



July 3, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicaid Program; Ensuring Access to Medicaid Services, [CMS-2442-P](#)

Submitted electronically via Regulations.gov

Dear Secretary Becerra and Administrator Brooks-LaSure:

NAMI appreciates the opportunity to submit comments on the proposed rule, Medicaid Program; Ensuring Access to Medicaid Services. NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for people affected by mental illness. Throughout our 40-year history, NAMI has fought for dignity, fairness, and equity for people with mental illness. Many of the people we represent receive health care as a result of Medicaid, the nation's largest payer of mental health servicesⁱ, which covers more than one in four adults with a serious mental illness (SMI)ⁱⁱ. We know that access to mental health services is essential for people with mental illness to successfully manage their condition, get on a path of recovery, and live healthy, fulfilling lives. Medicaid is essential to receiving that care, as people with Medicaid coverage are more than twice as likely to receive behavioral health treatment as adults without any health insuranceⁱⁱⁱ.

NAMI thoroughly appreciates the work of CMS to address a range of access-related challenges that impact how beneficiaries are served by Medicaid across all of its delivery systems. We believe that the various reforms in this proposed rule will increase access to care and, in particular, we appreciate the attention to behavioral health. NAMI urges CMS to finalize the proposed rule and not to push implementation dates any farther into the future than what is proposed.

Background on Medicaid and Mental Illness

The importance of Medicaid coverage for people with mental health conditions cannot be overstated. Medicaid is the single largest payer of behavioral health services in the country^{iv}, and 39 percent of beneficiaries have mild, moderate, or severe mental health or substance use disorder conditions^v. Among nonelderly adults with a moderate to severe mental illness or substance use disorder, Medicaid beneficiaries are more likely than those with private insurance to have chronic health conditions and to report fair or poor health^{vi}. As the proposed rule notes, the COVID-19 pandemic worsened underlying

mental illness and substance use disorders, particularly for some subgroups including young adults^{vii} and people of color^{viii}. Despite state and federal efforts to improve accessibility and quality, 35 percent of Medicaid-covered individuals with significant mental health concerns report not receiving treatment^{ix}, which highlights the great need for the proposed changes to increase access to care.

NAMI Comments

NAMI offers the following comments on specific proposals within the proposed rule:

Medical Care Advisory Committees (MCAC) (§ 431.12):

NAMI strongly supports the proposal to modify the current MCAC arrangement into two new groups: Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Group (BAG), which would be required to meet at least once per quarter, hold off-cycle meetings as needed, and offer in-person and virtual attendance options. We believe this proposal is a welcome step toward more meaningful stakeholder engagement, particularly Medicaid beneficiaries and their caregivers who have firsthand knowledge of the program's effectiveness and deficiencies. We support requiring at least twenty-five percent of MAC membership be Medicaid enrollees, who would also serve as part of the BAG, and that MAC and BAG recommendations should not be limited to medical care, but include other issues related to the effective administration of the program, including services, eligibility, care coordination, quality, communications, cultural competencies, and other issues. CMS should make clear that the scope of MAC and BAG advisory authority should extend to all aspects of a state's Medicaid program. We also support the proposed requirement to include representation from other stakeholders including state or local consumer advocacy groups, provider groups, managed care organizations, and other state agencies.

Engaging Medicaid beneficiaries and providing opportunities to meaningfully engage in BAG and MAC proceedings should be a priority. We support requirements to make MAC and BAG meetings accessible to people with disabilities and persons with Limited English Proficiency (LEP). State Medicaid agencies should provide staffing and other support for MAC and BAG proceedings. We urge HHS to further clarify and strengthen state requirements to engage Medicaid beneficiaries, including providing transportation assistance/reimbursement, childcare, financial reimbursement (for room, board, and any missed work), and varying meeting times and locations to allow participation of enrollees during working hours. We advise CMS to encourage states to consider multiple young people (high school and college age) and to use advisory groups or youth-led organizations within the state to contribute to the BAG. This is particularly important for behavioral health given the current youth mental health crisis^x.

Furthermore, the proposed rule outlines topics that must be discussed by the MAC and BAG. NAMI strongly urges CMS to add "accessibility of services, including the experience of individuals and families as they try to access services" to topics for the MAC and BAG. The rule recognizes the difficulty that so many Medicaid beneficiaries have accessing in-network, affordable care and yet, this topic is not part of the list provided in the regulation.

Home and Community-Based Services (HCBS):

NAMI generally supports the proposed updates to HCBS program standards and processes regarding care access, quality, and payment, geared toward making care provided more person-centered. NAMI supports a state-level requirement that a percentage of total payments for certain services be spent on direct care worker compensation. HCBS direct care workers perform difficult, and extremely important, work. Ensuring fair wages is the best way to keep pace with the growing demand for high-quality HCBS care. Historically, direct care services have been undervalued and undercompensated. HCBS direct care workers often work for low-wages, limited benefits, and turnover in these positions is high^{xi}. Medicaid's

generally low reimbursement rates suppress wages and impede recruitment and retention^{xii}. This directly contributes to chronic workforce shortages that negatively affect the availability and quality of care.

We note that CMS seeks comments on whether the proposed requirements related to the percent of payments going to the direct care workforce should apply to other services listed such as adult day health, habilitation, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness. We believe these services that serve people with mental health conditions should be included and encourage CMS to extend the direct care worker requirements to these settings.

While we appreciate the new HCBS requirements, we are concerned that these new regulations will not apply to Medicaid State plan mental health rehabilitative services. Mental health rehabilitative services often serve the same functions as HCBS waiver services, so to exclude the services from the proposed rule amounts to excluding people with mental health conditions from the proposed rule's added protections to HCBS. NAMI strongly recommends that CMS extend the proposed rule's requirements, safeguards, and benefits to mental health rehabilitative services.

Fee-for-Service (FFS) Payment:

NAMI supports the proposal to ensure that Medicaid payment rates are set at levels sufficient to ensure access to care for beneficiaries by requiring states to publish FFS payment rates and conduct a payment rate analysis comparing base Medicaid payment rates to Medicare rates for primary care, OB/GYN services, and outpatient behavioral health services. This includes creating new transparency and consultation requirements for FFS provider payment rates, including a requirement for states to publish analyses comparing the Medicaid FFS rates for certain services against corresponding Medicare FFS rates, as well as the establishment of an "interested parties' advisory group" to advise and consult on payment rates for certain HCBS; and modifying procedures for requesting federal approval to reduce or restructure FFS rates through a SPA by requiring additional supporting analyses with respect to SPAs that, based on a preliminary review, present potential risks to beneficiaries' access to services.

In particular, we support CMS' proposal to revamp current requirements in effect for state plan amendments (SPAs) that propose to reduce rate or restructure payments. CMS proposes creating a two-tiered approach that would require all rate reduction/restructuring SPAs to satisfy certain criteria and only require enhanced analysis and procedures for those that don't. We are concerned that this proposed two-tier structure CMS will still permit states to alter rates in ways that harm beneficiary access. Therefore, we suggest that CMS require states to submit the proposed rate analysis any time the state requests approval of a SPA that will reduce or restructure rates, and not only when the proposed rate fails to meet certain criteria.

We also agree with CMS's proposed clarification that CMS may disapprove SPAs that could result in diminished access if a state fails to submit the information discussed above, or if CMS concludes that the relevant information points to unresolved access issues. This provision helpfully codifies CMS' longstanding authority to use its authority to enforce access standards denying SPAs and/or taking compliance action to protect access for Medicaid enrollees.

We further encourage the comparison of Medicare and Medicaid rates beyond Evaluation and Management (E&M) codes to also include rates for psychologists, social workers and marriage and family therapists, as outpatient behavioral health providers who do not bill using E&M codes. We also

encourage using 100 percent of the comparable Medicare rate instead of the minimum 80 percent when reviewing a cut to rates in behavioral health care as data indicates that Medicare undervalues mental health care relative to physical health care, and many behavioral health providers do not take insurance leading to even higher rates in the private market. There is a separate section on outpatient behavioral health that appears to be linked to a Medicaid/Medicare comparison of Evaluation and Management (E&M) codes. CMS could clarify in this section that states must be transparent with respect to publishing rates for all providers of outpatient behavioral health services, including professionals and peer support specialists.

To that end, we encourage CMS to ensure that the rule specifically ensures payment rate transparency for peer support specialists and information on claims and unique beneficiaries of the peer support specialist workforce. Peer support specialists should not be included in the direct care worker category, as peer support specialists serve a very different population and have different training and supervision requirements than direct care workers, who typically work with a population of older individuals or people with disabilities receiving waiver services. However, the transparency required for Medicaid fee for service outpatient behavioral health providers should expressly require rate transparency regarding peer support specialists and number of beneficiaries and claims. This would provide additional information on a wider array of behavioral health services than psychiatric services.

Access Reporting: Waiver Waiting Lists

NAMI supports the proposed rule that would require states to report to CMS on waiver waiting lists. The information would include whether the State screens individuals for eligibility prior to placing them on the list, whether the State periodically screens individuals on the list for continued eligibility, and the frequency of rescreening, if applicable. States would also report on the number of people on the list who are waiting to enroll, and the average amount of time individuals newly enrolled in the waiver program in the past 12 months were on the list of individuals waiting to enroll. This information could help advocates, policymakers, and other stakeholders better understand the unmet need in states, and would allow individuals and families to plan for their future.

Access Reporting: Payment Adequacy

NAMI supports the proposal that the State report annually on the percent of payments for certain services that are spent on compensation. We agree that additional information about the median hourly wage and compensation by category would be helpful and suggest that CMS include such a requirement in the final rule. This information should be stratified by delivery system and where applicable, by plan, to capture differences between managed long-term services and supports and fee for service.

The value of the information for future rate-setting purposes outweighs any burden. Providers likely readily have this information, but direct care workers and other stakeholders may not. To allow for meaningful participation in the interested parties advisory group, information such as the median wages and compensation and historic trends should be equally available to all members of the public.

As noted above in comments on HCBS Payment Adequacy and for the same reasons, these provisions should also apply to 1905(a) state plan services for home health aides and personal care services.

Linkages to Managed Care Rules

NAMI believes that much of the proposals in the Managed Care rule intended to enhance access are also applicable and equally as important in fee-for-service, including independent third-party secret shopper and wait times requirements for outpatient behavioral health, requirements that states list rates for all

Medicaid services and clearly display such information on a website, and more. These provisions were designed to ensure beneficiaries can access services and CMS included behavioral health care as one of the categories because of the difficulties beneficiaries are finding in accessing these services in the Medicaid program. The low rates that create these difficulties in a managed care context are also a problem in fee for service Medicaid. States will not have incentive to adjust the rates and improve access to care if they are not documenting the difficulties in accessing services. A state should not be able to avoid accountability by choosing a fee for service program. All Medicaid beneficiaries should have the right to accessible, timely behavioral health services regardless of whether the program is fee for service or managed care.

Thank you for the opportunity to comment on this important proposed rule. We strongly support the initiatives outlined and urge you to consider our additional recommendations. We also urge CMS to implement them as soon as possible. If you have any questions, or would like to discuss, please contact Jennifer Snow, NAMI's National Director of Government Relations and Policy at jsnow@nami.org.

Sincerely,



Hannah Wesolowski
Chief Advocacy Officer
National Alliance on Mental Illness

ⁱ [Behavioral Health in the Medicaid Program—People, Use, and Expenditures : MACPAC](#)

ⁱⁱ [Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health \(samhsa.gov\)](#)

ⁱⁱⁱ [Medicaid's Role in Behavioral Health | KFF](#)

^{iv} [Behavioral Health in the Medicaid Program—People, Use, and Expenditures : MACPAC](#)

^v [Amid a Mental Health Crisis in the U.S., A New KFF Report Examines the Steps that State Medicaid Programs Are Taking to Help Shore Up the Availability of Crisis Services | KFF](#)

^{vi} [Demographics and Health Insurance Coverage of Nonelderly Adults With Mental Illness and Substance Use Disorders in 2020 | KFF](#)

^{vii} [Young Adult Anxiety or Depressive Symptoms and Mental Health Service Utilization During the COVID-19 Pandemic - ScienceDirect](#)

^{viii} [Health Officials Fear Pandemic-Related Suicide Spike Among Native Youth | KFF Health News](#)

^{ix} [How Does Use of Mental Health Care Vary by Demographics and Health Insurance Coverage? | KFF](#)

^x [School psychologists are scarce as schools face mental health crisis. \(usatoday.com\)](#)

^{xi} [State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages \(macpac.gov\)](#)

^{xii} [PCPID 2017: America's Direct Support Workforce Crisis \(acl.gov\)](#)