



Always There for Healthcare

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March 7, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted electronically: www.regulations.gov

RE: Request for Information: Building Behavioral Health Specialties within MA Networks (CMS 4192-P, Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Program)

Dear Administrator Brooks-LaSure:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to comment on challenges to achieving network adequacy in behavioral health among MA health plans.

Network adequacy is a major, longstanding obstacle to care for individuals with behavioral health needs. Now, due to the pandemic and recent events, we are seeing a crippling provider shortage coincide with a surge in demand for behavioral health services.

While limited provider networks can result in barriers to care in any field of medicine, they are particularly acute in behavioral health. MA plans struggle to build an adequate network of behavioral health providers, despite CMS requiring a minimum number of behavioral health providers and encouraging the use of telehealth providers. Further, disparate reimbursement rates and workforce shortages contribute to inadequate behavioral health networks.

The need to invest in behavioral health and address network adequacy has never been more urgent.

Reimbursement rates

Low reimbursement rates for behavioral providers contribute to inadequate MA plan networks. This stems from low Medicare fee-for-service rates. For example, Medicare reimburses a 45-minute therapy session at \$103.28, while for a similar medical office visit it reimburses at \$185.26. The low reimbursement rates contribute to low Medicare participation rates for behavioral health providers. This precludes MA plans from including some behavioral health providers in their networks.

Provider shortages

Workforce shortages also contribute to inadequate networks. HANYS members are committed to providing quality care to all New Yorkers. Maintaining a robust and stable workforce is the cornerstone of providing this care. COVID-19 has had a devastating impact on care providers, leading many to leave the healthcare field. The pipeline of new healthcare workers entering this field cannot support current demand.

Nationally, we expect the shortage of behavioral healthcare professionals and severe shortage of psychiatrists to worsen with retirements. In New York, the average age of psychiatrists is over 60 years old. As these providers age out of the workforce, the gap between supply and demand will continue to widen.

In addition, the number of available behavioral health providers is limited by unnecessarily restricting reimbursement to certain provider types. Medicare only covers mental health services provided by a psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner or physician assistant. It does not cover services provided by mental health counselors or marriage and family therapists. This restriction creates a barrier, particularly in rural areas where such counselors and therapists may be the only behavioral health providers.

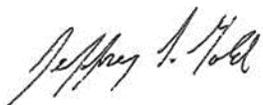
Network adequacy

In addition to the overall shortage of behavioral health providers, their lack of availability in MA plan networks is a major barrier to care. MA plan networks often include participating behavioral health providers who are not taking new patients or have long wait times for appointments. In addition, there are no requirements for MA plans to identify whether those behavioral health providers are accepting new patients. CMS should hold MA plans accountable for time and distance standards and develop network performance metrics that specifically include behavioral health providers.

Parity

Despite the expansion of behavioral health parity, the Mental Health Parity and Addiction Equity Act of 2008 does not apply to Medicare FFS beneficiaries or those in MA plans. Furthermore, treatment limitations still exist — Medicare has a 190-day lifetime limit on inpatient psychiatric care. This limit does not exist for inpatient medical care. Moreover, while cost-sharing in MA plans must be actuarially equivalent to Medicare fee-for-service, MA plans can still apply specialty copayments for behavioral health services. CMS should work with Congress to require that the 2008 parity law apply to Medicare FFS and MA plans.

If you have questions regarding our comments, please contact me at 518.431.7730 or jgold@hanys.org, or Victoria Aufiero, senior director, insurance, managed care and behavioral health, at 518.431.7889 or vaufiero@hanys.org.



Sincerely,
Jeff Gold, Esq.
Senior Vice President and Special Counsel, Managed Care and Insurance