AMERICAN PSYCHIATRIC ASSOCIATION

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January 31, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
200 Independence Avenue S.W.
Washington, D.C., 20201

Re: Request for Information; Essential Health Benefits (CMS-9898-NC)

Dear Administrator Brooks-LaSure,

The American Psychiatric Association (APA), the national medical specialty society representing over 37,400 psychiatric physicians and their patients, appreciates the opportunity to provide these comments on CMS-9898-NC, Request for Information; Essential Health Benefits (EHB). Our response will highlight barriers patients face in accessing mental health and substance use disorder (SUD) services, the importance of telehealth utilization in improving access to these EHB services, and the potential for the Collaborative Care Model to address gaps in coverage. It is also important to note that barriers to accessing and providing mental health and SUD care, while limiting utilization in the immediate, can lead to costlier need for crisis interventions in the future. Finally, aspects of EHB could be improved to better advance efforts in health equity, including increased availability of culturally-competent whole health care.

Barriers of Accessing Services Due to Coverage or Cost

Are there significant barriers for consumers to access mental health and substance use disorder services, including behavioral health services that are EHB? To what extent has the utilization of telehealth impacted access to the behavioral health services that are EHB, particularly during the COVID-19 pandemic? How could telehealth utilization better address potential gaps in consumer access to EHB for behavioral health services or other health care services?

The United States continues to see a rise in rates of suicide, overdoses, and increased depression and anxiety across nearly all ages and demographics. Unfortunately, despite this mental health crisis, many barriers exist for patients needing to access EHB mental health and substance use disorder (SUD) services. Patients often experience a delay in accessing care due to the persistent shortage of psychiatrists and coverage across the country. As demand for their services increase, psychiatrists continue to meet capacity limitations. Administrative barriers, such as inaccuracies

in insurance plan lists, prior authorization, and the need for references from primary care providers, further complicate accessing behavioral health services. Furthermore, many with commercial plans or Medicare, face disparate coverage, narrow networks, and a lack of mental health parity.

As a result of the public health emergency (PHE), increase in telehealth utilization and flexibilities have facilitated some much-needed improvement in accessing care, especially for the most under-resourced populations. Before the expanded access to telehealth stemming from the PHE, navigating the system to access timely mental health services was difficult for most patients. In 2022, according to an AHIP survey, 78% of commercially insured telehealth users in the past year said that telehealth made it easier for them to seek out healthcare when they need it. Patient satisfaction, convenience, and inability to find in-person appointments were some of the reasons given by respondents, as to why they found telehealth most helpful. The same survey noted that 73% of commercial telehealth users said that Congress should make permanent the provisions that allowed for coverage of telehealth services before paying their full deductible.

Telehealth has also allowed for wider-reaching accessibility to behavioral healthcare by underserved populations. Eliminating transportation needs, geographic limitations, and needing to take extended time off work have benefited minority and rural communities, as well as elderly populations. The 2022 AHIP survey also concluded that women telehealth users were almost four times more likely than men to say they took a telehealth appointment because they lacked child or elder care.

What efforts have plans found effective in controlling costs of EHB? To what extent do plans that provide EHB see increased utilization and higher costs if those efforts are not implemented?

For much of the care delivered, many plans have shifted to using largely non-physician providers with a smaller contingent of consulting physicians to control costs. Plans also continue to ignore requirements for parity established by the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Widespread discriminatory practices, including frequent and arduous prior authorization practices, limited provider networks, interference in medical decision-making, and improper denial of claims plague Americans seeking help for mental health challenges. Although such administrative barriers and denials of care are used as ways to control costs of EHB services in the immediate, they may lead to the exacerbation of mental health conditions and increased future cost for crisis services.

What strategies have consumers and providers seen plans implement to reduce utilization and costs, such as use of prior authorization, step therapy, etc.?

Aside from patients with plans maintaining extremely limited mental health provider networks, psychiatrists are subject to prior authorization administrative burdens, delays, and denials, as well as unrealistic and burdensome step therapy protocols. Prior authorization and step therapy are both implemented by plans in an effort to reduce utilization and costs and can lead to a delay or absence of mental healthcare, increasing the likelihood of a crisis later. Such interventions decrease utilization, likely delaying care until the patients' needs become more complex. On the other hand, when correctly

implementing telehealth services, plans can lower costs by increasing access and reducing the need for crisis services.

Addressing Gaps in Coverage

Are there examples of benefits that are essential to maintaining health, including behavioral health, that are insufficiently covered as EHB but that are routinely covered by other specific health plans or programs, such as employer-sponsored plans, Medicare, and Medicaid? To what extent does the EHB cover screening, consultative, and treatment modalities that supports the integration of both mental health and substance use disorder services into primary care?

Although certain billing codes now permit reimbursement for both primary care and mental health providers through integrated care, there is very limited support for implementation and coverage of the Collaborative Care Model (CoCM). The model is evidence-based and has been shown to both improve access to care and treatment outcomes, as well as reduce medical cost savings for patients receiving care for mental health and substance use disorders in the primary care setting. CoCM has proven adept in providing prevention, early intervention, and timely treatment of mental illness and SUDs. Many individuals first display symptoms of a mental health/SUD in the primary care setting but do not receive the necessary follow-up treatment. Often, they have difficulty finding a mental health clinician or avoid seeking treatment due to the stigma that still exists. CoCM provides a strong framework to address these problems by ensuring patients can receive timely behavioral health treatment within the office of their primary care physician.

CoCM integrates behavioral health care within the primary care setting and features a primary care physician, a psychiatric consultant, and a care manager working together in a coordinated fashion. Importantly, the team members use measurement-based care to ensure that patients are improving, and treatment is adjusted when they are not. 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.[1] Furthermore, the virtual nature of CoCM enabled care to continue throughout the public health emergency.[2]

Telehealth coverage and payment parity for mental health and substance use disorder services is also critical. Rather than cherry-picking modalities for patients seeking these services, plans should cover the modality that ensures access to timely, and potentially lifesaving care. For mental health and SUD services via tele-technologies that have proven effective even prior to the COVID-19 pandemic, they cannot be pulled back during a time the country is facing a continued opioid public health emergency and mental health crisis.

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[1] Washington State Institute for Public Policy Benefit-Cost Results for Adult Mental Health. Retrieved from: https://www.wsipp.wa.gov/BenefitCost?topicId=8

[2] Carlo AD, Barnett BS, Unützer J. Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. JAMA Psychiatry. 2021;78(4):355-356. doi:10.1001/jamapsychiatry.2020.3216

Aside from the required preventive services for children,[15] and the identification in section 1302(b)(1)(J) of the ACA for "[p]ediatric services, including oral and vision care" as one of the 10 categories of EHB, the EHB-benchmark plans largely do not differentiate between benefits for adults and benefits for children. Are there differences between adult and pediatric benefits and those populations' needs such that further delineation of pediatric benefits is warranted? How does the scope of health benefits for children compare between employer-sponsored group health plans and States' separate Children's Health Insurance Program plans?

Plans must take into account the different dynamics that children face in their ability to access mental health services. The COVID-19 pandemic had profound effects on children's mental health and the opportunity is now to change the course that otherwise leads to more complex care in the future. EHB for children must explicitly support family therapy and home services. Schools must also be a place of care for mental health services, reaching children and their families in settings that are commonly accessed.

Advancing Health Equity and Nondiscrimination Efforts

How should the EHB advance health equity by taking into consideration economic, social, racial, or ethnic factors that are relevant to health care access (for example, access to appropriate language services)?

Seemingly, a pillar of EHBs is equitable healthcare, no matter where race, ethnicity, gender , economic status, or geographic location. Requiring plans to effectively and comprehensively track data to help identify and monitor existing disparities could help inform how best to address the barriers to care. EHBs could also advance health equity through requiring culturally informed, linguistically appropriate care, which could continue to be advanced through the support of telehealth. Evolving technologies to better inform physicians on social determinants of health, such as housing, transportation, and employment should be supported. Moreover, encouraging financial investment by healthcare companies to connect pillars of underserved communities, such as religious institutions, schools, and community services to establish an effective pipeline to care for those who need mental health and SUD services would tremendously advance health equity efforts. Finally, working towards eliminating co-pays for prescriptions would vastly benefit underprivileged communities seeking mental health services.

In what ways could EHB better address health conditions that disproportionately affect underserved populations or large parts of the American population?

Large portions of Americans remain under or uninsured. Millions more chance losing their insurance immediately following the end of the PHE due to administrative obstacles. Intentional focus, including needs assessments, on areas that have large numbers of under or uninsured populations is an important step. Moreover, helping patients with other social services to align whole health will benefit those who have disproportionately faced inequitable health services. EHBs also have an obligation to assist with the

mental health and SUD crisis affecting every community across the country. Reimbursement for mental health and SUD treatments as dictated by parity laws must be enforced, but plans should also consider the value to reimburse preventative services at a higher rate to entice more physicians to offer services in communities that are disproportionately impacted by mental health and SUD disorders.

Thank you for your review and consideration of these comments. If you have any questions or would like to discuss any of these comments further, please contact Brooke Trainum (btrainum@psych.org), Director, Practice Policy.

Sincerely,

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