



January 5, 2024

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: [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](#)

Dear Secretary Becerra and Administrator Brooks-LaSure:

NAMI appreciates the opportunity to submit comments in support of the Medicare Contract Year 2025 Policy and Technical Changes proposed rule. NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization and we provide education, support, and advocacy in communities around the country. We are dedicated to building better lives for people affected by mental illness, including the millions of people with mental health (MH) and substance use disorders (SUD) who rely on Medicare for mental health treatment. Medicare is a lifeline for both older adults who live with mental health conditions as well as younger adults who are eligible because of a disabling mental health condition. Particularly given that suicide rates continue to increase among those 65 and olderⁱ, it is essential that the Medicare program meets the evident mental health needs of so many of its beneficiaries. We offer the following comments and recommendations on expanding the proposed network adequacy standards for outpatient behavioral health.

Overall, NAMI greatly appreciates the intent behind CMS's proposed rule to add Outpatient Behavioral Health to the list of provider specialties at § 422.116(b) for which Medicare Advantage (MA) plans must ensure adequate networks, and the corresponding time and distance standards at § 422.116(d)(2). We commend CMS for recognizing the importance of the

newly covered mental health counselors (MHCs) and marriage and family therapists (MFTs) under Medicare, as well as opioid treatment programs (OTPs) to meet the needs of beneficiaries with SUD. We strongly support examining network adequacy for these providers. However, we recommend that CMS require tracking of this facility type by separately reporting metrics for “Outpatient Mental Health” and “Outpatient Substance Use Disorder” providers rather than a combined category. Additionally, we recommend shortening the maximum time and distance standards to align with those for qualified health plans.

Create Separate Categories for Outpatient Mental Health and Outpatient Substance Use Disorder

Mental health and substance use disorder conditions are strongly intertwined, and over one-third of U.S. adults with mental illness also experience a co-occurring SUDⁱⁱ. However, it is paramount to recognize they are not the same, and collapsing MH and SUD facilities into one category will not track the availability of the respective services. Having access to one of these types of providers would currently not translate to greater access for a beneficiary who has a diagnosis in the other category.

As this proposed rule is written, an MA plan could contract exclusively with MHCs and MFTs to meet the proposed network adequacy standards without having any OTPs or SUD providers in network. While some Community Mental Health Centers do provide SUD treatment, they often do so only for people with co-occurring MH diagnoses, and there are no requirements in the conditions of participation that these facilities have staff to treat patients with SUD or the levels of care or medications necessary for such treatment. CMS has also proposed to include physician assistants, nurse practitioners, and clinical nurse specialists “who regularly furnish or will furnish behavioral health counseling or therapy services” in this category, without any requirement that these practitioners provide or submit claims for MH and SUD services. We believe the proposed category is currently too broad to achieve CMS’s stated – and critically important – purpose of improving access to outpatient MH and SUD treatment for Medicare beneficiaries in MA plans, and therefore recommend separating.

We further recommend that CMS not include practitioners that are not specifically licensed or certified to furnish MH or SUD services in this new facility category unless there are clear guardrails that demonstrate that such practitioners are regularly delivering MH and SUD services and meeting Medicare beneficiaries’ needs. As proposed, MA plans could include physician assistants, nurse practitioners, and clinical nurse specialists (an important group of practitioners who prescribe buprenorphine), but without a requirement that they actually deliver these services. Plans may also include practitioners who screen patients for MH and SUDs but do not have the skill, training, or expertise to treat those conditions and must then refer patients to specialists for the actual treatment of these conditions, which defeats the purpose of this proposed rule. Inclusion of these non-specialized practitioners in the network adequacy metrics would merely perpetuate the problems with ghost networks that are widespread in MA plansⁱⁱⁱ, and fail to meaningfully expand access to outpatient MH and SUD treatment in line with CMS’s intent.

We recommend that CMS limit the inclusion of practitioners in this category (or as previously discussed, two distinct categories for outpatient MH and outpatient SUD) to those who are licensed, certified, or accredited to treat MH and SUD, or otherwise within the scope of their practice, consistent with the network adequacy standards CMS adopted for qualified health plans last year^{iv}. At the same time, CMS should require the MA plan to demonstrate that a provider has submitted a sufficient number of MH or SUD claims for the respective category within the past year and regularly provide MH and/or SUD treatment consistent with CMS's intent. To further address the problem of ghost networks, we also recommend that CMS consider applying this requirement – MA plans only counting providers that have submitted a sufficient number of claims within the past year to reflect active engagement in the network – to all network adequacy standards.

Align Network Adequacy Standards with Those for Qualified Health Plans

NAMI strongly recommends shortening the proposed time and distance standards to make them consistent with the time and distance standards for qualified health plans (QHPs). Last year, CMS finalized maximum time and distance standards for QHPs^v, including an individual provider specialty type for “Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals),” which are approximately half those that are proposed by CMS for MA beneficiaries. For example, the QHP standard is 10 minutes and 5 miles for large metro areas, but the proposal for MA plans is 20 minutes and 10 miles. These proposed standards for MA seem arbitrary and inconsistent with CMS's overall behavioral health care strategy. CMS must not allow weaker rules to persist in Medicare compared to those for private insurance.

We urge CMS to continue establishing consistent standards across financing systems, which will help both patients and the plans that operate in these spaces. We believe the time and distance standards used for QHPs are more appropriate to meet the needs of individuals with SUD and MH conditions both because of the frequency at which MA enrollees must visit these providers and because Medicare beneficiaries are older and/or have disabilities, and therefore are more likely to experience greater transportation barriers. Although MH and SUD practitioners are collapsed into one category for QHPs, we nonetheless believe it is necessary to separate them for MA plans, as the former is subject to the Mental Health Parity and Addiction Equity Act, which requires a separate analysis of network adequacy for MH and SUD, while MA plans are still under no obligation to do so as they are not subject to the Parity Act.

As CMS considers these network adequacy standards, we also urge CMS to revisit the appointment wait time standards that it has established for MH and SUD, which are also drastically different from those for QHPs as well as those proposed for Medicaid managed care plans – both of which require routine MH and SUD services to be available to beneficiaries within 10 business days^{vi}, rather than the current 30-business day standard in MA plans.

Thank you for the opportunity to provide comments on this important issue. NAMI is grateful for the many proposals within this rule to strengthen coverage and care for people with MH

and SUD conditions covered by MA and we hope you will take our comments into consideration. If you have any questions or would like to discuss this issue, please do not hesitate to contact Jennifer Snow, NAMI National Director of Government Relations and Policy at jsnow@nami.org.

Sincerely,



Hannah Wesolowski
Chief Advocacy Officer
NAMI

ⁱ Sally C. Curtin, Matthew F. Garnett, and Farida B. Ahmad, “Provisional Estimates of Suicide by Demographic Characteristics: United States, 2022,” Centers for Disease Control and Prevention, Report No. 34, November 2023, <https://www.cdc.gov/nchs/data/vsrr/vsrr034.pdf>.

ⁱⁱ Substance Abuse and Mental Health Services Administration, “2021 National Survey on Drug Use and Health: Detailed Tables,” January 4, 2023, <https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables>.

ⁱⁱⁱ Senate Finance Committee, “Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks” (May 3, 2023), <https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf>.

^{iv} Centers for Medicare & Medicaid Services, “2023 Final Letter to Issuers in the Federally-facilitated Exchanges” 13 (Apr. 28, 2022), <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf>.

^v *Id.*

^{vi} *Id.* at 15; Centers for Medicare & Medicaid Services, “Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality,” 88 Fed. Reg. 28092, 28098-99 (proposed May 3, 2023).