

January 4, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4205-P
P.O. Box 8013
Baltimore MD 21244

Submitted electronically via <https://www.regulations.gov/document/CMS-2023-0187-0001/comment>

Re: Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (88 Fed. Reg. 78476, proposed Nov. 15, 2023)

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Social Workers (NASW), I am submitting comments on the notice of proposed rulemaking (NPRM) addressing Medicare Advantage (MA, or Part C), Medicare Part D prescription drug plans, and the Programs of All Inclusive Care for the Elderly (PACE) for contract year 2025 (CMS-4205-P; RIN 0938-AV24).

Founded in 1955, NASW is the largest membership organization of professional social workers in the United States, representing more than 110,000 social workers. We work to enhance the professional growth and development of our members, to create and maintain professional practice standards, and to advance sound social policies.

NASW's comments address CMS's proposals to improve access to behavioral health services and providers. We offer feedback on three topics:

- types of providers and practitioners
- time and distance standards
- appointment wait time standards

Types of Providers and Practitioners

Services for mental health conditions and substance use disorders (SUDs) are integral to the health care provided by MA organizations, and such services cannot be without robust provider networks.

NASW applauds CMS’s addition, for contract year 2024, of clinical social workers and clinical psychologists to the specialty types that must be evaluated as part of network adequacy reviews. Clinical social workers constitute the largest group of mental health providers in the United States¹ and work with Medicare beneficiaries in a variety of settings. They serve Medicare beneficiaries living with types of conditions, including co-occurring mental health, substance use, and physical health conditions. Using destigmatizing language and drawing on their person-centered, strengths-based approach, clinical social workers build strong rapport with beneficiaries to foster positive changes. Their expertise includes assessment, psychotherapy, screening, motivational interviewing, brief interventions, care coordination, and evidence-based treatment for substance use disorders (SUDs). In collaboration with other health care professionals, clinical social workers develop individualized plans of care that may include brief interventions, care coordination, and wraparound services.

Just as NASW supported CMS’s actions to strengthen MA network adequacy requirements for contract year 2024, we also support the intent of the current proposals to add Outpatient Behavioral Health as a new type of facility-specialty in § 422.116(b)(2) and to add Outpatient Behavioral Health to the time and distance requirements in § 422.116(d)(2). We concur that Medicare beneficiaries should have access to opioid treatment programs (OTPs), community mental health centers, and outpatient mental health and substance use treatment facilities. We acknowledge the inclusion in Outpatient Behavioral Health of marriage and family therapists (MFTs) and mental health counselors (MHCs), per Section 4121 of the Consolidated Appropriations Act, 2023 (Pub. L. 117–328), and other professionals who regularly furnish behavioral health counseling or therapy services, including psychotherapy or prescription of medication for SUDs. We agree wholeheartedly that, for purposes of the proposed new network evaluation standards, all applicable laws about the practice of medicine and delivery of health care services must be met and that specific health care professionals must be appropriately licensed or certified to furnish the applicable services.

However, combining mental health and SUD facilities in one category, as CMS has proposed, would prevent MA organizations and CMS from tracking the availability of each type of service. In practice, beneficiary access to one type of provider might not improve access for a beneficiary who has a diagnosis in the other category. Although some areas have programs that offer both mental health and SUD services, others do not. Thus, we are concerned that access to mental health services might not increase access to services for SUDs in some areas for the following reasons:

- Medicare covers community mental health centers but not community-based SUD treatment facilities. (Physicians at community-based SUD treatment facilities may bill Medicare for services; however, many such facilities neither employ nor have a partnership with a physician.) The Physician Fee Schedule (PFS) and Outpatient Prospective Payment System (OPPS) final rules for calendar year 2024 acknowledged these limitations in two ways: (1) authorizing OTPs as an approved setting for intensive outpatient treatment and (2) authorizing coverage of addiction counselors under the definition of community mental health centers. Yet, although some community mental health centers provide SUD treatment, they often do so only for people with co-occurring mental health diagnoses; additionally, the conditions of participation for

¹ Erikson, C., Schenk, E., Westergaard, S., & Salsberg, E. S. (2022). New behavioral health workforce database paints a stark picture. *Health Affairs Forefront*. <https://doi.org/10.1377/forefront.20220829.640971>

community mental health centers require neither staff to treat beneficiaries with SUD nor the levels of care or medications necessary for such treatment.

- OTPs play a pivotal role in mitigating addictions and overdoses. As the proposed rule has noted, Medicare fee-for-service claims data show that OTP providers had the largest number of claims for SUD services during 2020, and the number of Medicare beneficiaries who have been able to receive treatment from OTPs continued to rise in 2021. OTP access is especially critical for African Americans and Latinos, who have greater access to these facilities than to office-based SUD treatment.² On the other hand, OTPs may only treat Medicare beneficiaries with OUD, not with other types of SUDs. Yet, the proposed rule does not require MA plans to evaluate OTPs separately from other types of outpatient behavioral health providers.
- Many states prohibit mental health providers from treating people with SUD diagnoses unless the provider has a recognized certification in SUD treatment.

Consequently, under the current proposed rule, MA organizations would not actually be required to contract with SUD providers—including, but not limited to, OTPs—to meet network adequacy standards. NASW recommends that CMS strengthen its proposals in the following manner:

- Require separate network adequacy standards and reporting metrics for “Outpatient Mental Health” and “Outpatient Substance Use Disorder” providers, rather than a combined category. Optimally, CMS would create one category for OTPs and another for Outpatient SUD. In offering this recommendation, NASW acknowledges that CMS’s 2022 standards for qualified health plans (QHPs) combined mental health and SUD providers in one category, “Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals.”³ Nonetheless, more stringent standards are needed for MA plans—which, unlike QHPs, are not subject to the Mental Health Parity and Addiction Equity Act (2008).⁴
- Limit the inclusion of practitioners in each category to those who are licensed or certified to treat mental health conditions or SUDs (for the respective category) within the scope of their practice, consistent with the network adequacy standards CMS adopted for qualified health plans last year. Exclude practitioners who are not licensed or certified to furnish MH or SUD services within the respective provider category.
- Require the MA plan to demonstrate that a provider has submitted a sufficient number of mental health or SUD claims (for the respective category) within the past year, thereby

² Goedel, W. C., Shapiro, A., Cerdá, M., Tsai, J. W., Hadland, S. E., & Marshall, B. D. L. (2020). Association of racial/ethnic segregation with treatment capacity for opioid use disorder in counties in the United States. *JAMA Network Open*, 3(4), e203711. <https://doi.org/10.1001/jamanetworkopen.2020.3711>

³ Centers for Medicare & Medicaid Services. (2022, April 28). *2023 final letter to issuers in the federally-facilitated exchanges*. <https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf>

⁴ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110–460, 122 Stat. 5123 (2008).

operationalizing CMS's intent that the provider regularly provides mental health and/or SUD treatment.

Time and Distance Standards

The distance an individual must travel to obtain health care services and the time it takes to travel that distance impact the person's access to services. CMS's 2022 maximum time and distance standards for QHPs⁵ are approximately half those currently proposed by CMS for MA enrollees. NASW believes the shorter time and distance standards used for QHPs are more appropriate to meet the needs of individuals with mental health conditions and SUDs than the proposed MA standards. Mental health conditions and SUDs are chronic conditions that may require ongoing treatment, especially for individuals in recovery. Even when these conditions are stabilized, many people may benefit from psychotherapy or counseling on a weekly basis. Individuals who receive medications for mental health conditions or SUDs should have recurring evaluation and management visits; people who receive methadone from OTPs are visiting their providers even more frequently. Additionally, the shorter time and distance standards are especially important for Medicare beneficiaries, who tend to experience greater barriers to transportation because of age or disability.

Thus, NASW urges CMS to establish consistent standards across financing systems by shortening the MA time and distance standards, consistent with the QHP standards. Such consistency would not only increase access for MA enrollees but would also simplify processes for plans and providers.

Appointment Wait Time Standards

As CMS is aware, MA plans must make available nonurgent mental health and SUD appointments within 30 business days. As noted in our comments on the MA policy change NPRM for calendar year 2024, NASW appreciates that this standard aligns with the MA standard for other types of specialty services.⁶ Yet, this standard falls far below the 10-business-day standard CMS has proposed for Medicaid managed care plans,⁷ which is currently required for QHPs. Given this discrepancy, we encourage CMS to revisit the MA wait time standards for nonurgent mental health and SUD standards as it considers network adequacy standards in these areas.

⁵ Centers for Medicare & Medicaid Services. (2022, April 28). *2023 final letter to issuers in the federally-facilitated exchanges*. <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf>

⁶ Bedney, B. (2023, February 13). *NASW comments regarding CMS's proposed rule addressing contract year 2024 policy and technical changes to the Medicare Advantage program, Medicare prescription drug benefit program, Medicare cost plan program, Medicare Parts A, B, C, and D overpayment provisions of the Affordable Care Act, Programs of All-Inclusive Care for the Elderly, and health information technology standards and implementation specifications (CMS-4201-P)*. National Association of Social Workers. https://bit.ly/NASWcomments-MA-PACE-PartD_proposedrule-Feb2023

⁷ Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28092 (proposed May 3, 2023) (to be codified at 42 C.F.R. pts 430, 438, 457).

In conclusion, the NPRM has potential to improve access to mental health and SUD services for Medicare beneficiaries who are enrolled in MA plans. NASW appreciates the opportunity to comment on the proposed rule and your consideration of NASW's recommendations. Please contact me at bbedney.nasw@socialworkers.org if you would like additional information or have any questions.

Sincerely,

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Chief of Programs