



June 29, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Comments to Docket Number CMS-2439-P (Medicaid and CHIP Managed Care Access, Finance, and Quality) and Docket Number CMS-2442-P (Ensuring Access to Medicaid Services)

Submitted Electronically

Dear Administrator Brooks-LaSure:

The American Psychological Association Services, Inc. (APA Services) respectfully submits the following response to your proposed rules concerning state Medicaid and CHIP programs. APA Services is the companion organization of the American Psychological Association, which is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 146,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

As you know, the nation continues to grapple with the effects of a behavioral health crisis. High numbers of our psychologists report patients seeking treatment for anxiety disorders (79%), depressive disorders (66%), and trauma-related and stressor-related disorders (64%).¹ Unfortunately, the demand for these services far outpaces their availability, as evidenced by only 47.2% of the more than 57 million adults experiencing any form of mental illness and receiving any kind of treatment according to the latest available data.² These access disparities are especially prominent amongst those from communities of color and other chronically underserved communities. Throughout these proposed rules, we ask CMS to likewise refer to "behavioral health" as an overarching term encompassing signs of mental health, health behavior, and substance use needs.

On April 20th, 2022, APA Services submitted a [response](#) to the agency's Request for Information on improving Medicaid beneficiaries' access to care, and we are pleased to see some of our suggestions captured in these proposed rules, such as increased transparency and accountability

¹ American Psychological Association (Nov. 15, 2022), Psychologists struggle to meet demand amid mental health crisis: 2022 COVID-19 Practitioner Impact Survey, <https://www.apa.org/pubs/reports/practitioner/2022-covid-psychologist-workload>.

² Substance Abuse and Mental Health Services Administration. (2022). *Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report>.

for the benefit of enrollees and providers alike. APA Services also applauds the actions that CMS has taken to enhance Medicaid beneficiaries' access to services outside the scope of these proposed rules. For example, consistent with APA Services' recommendations last spring, CMS made commendable revisions to its billing guidance for Medicaid services furnished in schools. These reforms include greater flexibility for states in pursuing third-party reimbursement when monetary recovery would not be cost-effective, allowing state Medicaid agencies to establish different qualifications for school-based providers, and simplifying the billing process for Local Educational Authorities. These measures are essential to the continued availability of school-based providers who treat the approximately 3 million adolescents age 12-17 receiving mental health services in educational settings.³ In many rural, frontier, and underserved areas, schools are often the only realistic route to accessing services, and we commend CMS' efforts to embed service availability in these critical community resources.

APA Services applauds the agency for viewing the issues raised in these rules through the lens of their impact on patient access to services. We now offer the following suggestions to improve some of the key topics in these proposed rules:

- Include psychologists amongst the members in the Medical Care Advisory Committees (MCACs);
- Update the reimbursement rate transparency provisions to:
 - Subject “outpatient mental health services” to the same comparative rate analysis proposed for “outpatient behavioral health services”;
 - Include psychotherapy, psychological testing, and neuropsychological testing codes in the comparative rate analysis required under section 447.203(b)(2) of the proposed rules;
 - Raising the threshold outlined at §447.203(c)(1) from 80% of the comparable Medicare rate to 100% of the comparable Medicare rate; and
 - Establish a set of uniform standards for the provision of behavioral health services through state Medicaid programs.
- Update the new managed care oversight mechanisms to:
 - Include “behavioral health services” in the payment analysis expected of managed care systems under proposed rule §438.207(b)(3);
 - Require documentation of efficacy for items proposed to be furnished by managed care systems in lieu of services; and
 - Protect providers from excessive patient workloads in implementation of the new wait time and network adequacy standards.

As the Administration finalizes these rules, we ask that it do so with a primary goal of boosting provider participation in state Medicaid and CHIP programs, including those utilizing fee-for-service and managed care systems alike.

³ Ibid.

MCAC Reforms

CMS proposes to provide clearer standards for states on the composition and purpose of Medical Care Advisory Committees (MCACs) at 42 C.F.R. § 431.12. As the proposed rule correctly indicates, while some state Medicaid programs utilize MACs as an opportunity to fully engage with local patient and provider communities, others simply use them as a routine “rubber stamp” for policies the state Medicaid agency wishes to pursue. Meaningful activation of MCACs is essential to ensure that the coverage policies outlined in state Medicaid programs align with the needs of the various communities the program serves.

APA Services fully supports the reforms outlined in this proposed rule with some additional modifications. Nearly 40% of the nonelderly adult Medicaid population (13.9 million enrollees) has been diagnosed with a mental health or substance use disorder,⁴ and Medicaid remains the single largest source of coverage of mental and behavioral health services for adults and children alike.⁵ Countless studies confirm the interrelated nature of physical health and behavioral health.⁶

Representation by the behavioral health provider community is necessary to ensure that the Medicaid program is fully meeting the behavioral health needs of beneficiaries, and their medical impacts. Psychologists are the only provider group with expertise in testing, psychotherapy, and health behavior services, which would grant MCACs a more expansive view as to the kinds of services furnished to Medicaid beneficiaries in need of behavioral health treatment. Accordingly, APA Services recommends revising §431.12(d)(2)(B) as follows: “Clinical providers or administrators, *including psychologists*, who are familiar with the health and social needs of Medicaid beneficiaries and with the resources available and required for their care. This includes providers or administrators of primary care, specialty care, and long-term care.”

Reimbursement Rate Transparency

Reimbursement rates for psychologists’ services in public programs such as Medicaid⁷ have long been insufficient for practitioners to maintain a sustainable clinical practice serving significant numbers of beneficiaries. This disproportionately affects communities and geographic areas relying on these programs as a consistent source of accessing behavioral health treatment because it lowers the ability of providers in underserved areas to participate in the program. APA Services appreciates the clear intent of these rules to enhance transparency of reimbursement rates, as well

⁴ Kaiser Family Foundation, (Mar. 17, 2023), Medicaid Coverage of Behavioral Health Services in 2022: Findings from a Survey of State Medicaid Programs, <https://www.kff.org/medicaid/issue-brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs/>.

⁵ Medicaid and CHIP Payment and Access Commission, (June 2015), Behavioral Health in the Medicaid Program—People, Use, and Expenditures, <https://www.macpac.gov/publication/behavioral-health-in-the-medicaid-program%E2%80%95people-use-and-expenditures/>.

⁶ See, e.g., Julius Ohrnberger, Eleonora Fichera, Matt Sutton, The relationship between physical and mental health: A mediation analysis, *Social Science & Medicine*, Volume 195, 2017, Pages 42-49, ISSN 0277-9536, <https://doi.org/10.1016/j.socscimed.2017.11.008>.

⁷ Zuckerman, S., Skopec, L., et. al. (February 2021). Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare in 2019, *Health Affairs*, 40(2), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00611>.

as CMS' implicit acknowledgement of the connection between reimbursement rates for services and the ability of patients to access those services.

APA Services supports requiring state Medicaid agencies to publish reimbursement rates and conduct a comparative analysis of rates for “outpatient behavioral health services” relative to their Medicare counterparts. While APA Services appreciates the identification and inclusion of “behavioral health” services as “critical” services, there are often inconsistencies among programs as to how “behavioral health”, “mental health”, and “substance use disorder” services are classified, and we recommend that fee-for-service rates for “outpatient mental health services” also be subject to this analysis.

We are deeply concerned that proposed comparative payment rate analysis required under subsection (b)(3) is limited to “the most recently published Medicare payment rates effective for the same time period for the *evaluation and management (E/M) codes* applicable to the category of service.” For behavioral health, E/M codes are used predominantly for psychotropic medication management and do not capture the provision of psychotherapy services. Psychotherapy codes, on the other hand, are available and widely utilized by a broad array of behavioral health providers including psychologists, psychiatrists, social workers, and counselors and represent the predominant behavioral health services.

Neuropsychological assessments provide objective and reliable measurements of brain function, which affects medical management of patients by providing information about diagnosis, prognosis, and treatment of disorders that are known to impact central nervous system (CNS) functioning. Psychological assessment involves the use of reliable and research-validated methods (including but not limited to clinical interviewing) and standardized tests to evaluate cognitive, behavioral, and emotional functioning, intellectual abilities, personality, and psychopathology. To provide a more accurate view of the reimbursement rates for services that providers most commonly furnish in state Medicaid programs, APA Services recommends the analysis include psychotherapy codes, psychological testing, and neuropsychological testing.

APA Services also supports the general requirement at §447.203(c)(1) that, upon submission of a state plan amendment affecting provider rates, states must conduct an analysis and provide assurances that the program's rates meet or exceed 80% of the Medicare rate for the service. APA Services applauds CMS for including a clear enforcement mechanism for these provisions at §447.203(c)(3). However, APA Services recommends that the threshold be raised to 100% of the Medicare rate, as states have long reimbursed behavioral health providers lower for their services through their Medicaid programs and careful oversight must be paid to ensure that fee-for-service Medicaid programs, which are not bound by federal parity laws, are offering sufficient rates to attract a robust behavioral health workforce. APA Services also appreciates that the requirement for states to engage in meaningful public outreach concerning services and rates under §447.203(c)(1)(iii) and §447.203(c)(4) applies to state Medicaid programs regardless of whether their reimbursement rates meet the requisite threshold.

Additionally, coverage of behavioral health services is wildly inconsistent across different state Medicaid programs,⁸ often excluding critical health behavior services for patients with medical conditions such as Health Behavior Assessment and Intervention (HBAI) services.⁹ Additionally, many Medicaid programs do not cover all psychological and neuropsychological assessment services. APA Services recommends that CMS establish a set of uniform standards for the provision of behavioral health services through state Medicaid programs; APA Services would be happy to offer technical assistance to that end.

Accountability for Managed Care Systems

APA Services applauds the creation of an accountability mechanism on reimbursement rates and access for managed care entities who operate under the oversight of state Medicaid agencies. However, despite commendable efforts by CMS to enhance federal oversight of managed care systems, gaps continue to persist.¹⁰ APA Services appreciates the new requirement at 42 C.F.R. §438.207(b)(3) that managed care systems prepare a payment analysis for certain specified services, including mental health and substance use disorder services. However, given the inconsistent categorization of services referenced above, APA Services recommends that this requirement also apply to those classified as “behavioral health” and “health behavior” services.

APA Services is concerned about the proposed network adequacy standards for mental health and substance use disorder services at 42 C.F.R. § 438.68(b)(1). As APA Services has learned in the past with the implementation of similar network oversight measures, providers are often expected to indicate a degree of availability for new patients that does not match their current experience. Some programs merely ask providers whether they are available or not available to see new patients, but APA Services believes that in the determination of these standards, providers should have the option to indicate a “limited availability” for specific services. It signals to consumers that a psychologist may have only a few time slots available, which may become filled soon after the psychologist announces their availability. It also reflects that many psychologists have the flexibility to accept one or two more patients to their patient load if a patient has an issue that matches their particular expertise. This approach gives psychologists more power to direct limited remaining time to patients who could most benefit from their skills. By contrast, a binary

⁸ Kaiser Family Foundation, (Mar. 17, 2023), Medicaid Coverage of Behavioral Health Services in 2022: Findings from a Survey of State Medicaid Programs, <https://www.kff.org/medicaid/issue-brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs/>.

⁹ HBAI services refer to the provision of psychological interventions to patients diagnosed with a chronic medical condition. The goal of these services is twofold: (1) to evaluate the patient’s responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment; and (2) to intervene towards the promotion of functional improvement, minimization of psychological and/or psychosocial barriers to recovery, and improvement of coping with medical conditions. See, Health Behavior Assessment and Intervention: CPT Codes for Psychologists, <https://www.apaservices.org/practice/reimbursement/health-codes/2022-health-behavior-assessment-codes-factsheet.pdf>.

¹⁰ See, e.g., Government Accountability Office (June 28, 2022). Medicaid: State Directed Payments in Managed Care, GAO-22-105731, <https://www.gao.gov/products/gao-22-105731>.

“available/not available” data point may incorrectly suggest that a provider is available to take patients for any and all services.¹¹

Similarly, APA Services is concerned about the wait time standards for managed care plans outlined at 42 C.F.R. §438.68(e)(1) due to the potential that the implementation of these standards may lead plans to push network providers to accept patients beyond their current capacity rather than attract new providers to their network. Like the network adequacy standards outlined above, these criteria cannot exist in a vacuum and must be reflective of both the low supply of providers¹² and the outsized demand for their services within state Medicaid programs.¹³ Otherwise, qualified providers risk becoming excluded from managed care networks simply because they are already stretched too thin to take on new patients.

Finally, APA Services appreciates the creation of clearer guardrails for items furnished by managed care systems “in lieu of services” at 42 C.F.R. §438.16. While these flexibilities allow responsible managed care systems to furnish innovative forms of evidence-based treatments to enrollees, others may look solely at expected cost-savings, not expected patient benefit, as the metric of performance. For example, there is an emerging proliferation of new digital technologies that market themselves as “mental health apps.” However, many of these devices lack any evidence of efficacy for treatment of a patient experiencing symptoms of a mental or behavioral health disorder.¹⁴ Still, managed care entities seeking cost savings may look to furnish these devices over actual evidence-based treatment due to anticipated cost savings. Therefore, in the documentation section outlined at 42 C.F.R. § 438.16(d), APA Services recommends that managed care entities seeking to offer these items must include documentation of the item’s safety and efficacy.

Thank you again for the opportunity to weigh in on these proposed rules. To the extent that our psychologists can serve as a resource to your office, please feel free to reach out to Andrew Strickland, Senior Legislative and Regulatory Counsel, at any time (astrickland@apa.org).

¹¹ Last December, APA Services submitted a response to CMS’ Request for Information to inform the creation of a National Provider Directory, which contains a number of suggestions equally applicable to the network adequacy standards discussed in the current proposed rules:

https://drive.google.com/file/d/1yf3YjCPpnshnnz9KyGsftKGniZmwYTfr/view?usp=drive_link.

¹² See, e.g., Kaiser Family Foundation, A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs (Jan 10, 2023), <https://www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/>.

¹³ See, e.g., Medicaid and CHIP Payment and Access Commission, Access to Mental Health Services for Adults Covered by Medicaid (June 2021), [a](#).

¹⁴ Donker T, Petrie K, Proudfoot J, Clarke J, Birch M, Christensen H, Smartphones for Smarter Delivery of Mental Health Programs: A Systematic Review, J Med Internet Res 2013;15(11):e247, <https://www.jmir.org/2013/11/e247>.



Sincerely,

A handwritten signature in black ink, appearing to read "Kath B McGuire", with a long, sweeping horizontal line extending to the right.

Katherine B. McGuire
Chief Advocacy Officer
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Jared L. Skillings, PhD, ABPP
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