licensed clinical social workers, and opioid use disorder medication prescribers. To align with the *Continuing Appropriates Act of 2023*, we encourage CMS to expand this provision to add licensed family and marriage counselors and services. This change would help expand the behavioral healthcare workforce by optimizing the broader array of local clinicians who also play an important role in treating this population.
- Apply a 10% credit to network-adequacy assessment ratings for networks that include telehealth services by these newly specified behavioral healthcare provider types.

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- Extend network-adequacy assessment standards for “general access to services” to explicitly include behavioral healthcare services. We also ask CMS to consider specifying within this standard the need for opioid treatment program services, which should not require a physician referral as a prerequisite.
- Exempt from the prior authorization approval process, emergency department (ED) behavioral health services to evaluate and stabilize a patient. Further, when the treating physician deems such services as medically necessary, we support automatic coverage from the MA insurer, Medicaid managed care requires. We also encourage CMS to consider exempting opioid treatment programs from the prior-authorization process, given the urgency of their services – which are comparable to the lifesaving impact of mental health evaluation and stabilization services that EDs provide.
- Codify minimum appointment wait times for primary and behavioral healthcare services, including applying the current maximum standard used for the federal health insurance exchange marketplace: within 10 business days for non-urgent behavioral healthcare appointments. Specifically for urgent and emergency services, same-day access is essential and often life-saving. Therefore, CMS should codify a zero-wait standard for these critical situations. We note that some accrediting bodies, such as the National Committee for Quality Assurance, apply the long-standing criterion of 10 business days for non-urgent mental healthcare services.

To strengthen these proposed changes, we ask CMS to finalize several related improvements. First, in addition to maximum wait times, we urge the agency to codify maximum travel times and distances in its MA network-adequacy requirements, as well as inpatient coverage and education materials.

We also recommend a process for monitoring and, as needed, updating maximum standards for specific wait times and travel times/distances.

Finally, enrollees should be informed that when MA plans cannot secure services within maximum wait times and/or travel times/distances, medically necessary services will automatically be covered out-of-network commensurate with in-network rates or more, with no more than in-network cost-sharing for patients.

Clarifying “Original Medicare” Standards as Minimum Requirements for MA

NABH greatly appreciates the proposed rule’s clarification that MA insurers must at least meet Original Medicare’s coverage standards, which apply to fee-for-service Medicare. While this is not a new interpretation, this clarification, in addition to the rule’s proposed regulatory refinements on this issue, is valuable and timely, given MA insurers’ systematic denials of services that Original Medicare would have covered, as the HHS Office of the Inspector General noted in an April 2022 report.¹ Specifically, the rule restates that as a minimum standard, MA organizations must cover all Part A and B benefits (excluding hospice services and the cost of kidney acquisitions for transplant) using the same coverage Original Medicare provided. This means that MA medical-necessity evaluations may not deny coverage, including through utilization management (UM) and prior authorization, which Original Medicare would cover and pay for. In addition, the rule notes: “MA organizations’ flexibility to deliver care using cost-effective

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



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.

Patient-level Appeals. Given the recognized pattern of inappropriate denials by MA insurers, greater enrollee education is needed to inform affected patients of their current individual appeals rights. Such appeals rights are essential for challenging unwarranted denials and resuming medically necessary care.

Evaluating Coverage for Risk-adjusted Patients. To build upon the rule’s reinforcement of Original Medicare as the primary benchmark for MA coverage, we encourage CMS to go further by auditing MA plans to identify gaps between extra coverage and reimbursement for more medically-complex patients via risk-adjustment payment add-ons relative to the costs of any extra services for this group. In other words, when the insurer received extra reimbursement for covering sicker patients, in accordance with Original Medicare, it is appropriate to confirm whether this population is actually receiving additional treatment and related services, as intended by the risk-adjustment adjustment. In addition, it would be helpful for CMS and providers if plans shared with stakeholders data on covered days of behavioral health and other types of care versus the actual days of services delivered by providers, to assess alignment between coverage assured under Original Medicare, coverage approved by MA insurers, and services received by patients.

Improving Medical Necessity

The rule includes important and long-sought improvements related to determining whether a patient’s clinical status meets medical necessity standards for MA coverage. NABH supports the following proposals that would help, at least in part, rebalance the utilization review process to increase access for patients whose treatments are medically necessary but nonetheless too often denied. Specifically, we support:

- Requiring coverage determinations to include evaluations by a physician or other health care professional with relevant expertise in the field of medicine relevant to the requested service prior to any denial, already required of Medicaid managed care plans. While this requirement is important, CMS’ oversight of its implementation, both initially and on an ongoing basis, will be equally important. In particular, the definition of “relevant expertise” must ensure that 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 help institutionalize this policy improvement, we also support CMS’s requirement that UM reviews require the participation of at least one committee member with a meaningful level of clinical expertise related to the specific item or service.
- Annual review and updates by a UM committee of coverage policies to ensure consistency with Original Medicare’s national and local coverage decisions and guidelines.
- Such reviews would benefit patients with mental health and SUDs in MA who otherwise are improperly subjected to additional restrictions that reduce access.² In addition, annual reviews

² MA coverage criteria that go beyond those of Original Medicare result in additional denials. “*Coverage Denials: Government And Private Insurer Policies For Medical Necessity In Medicare,*” *Health Affairs*, January 2022.



would improve the accuracy of UM criteria relative to evolving clinical standards and modalities, such as the delivery of key services via telehealth. We also support the broader use of UM committees to review *all* internal coverage policies of an MA plan.

- Prohibiting 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 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.³

Streamlining Prior Authorization Requirements

Current prior authorization processes include multiple flaws that the rule addresses. These proposed remedies would materially improve the process that affects behavioral healthcare, SUD, and other patients and providers. It is important that these provisions also apply to the third-party contractors that some MA insurers use to conduct their prior authorization protocols:

- To improve continuity of care, extend prior-authorization approvals to a patient's full course of treatment, and apply a 90-day coverage extension for enrollees who switch to a new MA plan or from Original Medicare to MA.
- Limit prior authorization for coordinated care plan services to confirming the presence of diagnoses or other clinical criteria and/or ensure that an item or service is medically necessary. NABH supports this step to ensure the accuracy and reliability of pre-service delivery medical necessity determinations under MA. This provision will mitigate the operational instability and financial volatility caused when plans retroactively deny coverage for rendered services that the insurer had already deemed medically necessary.

The Proposed Reduction of Overpayment Window is Excessive

The NABH does not support the proposed shortening of the period available to providers who have discovered that a possible overpayment, during which such providers investigate and confirm if an actual overpayment occurred, and if so, process a refund back to the Medicare program. **Rather, to align with the current "reasonability diligence" standard of six months plus the subsequent 60-day window to process refunds, we urge CMS to continue allowing a reasonable time of approximately six months for providers to conduct such investigations and, when necessary, process a refund.**

Many of our members concurrently provide services under Medicare Parts A, B, C (MA) and D, all of which would be subject to this provision. Maintaining compliance with this broad array of coverage and payment rules, in addition to those of private insurers, is a complex undertaking involving material investments in personnel, software and other supports. In particular, the compliance efforts to ensure payment accuracy across these payors require more than the proposed 60-day period.

³ 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.

**National
Association
for Behavioral
Healthcare**



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Thank you for considering NABH's comments and recommendations related to this proposed rule. 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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