AMERICAN PSYCHIATRIC ASSOCIATION

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August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: File code CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Request for Information on Medicare Advantage

Dear Administrator Brooks-LaSure:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,000 psychiatric physicians and their patients, would like to take the opportunity to provide feedback on approaches to enhancing health equity, expanding access to care, advancing innovative care models for Medicare Advantage enrollees and support for affordability and sustainability of the program.

A. Advance Health Equity

APA applauds CMS's commitment to addressing health equity across its programs. Identifying health disparities and addressing gaps in care are important goals, and we support efforts to find the most useful and appropriate methods for collecting data on disparities and social determinants of health (SDOH). 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,[1] and has exacerbated these same determinants,[2] and worsened them in populations where racism is endemic.[3]

[1]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

[2] 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

[3] 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

What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? [(2)] Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?

APA supports reporting of SDOH Z codes and urges CMS to encourage health plans and healthcare systems to assess and improve their capabilities to screen, understand, and address the structural and social determinants of mental health, not just in the inpatient setting, including emergency rooms, but in all settings where care is provided. Prioritization will vary based on the setting and patient population being served by the healthcare provider. We also urge CMS to consider what other segments of the larger healthcare community are currently collecting. A growing number of states (i.e., NY, CA, Survey of State MH Medical Directors) and other entities (i.e., GNYHA) have been researching at this issue and may be a good source of information as how best to proceed as well as maximize and coordinate data collection.

With regard to effective approaches in Medicare Advantage for screening, documenting, and furnishing health care informed by SDOH, the National Committee for Quality Assurance (NCQA) has developed measures related to screening of social needs and corresponding interventions and will be implementing them in the HEDIS program for 2023. CMS should monitor the implementation of these measures and build on existing efforts to measure screening and interventions for social needs; alignment of measurement activities will ease documentation and reporting burdens and promote collection of comparable data. CMS should also encourage stratification of quality measures by social risk factors in order to identify disparities and opportunities for improvement.

Data collection and documentation should be streamlined with only the minimum necessary information relevant to the patient's condition or ongoing treatment documented. Overly burdensome administrative requirements will discourage accurate reporting. Incentivizing through increased reimbursement and streamlined processes should be done, given the resources that will be required to comply. Adequate funding, not only to support the additional data collection process but also to support care delivery itself, including care coordination for transitions between levels of care, is required. The potential benefits to the patient will be improved outcomes.

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 and 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 and further refining the list of SDOH.
In addition to SDOH**,** consideration should be given to the impact of Social Determinants of Mental Health (SDoMH). Factors such as stigma, lack of parity (access and payment), the flawed criminal justice system,

and the impact of social media, all of which disproportionately impact individuals with SMI and SUD. Most adults with SMI and SUD start experiencing symptoms by age 24, some as young as 14 years old; these individuals die 15-20 years younger and are more likely to be incarcerated.[4,5] For more on this, see the attached resource document from the American Psychiatric Association on the Social Determinants of Mental Health in Children & Youth. Early intervention and prevention strategies – further upstream prior to a hospital **a**dmission - related to SDOH and SDoMH are critical to impacting the development and/or progression of disease and resource costs over the lifespan.[6,7,8]

B. Expand Access: Coverage and Care

What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?

APA members have been increasingly concerned about the marketing practices of Medicare Advantage plans. In general, plans tout their benefits, like low copays or premiums, the inclusion of dental and vision care, but fail to mention limitations or gaps in coverage (i.e., limited networks, limited formularies, absence of access to case management for seriously mentally ill patients) or clearly explain the challenges that could arise if they want to revert to a traditional Medicare plan, especially if they've never been enrolled in traditional Medicare. Individuals enroll with limited knowledge or understanding of the constraints of the coverage. Medicare Advantage is seen as a poor option for individuals with a mental health or substance use disorder that requires ongoing care.

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[4] 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

[5] American Psychiatric Association, 2022, American Psychiatric Association/Report of the APA Presidential Task Force on Social Determinants of Mental Health, https://www.psychiatry.org/APA TF SDOMH March-Report.pdf. Accessed 6 June 2022.

[6] 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

[7] Shim, Ruth S, and Michael T Compton. "The Social Determinants of Mental Health: Psychiatrists' Roles in Addressing Discrimination and Food Insecurity." Focus (American Psychiatric Publishing) vol. 18,1 (2020): 25-30. doi:10.1176/appi.focus.20190035

[8] Compton, Michael T., and Ruth S. Shim. "The Social Determinants of Mental Health." FOCUS, vol. 13, no. 4, 2015, pp. 419–425., https://doi.org/10.1176/appi.focus.20150017.

Limitations as to health insurance literacy coupled with functional limitations/impairments due to physical, mental health or substance use disorders make the process to choose the best coverage challenging. Consideration should be given to providing additional supports to those with chronic conditions or those dually eligible for Medicare and Medicaid. Care needs to be given to ensure that the coverage information is written concisely at a fourth-grade level with comparisons across plans of key information clearly outlined and available in multiple languages. Guidance from an impartial, knowledgeable individual, who can ideally converse in the individual's native language could help guide individuals to make the best choice.

What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth In MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access?

Medicare Advantage has an opportunity to leverage telehealth technologies to improve health outcomes for beneficiaries. From an access standpoint, telehealth allows patients who have disabilities or barriers to in-person care to receive high quality care from their clinician of choice. Moreover, this is an opportunity to leverage applications to remotely monitor beneficiaries for mental health and substance use treatment as an additional tool of treatment. If implemented successfully, physicians can check in with their patients, review medication changes, and discuss behavioral interventions through tele-technologies with limited disruption to the beneficiary's day.

However, this does require both clinicians and beneficiaries to access broadband and to the technologies. The digital divide not only affects rural and lower socio-economic beneficiaries but also many elderly people lack access to broadband and associated technologies. And for some that have access, they may lack the knowledge or ability to use the technology. This can exacerbate health disparities among beneficiaries. As part of a mental health evaluation, psychiatrists are also assessing the patient's access to care and determining the best mode for that patient in the current circumstances. CMS must empower physicians to determine the best mode of treatment delivery based on clinical judgement and the needs of the patient.

How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

The same performance measures should be used to determine quality care when a physician determines that telepsychiatry services are clinically appropriate. APA encourages CMS to continue to collect data on mental health and substance use disorder treatment via tele-technologies to make permanent flexibilities granted during the public health emergency, such as removal of the six-month in person visit. Clinicians must use their clinical judgment, which includes assessing the patient's ability to use technologies, access in-person care, adhere to an appointment schedule, etc., when determining the venue/platform for each visit.

What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to

primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

CMS applies time/distance standards to MA plans for various types of providers and facilities and these standards are reduced in counties where telehealth is available. However, these standards do not assure that a sufficient number of providers are available. APA recommends adding appointment wait times standards to MH/SUD care with a provider that has the requisite level of knowledge and skill to treat the enrollees' MH/SUD condition. People who suffer from serious mental illness, such as major depressive disorder, a history of suicide attempts, eating disorders and co-occurring substance use or medical disorders, are often the most vulnerable patients and often need highly specialized care. The availability of any behavioral health provider does not satisfy the member's right to obtain network health services within the designated wait time if that provider lacks the education and training to treat the member's condition. To that end, APA recommends that psychiatrists be one of the specialties that have an appointment wait time standard and that the appointment wait time thresholds be based on routine, urgent and emergent standards and transition of care needs or post discharge follow up and recommends time frames of one month for routine appointments, one week for urgent appointments and immediate for emergency care, including referral to an emergency room that has an agreement for back up psychiatric care. APA also recommends requiring MA issuers to report on the number of providers who have billed for patient services within the past 4-6 months, which is more reflective of a member's access to health services than those who are listed as within a certain time/distance metric. Consumers commonly complain about making numerous phone calls to providers who, while listed as network members, are not available to care for the patient. However, people who suffer from MH/SUD are unlikely to complain when they cannot find care, either due to stigma or the overwhelming demands of managing their illness. APA also recommends conducting regular patient satisfaction surveys around network access questions such as how many providers the patient contacted before finding an appointment and how long did the patient have to wait for an appointment.

How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

APA finds the growing trend towards use of restrictive utilization management techniques, like prior authorization, to control costs concerning. These concerns are not without merit. In April 2022, HHS released a report from the Office of Inspector General (OIG) finding that MA organizations have inappropriately denied prior authorization and payment requests for covered healthcare services and

raising concerns about beneficiaries' access to medically necessary care and the administrative burden to providers who must respond to their requests. [9]

The process of requiring prior authorization for payment or dispensing of psychotropic medication by third party insurance plans or other entities is detrimental to patients care. This process often results in delays for patients in receiving life-sustaining medications (authorization denials and the need to prescribe a non-first choice medication), and always results in psychiatrists using large amounts of what would otherwise be clinical time to complete the essential prescribing transaction. **APA recommends against any requirement of prior authorization for psychotropic medications prescribed by psychiatrists prior to payment by insurers, except for instances of clear outlier practices or an established evidence base which implicates concern for patient safety.** In those instances, the decision to require prior authorization or documentation should be made only by a Board-Certified Psychiatrist.

With regard to requiring prior authorization for MH/SUD services, the APA recommends the following requirements[10]:

- based on clinical care concerns and not costs alone;
- allow for flexibilities based on the patient's clinical situation and the care plan developed by the provider in consultation with his/her patient;
- an appeals system that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues;
- not interrupt the continuity of care; and
- be transparent and fair.

Example: An APA member recently reported a patient spent an unnecessary five months in a locked psychiatric facility after having their psychiatric issues resolved but failing to secure a bed in a SNF for necessary physical therapy. Discharge was delayed while facility social workers attempted to find an appropriate placement; attempts (over 51) to find an appropriate placement were hampered when the MA plan's utilization review failed to authorize treatment in a SNF that could provide the necessary care. The patient was finally released to a setting without the necessary physical therapy. The patient was discharged six months after being admitted. The insurance plan issued a denial for lack of medical necessity, paying for one month of care and denying coverage for the other five months. In addition to the cost of the uncovered days, the stay required the patient to use up a large number of her available Medicare inpatient days.

C. Drive Innovation To Promote Person-Centered Care

[9] Some Medicare Advantage Organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care. OEI-09-18-00260 04-27-2022. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp. Published April 27, 2022. Accessed August 31, 2022.

[10] Prior authorization and Utilization | AMA - American Medical Association. Practice Management - Prior Authorization. https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf. Accessed August 31, 2022.

Incentivize implementation of The Collaborative Care Model

APA encourages MA plans to incentivize the implementation of the Collaborative Care Model (CoCM) in primary care and the use of measurement-based care (MBC) in primary and specialty care. CoCM is an evidence-based model that integrates behavioral health care within the primary care setting through a team-based approach that includes a primary care clinician, a psychiatric consultant, and a care manager. The model is a population-based approach, that includes care management activities, and the use of validated rating scales to access progress and adjust treatment when patients are not improving. CoCM is supported by more than 90 randomized controlled trials and has been shown to double the number of patients with meaningful clinical improvement relative to usual care. It is effective in reducing disparities by race and ethnicity in depression outcomes. In addition to demonstrated clinical efficacy, CoCM's population-based approach helps to alleviate the psychiatric workforce shortage by leveraging the expertise of the psychiatric consultant. One psychiatric consultant can help guide the treatment of many more patients within a CoCM model than if that same clinician was treating patients on a one-to-one basis.

Providing effective treatment within primary care frees up specialty care capacity for patients needing a higher level of care. Additionally, the CoCM has tremendous potential to produce significant cost savings. For example, one cost/benefit analysis demonstrated that this model has a 12:1 benefit to cost ratio for the treatment of depression in adults. Finally, primary care physicians have reported an increased sense of well-being and feel better prepared to provide care to patients with mental health and SUD. All of these feature's function to improve both mental and physical health and prevent downstream hospitalizations, or emergency room visits (not only for mental health or SUD conditions but physical health conditions as well) ultimately improving outcomes while reducing overall-costs to our healthcare system.

We encourage MA plans to provide incentives (increased reimbursement, funds for start-up costs and technical assistance) and pay for CoCM using the established CPT codes (99492-99494, GXXXX), to promote adoption of the model within primary care practices. These are practice supports that better able practices to get over the hump of practice transformation.

Incentivize the Adoption of Measurement-Based Care (MBC)

Consideration should also be given to providing financial support and technical assistance to implement measurement-based care (MBC) in both primary care clinicians, either within the context of a collaborative care implementation or as a stand-alone activity. MBC, a core component of the Collaborative Care Model, has been shown to be effective in improving outcomes and patient and

provider satisfaction in both primary and specialty care.[11,12,13,14] In their recent (2022) report to Congress, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) highlighted the positive effects of MBC; accrediting organizations and payers have also begun to recognize its value. MBC increases screening and can improve early identification and prevention and is more effective in improving outcomes than screening alone.

As with CoCM, clinicians in both primary care and specialty care have been slow to adopt this model of care. A 2020 JAMA Psychiatry article (Lewis et al) summarized several barriers faced by individual clinicians and organizations including concerns about patient response burden, patient confidentiality, the time and effort it takes to collect the information and track over time, lack of an electronic medical record or one that can facilitate MBC and the increase administrative burden on staff or individual clinicians.[15] Implementation will require stakeholder buy-in and adapting to change.[16]

Coverage of *99484 and GBHI1 (Care management services for behavioral health conditions*) provides a starting point however does not fully account for the costs to implement the model. The current valuation does little to incentivize MBC. As with CoCM, providing funding to implement, reimbursement mechanisms that incentivize change, and support through technical assistance could reduce the barriers to adoption. This is one way for those primary care practices that may not choose to implement CoCM to improve outcomes for their patients suffering from mental health and substance use disorders.

D. Support Affordability and Sustainability

What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

Regarding policies that CMS could explore to ensure MA payment promotes high quality care for enrollees, we would encourage incentivizing the adoption of measurement-based care, as mentioned above, which has been shown to improve outcomes and increase patient satisfaction with care. In addition, MA should consider collecting and reporting outcome data periodically, covering a random

[11]Fortney, (J. C., Unützer, J., Wrenn, G., Pyne, J. M., Smith, G. R., Schoenbaum, M., & Harbin, H. T. (2017). A Tipping Point for Measurement-Based Care. Psychiatric Services (Washington, D.C.), 68(2), 179–188.

[12] Alter, C.L., Mathias, A., Zahniser, J., Shah, S., Schoenbaum, M., Harbin, H.T., McLaughlin, R, & Sieger-Walls, J. (2021, January). Measurement Based Care in the Treatment of Behavioral Health Disorders. Dallas, TX: Meadows Mental Health Policy Institute. mmhpi.org

[13] Hu J, Wu T, Damodaran S, Tabb KM, Bauer A, Huang H. The effectiveness of collaborative care on depression outcomes for racial/ethnic minority populations in primary care: a systematic review. Psychosomatics. 2020, online first.

[14] Snowber K, Ciolino JD, Clark CT, Grobman WA, Miller ES. Associations Between Implementation of the Collaborative Care Model and Disparities in Perinatal Depression Care. Obstet Gynecol. 2022;140(2):204-211. doi:10.1097/AOG.0000000000004859

[15] Lewis CC, Boyd M, Puspitasari A, et al. Implementing Measurement-Based Care in Behavioral Health: A Review. JAMA Psychiatry. 2019;76(3):324-335. doi:10.1001/jamapsychiatry.2018.3329

[16] Fortney, (J. C., Unützer, J., Wrenn, G., Pyne, J. M., Smith, G. R., Schoenbaum, M., & Harbin, H. T. (2017). A Tipping Point for Measurement-Based Care. Psychiatric Services (Washington, D.C.), 68(2), 179–188.

sample of beneficiaries. This will allow for comparison of outcomes between patients in traditional Medicare and those in Medicare Advantage. Outcome measures should go beyond process markers like hospitalization rates and ED visits to include actual quality of life measures, as well as measures of function and recovery.

What methodologies should CMS consider to ensure risk adjustment is accurate and sustainable? What role could risk adjustment play in driving health equity and addressing SDOH?

Adequate risk adjustment approaches can reduce incentives for cherry-picking by enabling the provision of additional resources for plans serving higher-risk populations, diminishing the likelihood of the most disabled, most costly patients being funneled into traditional Medicare while healthier patients are absorbed into MA, undermining the financial stability and sustainability of the traditional Medicare program.

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

Sincerely,

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