



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; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, [CMS-2439-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; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality." 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}.

States use a combination of fee-for-service (FFS) and managed care arrangements to deliver behavioral health care to Medicaid beneficiaries, with these services increasingly being provided by managed care organizations (MCOs) in recent years^{ix}. Most states continue to rely on MCOs to administer and manage inpatient and outpatient behavioral health services, and the majority of MCO states carve behavioral health services into their MCO contracts^x. 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^{xi}, which highlights the great need for the proposed changes to increase access to care within Medicaid managed care.

NAMI Comments

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

Access: Enrollee Experience Surveys (§§ 438.66(b) and (c), 457.1230(b))

Unfortunately, it has been well documented that the overall quality of mental health care in the United States is quite poor compared to care for other medical conditions. Giving patients a greater voice in the care they receive is key to improving quality. We believe that giving beneficiaries more opportunities to share their experiences has great potential to incentivize improvements in the quality of mental health care delivered in the Medicaid program. Therefore, NAMI strongly supports the proposal to require states to conduct annual enrollee experience surveys and encourages CMS to finalize this requirement. We also support requirements to make that information fully transparent, which we believe will enhance usability for beneficiaries. To address unique needs related to mental health care, we further encourage CMS to require the inclusion of questions directly related to mental health access in the patient experience survey.

We note that CMS requests comments on whether to mandate using a specific enrollee experience survey, define characteristics of acceptable survey instruments, and operational considerations of enrollee experience surveys states use currently. While NAMI does not take position on particular survey instruments used, we note the proposed rule's overall theme of alignment and comparability and strongly recommend that CMS require a consistent minimum standard to facilitate meaningful and consistent comparison across states. The Agency for Health Care Research and Quality (AHRQ) has specifically designed several tools to measure patient experience for health plans specific to mental health and substance use care^{xii}. These include the supplemental items to add to the CAHPS survey, a set of six questions to ask people about their experience accessing behavioral health care. AHRQ has also developed the Experience of Care and Health Outcome Survey (ECHO) which asks health plan enrollees about their experiences with behavioral health care.

Access: Federal Minimum Standards for Wait Times (§§ 438.68(e), 457.1218)

We fully agree that barriers to accessing care are significant, and there is a strong need for increased oversight of network adequacy and overall access to care. As a result, NAMI strongly supports the proposal to create federal minimum standards for appointment wait times. We particularly support the proposal to include outpatient mental health and substance use disorder as one of four types of services in which states would be required to develop and enforce wait time standards for routine appointments. We also appreciate the inclusion of wait time standards for primary care, as primary care providers are

often the first point of contact for patients with mental health concerns and have significantly increased their provision of mental health care over the years^{xiii}.

We believe the proposed 10 business days for routine outpatient mental health and substance use disorder appointments and no longer than 15 business days for routine primary care appointments, as aligned with Marketplace standards, are appropriate. We encourage CMS to implement these minimum standards for mental health and SUD as expeditiously as possible.

We also support CMS's proposal to impose a ninety percent compliance rate on managed care plans. Setting a precise compliance threshold will ensure that stakeholders—including states, insurance regulators, enrollees, providers, and advocates—have a common benchmark to evaluate whether managed care plans' networks comply with the standard.

In addition to routine care, we also encourage CMS to think about wait time standards for mental health crisis response services in the future. Given the establishment of 988 last year, states around the country are expanding access to the full array of crisis response services, particularly mobile crisis response and crisis stabilization. As this work continues, it will become increasingly important to monitor beneficiary access to these critical services. NAMI looks forward to working with CMS to consider how wait time standards might be appropriate for mental health crisis response services.

We also encourage CMS to consider further quantitative standards beyond wait times to promote access. State quantitative standards should include time/distance standards or some similar geographic measure of access, which would also create alignment with Marketplace policy. Distance standards are critical to beneficiaries, particularly those in rural areas, who may otherwise have to travel unreasonable distances for simple medical appointments.

Lastly, we urge CMS to remove the ability of states to grant exceptions to network adequacy requirements related to appointment wait times.

Access: Secret Shopper Surveys (§§ 438.68(f), 457.1207, 457.1218)

Inaccurate directories and so-called “ghost networks” hinder access to care, causing far too many individuals to face barriers in connecting to a provider at the very beginning of trying to find help. This is especially problematic for people experiencing symptoms of MH/SUDs, which may make reaching out for help and calling long lists of unavailable providers particularly difficult. This contributes to long delays in getting needed MH/SUD care. As a result, NAMI strongly supports the proposal to conduct annual secret shopper surveys of managed care plan compliance with appointment wait time standards and electronic provider directory accuracy for primary care providers, OB/GYN providers, and outpatient mental health and substance use disorder providers.

NAMI also supports the proposal to only count appointments offered via telehealth towards compliance with appointment wait time standards if the provider also offers in-person appointments and that telehealth visits offered during the secret shopper survey be separately identified in the survey results. While telehealth has become an important tool to help improve mental health care access, telehealth should not supplant in-person services for those who need them. This is particularly true given that telehealth use can vary substantially across populations: a recent Medicaid budget survey noted that telehealth utilization is higher among White Medicaid enrollees compared to enrollees of color^{xiv}. In addition to telehealth, we encourage CMS to use the secret shopper survey to develop or verify other key metrics, such as linguistically and culturally competent services and accessibility.

Access: Provider Payment Analysis (§§ 438.207(b), 457.1230(b))

We agree with the assessment by CMS on the need for greater transparency in Medicaid and CHIP provider payment rates in order for states and CMS to monitor and mitigate payment-related access barriers. Lower payment rates as well as disparities in pay between physical and mental health providers limit participation in Medicaid and further exacerbate existing workforce shortages^{xv}. Psychiatrists, for example, receive lower Medicaid reimbursement than primary care providers for similar services^{xvi}. This inequity in reimbursement rates is a contributing factor to the vast number of mental health providers who do not accept any insurance and only see patients on an out-of-network basis. On average, only 36 percent of psychiatrists accept new Medicaid patients^{xvii} – far lower compared to other payers and compared to rates for physicians overall^{xviii}. Even when providers accept Medicaid, they may only take a few patients or may not be presently taking new Medicaid patients^{xix}.

As a result, NAMI strongly supports the proposal to require that managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) submit annual payment analysis showing their level of payment for certain services. We are also supportive of the requirement to use paid claims data from the immediate prior rating period to determine the total amount paid for evaluation and management current procedural terminology (CPT) codes for primary care, OB/GYN, mental health, and SUD services. We further support separating rates by pediatrics and adults, because shortages in pediatrics are more acute, and by region to ensure access in rural communities.

We encourage CMS to include additional codes beyond Evaluation and Management (E&M) codes in the Medicare comparison requirements so therapy codes by psychologists, social workers, and other clinicians can be assessed relative to Medicare rates. Additionally, CMS should also clarify that states should provide rate information for peer support specialists. Most states currently allow certified peer support specialists to bill for recovery support services, yet payment rates vary significantly. Since peer support specialists are not currently covered by Medicare as an independent category of providers, it is important to clarify that information on their rates and services is required.

Access: Remedy Plans to Improve Access (§ 438.207(f))

NAMI supports the proposal to require that managed care programs (in addition to FFS programs) submit corrective action plans when access to care issues are identified, which identify specific steps, timelines for implementation and completion, and responsible parties. However, NAMI is concerned about the lack of enforcement and financial incentives for managed care plans to comply with accurate networks and strengthen enforcement beyond corrective action plans. NAMI urges CMS to require state to impose financial consequences after a year of non-compliance if the MCO is not meeting these new network adequacy standards. A 2021 analysis of state laws confirms that having a requirement for accurate directories does not lead to compliance^{xx}. Without any financial incentive to do better, CMS may inadvertently make the problem worse. If people with mental health conditions switch to plans that have more accurate directories and wait times, those plans will incur higher mental health treatment costs and thus, the plans with highly inaccurate directories and long wait times will financially benefit from that information being transparent. CMS should be clear that there will be financial consequences from non-compliance, or the problem will continue or get worse.

State Directed Payments (42 CFR 438.6, 438.7, 430.3)

NAMI supports the provisions of the proposed rule that require increased transparency and accountability for state directed payments (SDP) funding, including requirements for more detailed

payment reporting that more clearly establish that SDPs are actuarially sound and linked to Medicaid reimbursable services. The public and stakeholders should be able to ascertain how many Medicaid dollars have actually been paid to specific providers, and CMS should not allow SDPs to operate without collecting this critical information. Likewise, we support the requirement for final evaluation reports. Finally, we urge CMS to consider policy to ensure that SDPs are not used to make up for inefficient state policies, such as not expanding Medicaid. Numerous studies have shown the economic benefits of Medicaid expansion for providers, and SDPs should not reduce the financial incentives for states to expand lifesaving coverage to millions of patients^{xxi}.

Medical Loss Ratio (MLR) Standards (§§ 438.8, 438.3, and 457.1203)

NAMI strongly supports the proposal to modify MLR methodologies and processes to align more closely with comparable MLR requirements for the commercial health insurance market, increase accuracy of plan reporting for rate-setting purposes, and allow for more consistent comparisons across each plan's different managed care business lines and from state to state.

NAMI also appreciates the proposed requirement that states, through contracts with managed care plans, include specific provisions related to provider incentive contracts to prevent the use of incentive payments as a means to reach MLR requirements. We note that a majority of states use or planned to use a financial incentive to promote behavioral health quality improvements^{xxii}. Despite activity in this area, detailed performance information at the plan-level is not frequently made publicly available by state Medicaid agencies, limiting transparency and the ability of Medicaid beneficiaries (and other stakeholders) to assess how plans are performing on key indicators related to access and quality^{xxiii}.

In Lieu of Services and Settings (ILOS) (§§ 438.2, 438.3, 438.7, 438.16, 438.66, 457.1201, 457.1207)

NAMI strongly supports the proposal to codify and build on recent CMS policy changes regarding "in lieu of services" (ILOS) and strengthen enrollee protections. We believe this will help eliminate uncertainty for states in designing ILOS, which will hopefully lead to an increase in investments by health systems in addressing social needs. Currently, MCOs have flexibility under risk contracts to provide a substitute service, setting for a service or setting covered under the State plan, when medically appropriate and cost effective, to enrollees at the managed care plan and enrollee option. ILOSs can be an innovative option in Medicaid and CHIP managed care programs to address social determinants of health (SDOHs) and health-related social needs (HRSNs). However, there is currently insufficient standardization of ILOS processes and services.

We support many of the provisions in the proposed rule as it will create better transparency and standards for ILOS services and encourage longer-term investments through ILOS. First, we specifically support broadening the definition of ILOS to include substitutions that are based on longer-term investments in care. Some services and supports for individuals with chronic illnesses may take years to yield "savings" in the form of reduced use of state plan services, but providing these services and supports are important to improving health. We also support the provisions ensuring that ILOS must be medically appropriate substitutions.

NAMI questions the utility of creating a 5% cap on ILOS. We note that many ILOSs are effective and meaningful in improving health outcomes for beneficiaries. For example, peer support services are often ILOS, as well as inpatient mental health or substance use disorder treatment. The 5% cap does not appear to be based on evidence, and we anticipate that the percentage might vary by state. Without a stronger rationale, we encourage CMS to evaluate the issue of a 5% cap more thoroughly before adding it as a regulatory requirement.

Finally, CMS notes that one of the most commonly utilized ILOSs is inpatient mental health or substance use disorder treatment provided during a short-term stay (no more than 15 days) in an IMD. NAMI appreciates the proposal to explicitly provide an exception from new ILOS requirements for short term stays for inpatient mental health or substance use disorder treatment in an IMD. This proposal does not replace or alter existing Federal requirements and limitations regarding the use of short term IMD stays as an ILOS, or the availability of FFP for capitation payments to MCOs and PIHPs for enrollees who utilize an IMD.

Medicaid Managed Care Quality Rating System (§§ 438.334 and 457.1240)

NAMI strongly supports the proposal to establish a national framework and enhance requirements for managed care quality rating systems (QRSs), helping states build publicly available dashboards featuring core quality measures to help new and returning enrollees select managed care plans that most suit their needs. NAMI thoroughly supports the one-stop-shop concept, but we strongly emphasize the need for usability, functionality, and human-centered design, as well as ensuring that such a website with so much meaningful information is truly accessible.

We note that CMS requests comments on the proposed initial mandatory measure set. NAMI appreciates the array of mental health- and SUD-focused measures within the Proposed MAC QRS Mandatory Measure Set. We encourage CMS to look at comments holistically; for example, while we understand the practical considerations that led CMS to omit a measure on postpartum depression screening, we encourage CMS to simultaneously consider future ways to make this measure functionable. Women are more likely to develop depression during the first year following childbirth than at any point in their lives^{xxiv}. When left untreated, mental health conditions are the second leading cause of pregnancy-related death that occur within 43 days to one year after the end of pregnancy^{xxv}. In short, it is essential that CMS finds a way to track this critical metric.

Quality Assessment and Performance Improvement Program, State Quality Strategies and External Quality Review (§§ 438.330, 438.340, 438.350, 438.354, 438.358, 438.360, 438.364, 457.1201, 457.1240, 457.1250)

NAMI strongly supports the proposal to require that States make their quality strategy available for public comment at the 3-year renewal, regardless of whether or not the State intends to make significant changes, as well as whenever significant changes are made. A State Medicaid agency must post on its website the results of its 3-year review and submit to CMS a copy of their initial quality strategy for feedback and a copy of the revised quality strategy whenever significant changes are made. We urge CMS to finalize this requirement so that stakeholders can have more insights into states' plans for quality improvement.

Implementation Timelines

CMS asks about the appropriateness of slated implementation timelines for all provisions. We believe there is enormous benefit for beneficiaries in these proposed rules and therefore encourage the agency to implement them as expeditiously as possible. We recognize that Medicaid agencies are juggling many competing demands, including the post-Covid eligibility redetermination process, and might request additional implementation time. We believe you have struck an appropriate balance and encourage CMS not to push implementation dates farther into the future than proposed.

Thank you for the opportunity to comment on this important proposed rule. We strongly support the initiatives outlined, and we urge CMS to implement them as soon as possible. If you have any questions, or would like to discuss our comments, 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

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- 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 do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs | KFF](#)
 - ^x [How do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs | KFF](#)
 - ^{xi} [How Does Use of Mental Health Care Vary by Demographics and Health Insurance Coverage? | KFF](#)
 - ^{xii} [CAHPS ECHO Survey Measures | Agency for Healthcare Research and Quality \(ahrq.gov\)](#)
 - ^{xiii} [Trends in office-based mental health care provided by psychiatrists and primary care physicians - PubMed \(nih.gov\)](#)
 - ^{xiv} [How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023 – Telehealth – 10030 | KFF](#)
 - ^{xv} [Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019 | Health Affairs](#)
 - ^{xvi} [Comparison of Medicaid Reimbursements for Psychiatrists and Primary Care Physicians | Psychiatric Services \(psychiatryonline.org\)](#)
 - ^{xvii} [Physician Acceptance of Medicaid Patients \(macpac.gov\)](#)
 - ^{xviii} [Physician Acceptance Of New Medicaid Patients: What Matters And What Doesn't | Health Affairs](#)
 - ^{xix} [In Medicaid Managed Care Networks, Care Is Highly Concentrated Among A Small Percentage Of Physicians | Health Affairs](#)
 - ^{xx} [Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories by Abigail Burman :: SSRN](#)
 - ^{xxi} [What Does the Recent Literature Say About Medicaid Expansion?: Economic Impacts on Providers | KFF](#)
 - ^{xxii} [How do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs | KFF](#)
 - ^{xxiii} [10 Things to Know About Medicaid Managed Care | KFF](#)
 - ^{xxiv} [Perinatal depression: prevalence, screening accuracy, and screening outcomes - PubMed \(nih.gov\)](#)
 - ^{xxv} [Building U.S. Capacity to Review and Prevent Maternal Deaths | CDC Foundation](#)