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June 30, 2023

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The Honorable Chiquita Brooks-LaSure, Administrator
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)

**Re: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP)
Managed Care Access, Finance, and Quality (File Code CMS-2439-P)**

Dear Administrator Brooks-LaSure:

Rebecca W. Brendel, M.D., J.D.
Vivian B. Pender, M.D.
Jeffrey Geller, M.D., M.P.H.
Past Presidents

The American Psychiatric Association (APA), the national medical specialty society representing over 38,000 psychiatric physicians and their patients, appreciates the opportunity to comment on the proposed rule: [Medicaid Program; Medicaid and Children's Health Insurance Program \(CHIP\) Managed Care Access, Finance, and Quality](#) (the "managed care proposed rule"). APA shares the Biden Administration's commitment to protect and strengthen Medicaid and the Affordable Care Act (ACA) and to make high-quality healthcare accessible and affordable for every American, including Medicaid and CHIP beneficiaries enrolled in managed care. We applaud CMS's efforts to set standards that are more comprehensive and consistent across delivery systems and coverage authorities.

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Network Adequacy/Access to Care

We applaud and support CMS's efforts to improve access by proposing that States be required to:

- develop and enforce a 90 percent compliance with a 10-business day maximum appointment wait time standard for routine mental health and substance use disorder outpatient services, both adult and pediatric populations;
- use an independent entity to conduct an annual secret shopper survey¹ to assess appointment wait time standards and provider directory accuracy and to identify and correct inaccuracies and post survey results to their websites;
- submit remedy plans to address access problems including specific steps, timeframes, and parties responsible to achieve improvement within 12 months;

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¹ In 2017, APA conducted a secret shopper study of psychiatrists listed in online directories for three of the largest insurance carriers serving the Washington, D.C., area. The study found only 14% of the psychiatrists in the publicly listed networks were able to offer new outpatient appointments, with a mean waiting time of 19 days; only 7% of listed psychiatrists overall were able to offer a new outpatient appointment within two weeks.

"Availability of Network Psychiatrists Among the Largest Health Insurance Carriers in Washington, D.C.," Psychiatric Services. May 1, 2017, <https://doi.org/10.1176/appi.ps.201600454>

- conduct annual enrollee experience surveys for each managed care plan, post the results on their website, and report the information to CMS; and
- post to their website documentation of compliance with the Mental Health Parity and Addiction Equity Act.

We also recommend:

- CMS provide standardized definitions, methodologies, and templates for use in conducting secret shopper studies and in measuring wait times so that results can be reliable and comparative across States. The independent entity conducting the secret shopper studies should be required to contact the enrollee help line to find out what kinds of assistance callers have been requesting.
- In instances where States' remedy plans do not fix the managed care plans' lack of access, enforcement must be real, and that CMS identify a standard threshold to disallow Federal financial participation for noncompliance with remedial plans. We also recommend fines be levied for insufficient and incomplete reports. Finally, out of network care must be made available to beneficiaries when they are unable to access in network care.
- CMS ensure that the enrollee experience surveys include questions related to mental health access, including access to treatment at the appropriate level of care (e.g., hospitalization, intensive outpatient programs/partial hospitalization programs, outpatient medication management and therapy, drug detoxification and rehabilitation) for psychiatric conditions and substance use disorders.
- CMS ensure that parity compliance, as mandated by MCO contracts, is meaningful. MCO contracts must include standards for the parity reports and identify triggers for when the State must evaluate the MCO for compliance.

We support requiring that provider directories identify the delivery modality clinicians use; permitting telehealth visits to meet appointment wait time standards if the clinician also offers in-person appointments; and reporting telehealth visits separately in the secret shopper survey results. We agree with CMS that separately identifying telehealth visits will give more accurate information about the utilization of telehealth.

APA applauds CMS's efforts to bring more transparency around clinician reimbursement rates. We support CMS's proposal to require a payment analysis of evaluation and management codes for mental health and substance use services as compared to Medicare payment rates and submit the analysis by the plans to the States and CMS.² **We urge CMS to include rates for all mental health and substance use disorder services in the analysis, including those outside the evaluation and management section.** This information will provide States and CMS with important information to assess the adequacy of payments to clinicians in managed care plans, particularly in cases of network inadequacies, lack of quality care or enrollee complaints.

² On average, Medicaid paid psychiatrists at 81% of the Medicare rates. Reimbursement For Psychiatric Services: Comparisons Across States And With Medicare. Health Affairs. April 2023. <https://doi.org/10.1377/hlthaff.2022.00805> . Accessed June 12, 2023.

We also support CMS’s proposal that States be required to consider this payment analysis and whether reimbursement rates are a contributing factor to a plan’s inability to meet network standards when determining whether to grant an exception for failure to meet timely appointment wait time standards. **In the case of low rates, CMS should require States to take corrective action, especially when networks are determined to be inadequate. Reimbursement rates are a critical component of building a network and low rates can discourage clinicians from joining networks and ultimately harm access.** Reimbursement rates are, however, not the only factor that discourages psychiatrists from caring for Medicaid patients. As one of our members wrote to us:

“Not accepting Medicaid in a solo practice is more complex than just reimbursement rates, and higher payment rates would not simply change my mind. These are typically complex and socially disadvantaged individuals that require a team approach to care. The amount of time required to manage social and disability matters, prior authorization items, and the high rates of no-shows for appointments all result in large amounts of un-reimbursed time.”

Aligning Medicaid reimbursement rates so that they are at a minimum on par with Medicare rates and decreasing administrative burdens/paperwork could help to enlist and retain clinicians in the network. Rates need to be equitable across settings and the full continuum of care must be available and reimbursed.^{3,4} Psychiatrists in private practice report a reluctance to accept Medicaid patients in part because the patients may require additional support the clinician is not able to provide in their practices, such as case management, housing assistance, and wrap around services. Creation of novel programs to fill those gaps should be considered. **We urge CMS to adopt stronger prior authorization standards that reduce the demands for prior authorizations, such as not requiring prior authorizations until a clinician fails to meet clearly defined national standards. We also urge CMS to mandate the use of consistent medical necessity standards, such as LOCUS or ASAM, which will standardize practices and reduce administrative burden.**

APA supports the proposed effective dates for the appointment wait times standard – 3 years after the final rule takes effect – and the “secret shopper” surveys – 4 years after the final rule takes effect. We recommend that CMS post on its website the performance metrics for individual MCOs that are currently available—not just those relating to network adequacy, but all the access and quality metrics that States currently report.

³ In 2017, commercial insurance reimbursement rates for primary care were 23.8% higher than that for behavioral health, which is an increase from 20.8% higher in 2015. Melek, Steve, Davenport, Stoddard, Gray, T.J. “Addiction and Mental Health vs Physician Health: Widening Disparities in Network Use and Provider Reimbursement.” October 2019. <https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p> . Accessed June 12, 2023.

⁴ Battling The Mental Health Crisis Among The Underserved Through State Medicaid Reforms, Health Affairs. February 10, 2020. <https://www.healthaffairs.org/doi/10.1377/forefront.20200205.346125>. Accessed June 11, 2023.

The proposals above are focused on increasing access to care by reducing appointment wait times, addressing the reliability of provider directories and identifying and reducing barriers to participation. However, those alone are not sufficient to ensure patients have timely access to care. There remains a well-documented and growing behavioral health workforce shortage.^{5,6} There simply are not enough mental health clinicians to care for patients regardless of insurance status.

Recognizing that most individuals seek care in primary care, APA encourages CMS to incentivize managed care plans to encourage adoption of the Collaborative Care Model (CoCM), the population-based approach that improves behavioral health outcomes in primary care settings including in FQHCs and RHCs. Supporting sustainable levels of Medicaid reimbursement for this model of care within primary care could not only improve access but also the quality of care and serve to prevent long-term costs through prevention and early intervention. Incentivizing adoption of the model through enhanced reimbursement and implementation support has been shown to be an effective strategy available to payers as noted in a 2020 *Psychiatric News* article on Blue Cross Blue Shield of Michigan’s approach to improving access and quality of care and a May 2023 report from Meadows Mental Health Policy Institute, *Improving Behavioral Health Care for Youth Through Collaborative Care Expansion*, that features ongoing initiatives to incentivize adoption of CoCM in the adolescent population in New York, North Carolina, Texas and Washington.^{7,8}

Quality and Health Equity

APA supports CMS in requiring the mandatory Medicaid core measure set proposed in this rule. We appreciate that significant attention has been paid to improving the quality of care for mental health conditions, especially for the vulnerable populations who rely on Medicaid and CHIP. We look forward to continuing to work with CMS to better understand how health inequities impact quality measurement. We support building in capacity on all behavioral health quality measures to stratify measures by sociodemographic factors (race, ethnicity, sexual identity, gender) as well as Social Determinants of Health (SDOH).

If finalized, this rule will strengthen the implementation and enforcement of necessary services across all eligible groups in every state. APA applauds CMS’s commitment to addressing health equity across its

⁵ Data from the Health Resources and Services Administration (HRSA) show that an estimated 47% of the population lived in one of 6,469 mental Health Professional Shortage Areas (HPSAs) as of December 2022, and the nation needs an additional 7,902 mental health providers to fill these shortage gaps.

Health Resources and Services Administration (HRSA). Designated Health Professional Shortage Areas Statistics. March 31, 2023. Accessed June 12, 2023. <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>

⁶ University of Michigan Behavioral Health Workforce Research Center. Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH; 2018. https://behavioralhealthworkforce.org/wp-content/uploads/2019/02/Y3-FA2-P2-Psych-Sub_Full-Report-FINAL2.19.2019.pdf . Accessed June 12, 2023.

⁷ Richmond, Linda. “Payors Train PCPs to Treat Mental Health in House.” *Psychiatric News*, 30 November 2021, <https://doi.org/10.1176/appi.pn.2021.11.4> . Accessed June 15, 2023

⁸Meadows Mental Health Policy Institute. “Improving Behavioral Health Care for Youth Through Collaborative Care Expansion” https://mmhpi.org/wp-content/uploads/2023/05/Improving-Behavioral-Health-Care-for-Youth_CoCM-Expansion.pdf. May 2023. Accessed June 14.

programs. Identifying health disparities and addressing gaps in care are important goals. In recent decades, research has made clear that social factors are the dominant contributors to mental illness and morbidity and drive enormous inequities in health and mental health. The prevalence of COVID-19 has disproportionately impacted individuals from marginalized communities and those with serious mental illnesses (SMI) or substance use disorder (SUD) who are at greater risk of infection due to social determinants of health (SDOH) factors,⁹ and has exacerbated these same determinants,¹⁰ and worsened them in populations where racism is endemic.¹¹

APA urges CMS to support increased funding for research to better understand the mechanisms by which structural and social determinants affect mental illness and recovery, and to develop and disseminate evidence-based interventions to promote mental health equity and improve the social and mental health needs of patients and their families. This includes identifying and testing screening tools/assessments used for data collection, further refining the list of SDOH, and providing funding to pay for the needed time and infrastructure to administer and review this data.

Thank you for your review and consideration of these comments. If you have any questions or would like to discuss these comments further, please contact Becky Yowell, Director Reimbursement Policy and Quality (QualityandPayment@psych.org).

Sincerely,

A handwritten signature in blue ink that reads "Saul Levin" with "M.D., M.P.A." written in smaller text to the right.

Saul M. Levin, M.D., M.P.A., FRCP-E, FRCPSych
CEO and Medical Director

⁹ Shim, Ruth S, and Steven M Starks. "COVID-19, Structural Racism, and Mental Health Inequities: Policy Implications for an Emerging Syndemic." *Psychiatric services* (Washington, D.C.) vol. 72,10 (2021): 1193-1198. doi:10.1176/appi.ps.202000725

¹⁰ Bernardini, Francesco et al. "Social Determinants of Mental Health As Mediators and Moderators of the Mental Health Impacts of the COVID-19 Pandemic." *Psychiatric services* (Washington, D.C.) vol. 72,5 (2021): 598-601. doi:10.1176/appi.ps.202000393

¹¹ Jeste, Dilip V, and Vivian B Pender. "Social Determinants of Mental Health: Recommendations for Research, Training, Practice, and Policy." *JAMA psychiatry* vol. 79,4 (2022): 283-284. doi:10.1001/jamapsychiatry.2021.4385