

March 6, 2023

Meena Seshamani, MD, Ph.D.  
Deputy Administrator and Director  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

**Re: Docket No. CMS-2023-0010-0002; Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies**

Dear Dr. Seshamani,

Thank you for the opportunity to offer comments on Medicare Advantage payment policies. We write as some of the leading mental health and substance use disorder organizations who have affiliates and partners in states and local communities. We have seen first-hand the continued behavioral health crisis in our country. We applaud CMS for its behavioral health strategy and write to provide some recommendations for strengthening implementation of the strategy through payment policy.

We have the following recommendations:

- 1) Closely examine the reduction of behavioral health codes, particularly those including recurrent depression, and monitor the impact of the reduction in the number of behavioral health codes included in the CMS-HCC risk adjustment model, especially depression codes, to ensure there are no unintended consequences.
- 2) Finalize the proposal to broaden the mental health conditions assessed by Health Outcomes Survey (HOS) by adding information on anxiety disorders.
- 3) Add the HEDIS Depression Screening and Follow-up for Adolescents and Adults measure to the 2026 Star Ratings display page and consider additional behavioral health measures in the future.
- 4) Add the Initiation and Engagement of Substance Use Disorder (SUD) Treatment measure to the Star Rating in future pending rulemaking.
- 5) Collect information on unmet health-related social needs and whether plans provided screening and referral relating to those needs.
- 6) Take steps to add MH/SUD to Timely Follow-Up After Acute Exacerbations of Chronic Conditions and Align with the Medicaid Adult Core Set.

**Closely examine the reduction of behavioral health codes, particularly those including recurrent depression, and monitor the impact of the reduction in the number of behavioral health codes included in the CMS-HCC risk adjustment model, especially depression codes, to ensure there are no unintended consequences.**

CMS proposes to implement a revised version of the CMS-HCC risk adjustment model that includes a significant reduction in the number of behavioral health conditions used in the model. Some of these codes involve recurrent depression and other conditions which we are concerned should result in greater payment and preventive services to intervene early. Given the size of the change, we request CMS carefully examine the codes, especially those involving recurrent depression and any other condition which requires additional care. We urge you to take a deliberative and careful approach to considering these codes as it is very difficult for us to ascertain the effect in the 30-day comment period.

We also urge CMS to monitor the impact of these changes to ensure there are no unintended consequences that negatively impact patient access to evidence-based services. In particular, we ask that CMS ensure patients who are dually eligible for Medicare and Medicaid or those with chronic behavioral health conditions receive appropriate care. As indicated below, we also fully support CMS's efforts to ensure mental health access and urge careful monitoring to ensure that rates and services are not reduced.

**Finalize the proposal to broaden the mental health conditions assessed by Health Outcomes Survey (HOS) by adding information on anxiety disorders.**

We agree with CMS that broadening the mental health conditions assessed by the Health Outcomes Survey will further its equity goals by allowing CMS to understand the relationship between social needs and health conditions. As CMS notes, anxiety is a very common health condition for older Americans. Mental Health America, one of the signers of this letter, operates a no cost, virtual screening platform. It uses the GAD-7 for the anxiety screen, and 2022 data indicates that for people over 65, anxiety was the second most common screen (24% of screeners 65+ took an anxiety screen) and approximately 55% scored with moderate to severe anxiety.

We support the tool proposed – The GAD-2 along with the PHQ-2 – as a well-known, easily administered tool. We urge CMS to continue considering new mental health conditions to add, including late onset psychosis and mental health conditions that accompany dementia.

**Add the HEDIS Depression Screening and Follow-up for Adolescents and Adults measure to the 2026 Star Ratings display page and consider additional behavioral health measures.**

As mental health and substance use organizations, we fully support adding behavioral health measures to the Star Rating System because financial incentives have been lacking for improved and integrated behavioral health care.

Depression is one of the most common mental disorders in the United States. An estimated 21.0 million adults in the United States had at least one major depressive episode, or 8.4% of all U.S. adults.<sup>1</sup> Yet depression in older adults is generally underdiagnosed and undertreated.<sup>2</sup> A strong body of evidence supports depression screening and treatment in primary care to provide early identification and intervention. Consequently, we support the HEDIS measure focused on Depression Screening and Follow-up which measures the percentage of members who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. As CMS notes, this aligns with the U.S. Preventive Services Task Force recommendations regarding screening and follow-up for depression (Depression in Adults: Screening - Healthy People 2030 | [health.gov](https://www.health.gov)) and supports CMS's efforts to implement a core set of measures across quality programs given that these measures are also included in the Medicaid Core Measure Set, the Medicare Shared Savings Program and the federally qualified health centers quality measures.

This measure will be particularly helpful to promote integrated primary care, a goal of the Administration's behavioral health strategy. Integrated care advances equity because services are more accessible, and disparities are reduced.<sup>3</sup> We would urge that follow up care options should be inclusive of referrals to various treatment options, not just medication. For older adults, isolation is highly correlated with depression and CMS can remind plans that peer support can be a helpful service to address both conditions.

CMS also indicated interest in including more behavioral health measures in the STAR rating system and measuring access to mental health and addiction services. We would recommend that CMS consider emerging measures that indicate functioning and recovery. We further recommend that CMS consider the tremendous access issues and make them part of the display page by requiring plans to indicate the percentage and number of providers in their directory that have billed in the prior year. A recent Health Affairs article showed the very high percentage of listed behavioral health providers in Medicaid directories are not actually billing, creating "ghost networks."<sup>4</sup>

**Add the Initiation and Engagement of Substance Use Disorder (SUD) Treatment measure to the Star Rating in future pending rulemaking.**

We appreciate CMS's consideration of adding the updated HEDIS measure to the Star Rating in future rulemaking and urge CMS to do so as quickly as possible. With overdose deaths remaining near all-time highs, it is critical that initiation and engagement of SUD treatment be part of the Star Rating measures. While having this measure on the display page is important, when Medicare beneficiaries are choosing among Medicare Advantage plans, the Star Rating provides beneficiaries with critical information. Not having SUD treatment initiation and

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<sup>1</sup> Retrieved from: <https://www.nimh.nih.gov/health/statistics/major-depression>

<sup>2</sup> Retrieved from: <https://web.uri.edu/pharmacy/meet/identifying-older-adults-with-major-depressive-disorder-from-medicare-current-beneficiary-survey-data/>

<sup>3</sup> Retrieved from: <https://pubmed.ncbi.nlm.nih.gov/32773077/>

<sup>4</sup> Retrieved from: <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00052>

engagement as one of the measures making up the Star Rating reduces the importance of this measure among Medicare Advantage plans.

Additionally, as CMS notes, for the 2022 measurement year, NCQA's has made changes to address several issues with the prior measure. We support changes that will improve the quality of data and encourage the use of pharmacotherapy regardless of whether an individual with SUD accepts concomitant psychosocial treatment, providing all the more reason for CMS to include the improved measure in the Star Ratings. Nonetheless, we urge CMS to carefully evaluate any implications of removing emergency departments from the measure's negative SUD history period, particularly given the American College of Emergency Physicians' comments to this Advanced Notice that express concern about whether such a removal would discourage the tracking of buprenorphine initiation in emergency departments. As ACEP notes, there is an abundance of evidence showing the need to initiate medications to treat SUDs, including medications for opioid use disorder and alcohol use disorder, in emergency departments.<sup>5</sup>

### **Take steps to add MH/SUD to Timely Follow-Up After Acute Exacerbations of Chronic Conditions and Align with the Medicaid Adult Core Set.**

We appreciate CMS's noting that timely follow-up care after acute exacerbations is a critical to effectively treating chronic conditions, and we welcome the addition of the measures of follow-up care for six chronic conditions. We further appreciate the work that has gone into creating this measure, including by the measure steward, IMPAQ International.

Nonetheless, our organizations note the lack of any MH/SUD conditions in this measure, despite the fact that a large number of these disorders first present early in life and are frequently lifelong, chronic conditions that can have periodic exacerbations. We believe the lack of inclusion of MH/SUDs in this measure is an urgent issue to address, particularly given that far too many individuals with MH/SUDs receive no follow-up care after an emergency department visit or hospitalization. Only one-third of patients who visited an emergency department for a mental illness received any follow up within 30 days, with the lack of follow-up associated with both an increased risk of hospitalization.<sup>6</sup> Other research found that only 16 percent of individuals with an opioid use disorder who had been treated in an emergency department for an overdose received any form of treatment within three months.<sup>7</sup>

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<sup>5</sup> Comment Letter from the American College of American Physicians on "Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," February 23, 2023. Retrieved from: <https://www.acep.org/globalassets/new-pdfs/advocacy/2.20-acep-response-to-2024-ma-and-part-d-advance-notice.pdf>.

<sup>6</sup> Geissler KH, Cooper MI, Zeber JE. Association of Follow-Up After an Emergency Department Visit for Mental Illness with Utilization Based Outcomes. *Adm Policy Ment Health*. 2021 Jul;48(4):718-728. doi: 10.1007/s10488-020-01106-2. Epub 2021 Jan 12. PMID: 33438094.

<sup>7</sup> Kilaru AS, Xiong A, Lowenstein M, et al. Incidence of Treatment for Opioid Use Disorder Following Nonfatal Overdose in Commercially Insured Patients. *JAMA Netw Open*. 2020;3(5):e205852. doi:10.1001/jamanetworkopen.2020.5852

We note that CMS has already put in place similar measures in the Medicaid program. The 2023 and 2024 Core Set of Adult Health Care Quality Measures for Medicaid include both Follow-Up After Emergency Department Visit for Substance Use and for Mental Illness Age 18 and Older (FUA-AD and FUM-AD).<sup>8</sup> We urge CMS to incorporate timely follow-up measures to track appropriate care after an emergency department visit or hospitalization for substance use or mental illness into the Medicare Advantage display page and into the Star Ratings. We further urge CMS to take steps to align Medicare Advantage MH/SUD measures with the Medicaid Adult Core Set.

Finally, we note that proper inclusion of MH/SUD follow-up measures after an emergency department visit or hospitalization could well ameliorate the potential concern referenced above of the proposal to remove emergency department visits from the Initiation and Engagement of Substance Use Disorder Treatment measure.

**Collect information on unmet health-related social needs and whether plans provided screening and referral relating to those needs.**

We urge CMS to move forward with a potential HOS question that would focus on a enrollees' unmet health-related social needs, including housing instability, food insecurity, and transportation availability. Our organizations seek to address behavioral health disparities and view social needs as significant drivers of behavioral health inequity.<sup>9</sup> Each of these areas has enormous implications for mental health and substance use. Unstable housing and food insecurity, for instance, both contribute to and exacerbate MH/SUDs. Without each, treatment progress can be severely hindered, with recovery too often put out of reach. Lack of transportation is also a significant barrier to individuals accessing needed MH/SUD treatment and can exacerbate isolation and loneliness.

We support both the SNS-E measure, which captures screening and assessment by the plan and its provider. We applaud CMS's initiative to develop an additional measure that would complement the SNS-E measure to further advance equity. We urge CMS to add the HOS questions that would assess enrollees' perceptions of unmet needs and of the plans' assessment and intervention. Measuring such perceptions are critical to making progress in addressing the actual needs of enrollees, not simply measuring actions by plans and providers, even if they are not ultimately beneficial to the enrollee.

Thank you for the opportunity to provide feedback and for your work to support people with mental health and substance use conditions. Please reach out to Mary Giliberti, Chief Public Policy Officer at Mental Health America ([mgiliberti@mhanational.org](mailto:mgiliberti@mhanational.org)) and Jennifer Snow, National Director of Government Relations and Policy, ([jsnow@nami.org](mailto:jsnow@nami.org)), if you have any questions or would like to discuss our feedback on this rate notice.

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<sup>8</sup> Retrieved from: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-adult-core-set.pdf>.

<sup>9</sup> Retrieved from: <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.7.42>

Sincerely,

American Psychiatric Association

Inseparable

The Kennedy Forum

Mental Health America

National Alliance on Mental Illness (NAMI)