AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

February 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Medicare Program; 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 and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Dear Administrator Brooks-LaSure:

The American Psychiatric Association (APA), the national medical specialty society representing over 38,000 psychiatric physicians and their patients, submits these comments in response to Medicare Program; 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 and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications issued by CMS on December 27, 2022.

As has been widely reported, the United States is experiencing a crisis of mental health and well-being with the consequences of the pandemic reflected in rising rates of suicide, record overdose deaths, and increased depression and anxiety across nearly all ages and demographics. We applaud CMS for its efforts to increase access and ensure continuity of care for individuals with mental health and substance use disorder (MH/SUD); improve price transparency and market competition under the Part D program; strengthen consumer protections to ensure Medicare Advantage (MA) and Part D beneficiaries have accurate and accessible information about their health plan choices and benefits; strengthen CMS oversight of MA and Part D plans; and improve the integration of Medicare and Medicaid programs for individuals enrolled in dual eligible special needs plans (D-SNPs).

We appreciate and support CMS's interest in advancing health equity across all programs. MA plans have an opportunity to provide extra benefits (i.e., hearing, dental and vision) not offered under traditional fee-for-service Medicare. They also

have flexibility to offer wellness programs, non- emergency transportation, meal delivery services, and in-home support services; benefits that can reduce hospitalizations and improve overall health status. **We encourage CMS to continue to consider social determinants of health in their policy making including social determinants of mental health (SDoMH) such as stigma, lack of parity (access, coverage and payment), the flawed criminal justice system and the impact of social media, all of which disproportionately impact individuals with serious mental illness and those with substance use disorders.** We encourage MA plans to consider how best they can support this population.

Consolidated Appropriations Act

Before finalizing this rule, CMS must align all regulatory requirements and language with the Consolidated Appropriations Act which included important changes to the X-waiver, intended to broaden buprenorphine access beyond those with access to traditional OUD treatment providers. The NRPM proposes to add a new requirement to the provider directory to include data elements for certain providers who offer medications for opioid use disorder (MOUD). **Connecting beneficiaries to the right provider in the most efficient manner is utmost important for CMS, however, this proposal may not ensure that outcome. The directory must be able to routinely communicate with the SAMHSA Buprenorphine Practitioner Locator (BPL) to prevent additional burden on the provider to update information in multiple places. Moreover, there must be an opt-in option for the directory in case the provider is not in a position to increase the capacity of patients.** The last thing CMS should create is a chilling effect on providers treating OUD beneficiaries due to increased or perceived burdens.

In addition, clarity is needed regarding whether this would meet the requirement under 42 CFR Part 2 as "holding itself [program. Individual, entity] out". We are concerned that it could unintentionally force a second regulatory framework on providers. Again, potentially leading to a chilling effect in services offered. **APA also recommends CMS assess the network adequacy for MOUD providers in an area through claims data to determine if a plan must provide technical assistance to train more in a provider shortage region.**

Utilization Management/Prior Authorization

APA supports CMS's proposals to ensure MA enrollees receive the same access to medically necessary care that they would receive in traditional Medicare. **APA recommends that the utilization management (UM) committee also develop, implement, and oversee activities by MA organizations related to utilization review to ensure that beneficiaries are not denied needed care to which they are entitled. We urge CMS to require plans to reallocate UM resources to focus primarily on ensuring patients with high clinical need, psychosocial complexity, a history of repeat admissions, frequent ED visits, prolonged inpatient stays, and homelessness or other issues based on social determinants of health get access to the appropriate level of care.** Instead of focusing on medical necessity determinations for all patients, UM efforts should concentrate on patients with these complex necessities and aim to identify the service and care management requirements that can be addressed to optimize the likelihood of improved outcomes including successful transitions from inpatient settings to community-based care.

Our members report that MA plans frequently use prior authorizations to delay patient care. Determinations are made by plan employees who do not have expertise in mental health or substance use disorders and seem to be "reading off a checklist." Members estimate that the vast majority (as high as 80-90%) of the initial denials are overturned on appeal making it appear that the initial decision was done to delay care. According to our members, the Medicare Advantage UM system is geared toward delaying care. In the inpatient setting long delays lead to patient discharges from inpatient care without adequate discharge plans in place resulting in patients failing to connect with community care, higher risk for suicide, and hospital readmissions. The prior authorization process also complicates and delays care in the emergency room setting where individuals seeking care are boarded while waiting authorization. The chaotic and noisy emergency room setting is an environment that can further exacerbate their acute symptoms and in some cases, increases the potential for disruption or violence toward medical staff. Prior authorization/utilization review activities should be reserved for those who are misusing it and not used routinely for all.

APA urges CMS to require that MA plans base utilization review on generally accepted clinical standards of care developed by leading clinical professional societies, such as the ASAM Criteria and LOCUS. CMS should follow the lead of states that are incorporating this standard for UM into their requirements for state-regulated health plans as in California, Illinois, and Oregon.

We encourage CMS to require the utilization committee to continuously oversee the PA process instead of reviewing it once annually; that plans have more than one independent physician on their UM committees; and further strengthen the UM process by requiring the reviewer be qualified in the same specialty, experienced with the treatment in question and licensed in the state.

We applaud and support CMS's efforts to streamline and improve transparency of the prior approval (PA) process and ensure continuity of care of enrollees in both Medicare Advantage and Part D programs. We support applying the PA for the duration of treatment requirements to Part D as well. Ensuring safe transitions in care are especially important for individuals with chronic MH/SUD. APA recommends that medication used to treat opioid addiction should not be subject to any prior authorization. The prior authorization process results in delays in care and a barrier to accessing lifesaving treatment due to an increased risk of stigmatization of the beneficiary and is detrimental to patients with Opioid Use Disorders.

We urge CMS to reinstate their prohibition on step therapy for Part B drugs in Medicare Advantage. Finally, APA remains concerned that without meaningful enforcement of these requirements, including the improper denial of services, beneficiaries will be unable to access the essential care they are entitled to.

Network Adequacy Standards

APA applauds CMS's proposals to improve access to MH/SUD care by: 1) requiring MAOs to demonstrate that they meet network adequacy standards for three new clinician specialty types -- clinical psychology, clinical social work, and prescribers of medication for opioid use; 2) clarifying that the definition of

"emergency medical conditions" includes both physical and mental conditions, and behavioral health services that qualify as emergency services may not be subject to prior authorization; 3) implementing standards for wait times for primary care and to extend those standards to behavioral health services; and 4) adding behavioral health services to the types of services for which MA organizations must have programs in place to ensure continuity of care.

In evaluating network adequacy within MA plans, **APA recommends standards look not only at provider type, and availability but also ensure that access to the full range of services (i.e., inpatient, partial hospitalization, intensive outpatient, crisis services) is available prior to approval for participation in Medicare.** Comprehensive services should be available for everyone across the continuum of care, incorporating patient, family and/or caregiver preferences in addition to clinical needs.

While we support CMS's proposal to add appointment wait time standards to MH/SUD care, **we recommend the standard include the requirement that the clinician have the requisite level of knowledge and skill to treat the enrollees' MH/SUD condition.** People who suffer from serious mental illness, such as major depressive disorder, a history of suicide attempts, schizophrenia, eating disorders and co-occurring substance use or medical disorders, are often the most vulnerable patients and often need highly specialized care. The availability of any behavioral health clinician does not satisfy the member's right to obtain network health services within the designated wait time if that clinician lacks the education and training to treat the member's condition. To that end, **APA recommends that psychiatrists be one of the specialties that have an appointment wait time standard and that the appointment wait time thresholds be based on routine, urgent and emergent standards and transition of care needs or post discharge follow up. We recommend time frames of one month for routine appointments, one week for urgent appointments and immediate for emergency care, including referral to an emergency room that has an agreement for back up psychiatric care. APA also recommends requiring MA issuers to report on the number of clinicians who have billed for patient services within the past 4-6 months, which is more reflective of a member's access to health services than those who are listed as within a certain time/distance metric.** Patients commonly complain about making numerous phone calls to clinicians who, while listed as network members, are not available to care for the patient. However, people who suffer from MH/SUD are unlikely to complain when they cannot find care, either due to stigma or the overwhelming demands of managing their illness**. APA also recommends conducting regular patient satisfaction surveys around network access questions such as how many clinicians the patient contacted before finding an appointment and how long did the patient have to wait for an appointment. We are concerned about the proposed changes to the Star Rating system within the Quality Rating Section of this rule that would reduce the weight of patient experience/complaints and access measures. Given there are limited mechanisms to hold plans accountable for network adequacy we encourage CMS to thoughtfully consider the impact this could have in ensuring appropriate access.**

Increasing Access to MH/SUD Care

Reimbursement Rates

Several studies have documented the disparities in reimbursement rates between mental health clinicians and their physical medicine colleagues.[1,2,3] The 2022 OIG report on "Ghost Networks"[4] cited low reimbursement rates as a contributing factor in low network participation, further compounding access to care issues, and driving patients toward out of network care, or no care at all. The 2019 update to a Milliman study that included data on reimbursement rates found the disparity continues and has increased over time since the release of their initial report. Their 2019 follow-up report found that the disparity in reimbursement rates between primary care physicians and psychiatrists actually grew, increasing from a differential of 20.8% higher in 2015 to 23.8% in 2019.[5] **APA urges CMS to require MA plans to demonstrate that rates paid to MH/SUD clinicians are comparable to those paid to medical/surgical clinicians for similar services. In addition, demonstration of comparable rates should be a prerequisite for any exception to MA network adequacy requirements.**

Incentivize Adoption of Evidence-Based Models of Care (CoCM, MBC)

APA strongly recommends MA plans incentivize the adoption of the Collaborative Care Model (CoCM) within primary care settings as well as the use of Measurement-Based Care (MBC) techniques in both primary and specialty care. These models of care, which have been shown to increase access to care, improve the quality of care, and are effective in both acute care and care for patients with chronic conditions, align well with CMS's quality improvement objectives including improved care coordination. CoCM, is a population-based team approach to the identification and treatment of individuals with MH/SUD in primary care settings that has been shown to improve outcomes, and reduce disparities in care among racial and ethnic minorities.[6,7] CoCM alleviates the psychiatric workforce shortage by leveraging the expertise of the psychiatric consultant to provide treatment recommendations for a

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[1] Pelech D, Hayford T. Medicare Advantage And Commercial Prices For Mental Health Services. *Health Aff (Miwood)*. 2019;38(2):262-267. doi:10.1377/hlthaff.2018.05226

[2] Melek, S., Davenport, S. & Gray, T.J., Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement (Nov. 19, 2019)

[3] Pelech D, Hayford T. Medicare Advantage And Commercial Prices For Mental Health Services. Health Aff (Millwood). 2019;38(2):262-267. doi:10.1377/hlthaff.2018.05226

[4] United States Government Accountability Office. Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts.; 2022. https://www.gao.gov/assets/gao-22-104597.pdf

[5] Melek, S., Davenport, S. & Gray, T.J., Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement (Nov. 19, 2019)

[6] Hu J, Wu T, Damodaran S, Tabb KM, Bauer A, Huang H. The effectiveness of collaborative care on depression outcomes for racial/ethnic minority populations in primary care: a systematic review. Psychosomatics. 2020, online first.

[7] Snowber K, Ciolino JD, Clark CT, Grobman WA, Miller ES. Associations Between Implementation of the Collaborative Care Model and Disparities in Perinatal Depression Care. Obstet Gynecol. 2022;140(2):204-211. doi:10.1097/AOG.0000000000004859

population of patients, and has tremendous potential to produce significant cost savings.[8] Other demonstrated benefits of the model include increased patient engagement and improved care coordination; the ability to provide virtual care[9]; and an increased sense of well-being among primary care physicians who report feeling better prepared to provide care to patients with MH/SUD. These elements function to improve both mental and physical health and prevent downstream hospitalizations, or emergency room visits (not only for MH/SUD but physical health conditions as well) ultimately reducing overall-costs to our healthcare system.[10] Objectives that align well with those in place for MA plans.

CoCM is currently being implemented in many large health care systems and practices and is also reimbursed by Medicare and some MA plans, many private insurers, and a growing number of state Medicaid programs. Despite its strong evidence base and availability of reimbursement, uptake of CoCM by primary care physicians and practices remains low due to several barriers including the up-front costs associated with implementation; concerns that reimbursement rates for billable services are insufficient to cover costs or incent practices to implement; patient attrition due to copays/cost-sharing requirements including high-deductible plans; billing challenges related to tracking and limitations on time.

We strongly encourage MA plans to develop reimbursement mechanisms to incentivize the implementation of the model and streamline billing and documentation requirements to reduce barriers. A 2021 report from Rand supported the launch of a National Care Coordination Initiative,[11] including financial support to defray implementation costs and higher reimbursement rates for the CoCM codes (99492-99494, G2214) for the first three years to ensure practices maintain the model. Congress recently approved funding to states to support implementation of the CoCM in primary care practices as part of the Consolidated Appropriations Act of 2023. Providing additional financial incentives, such as an increase in the reimbursement rates associated with the model in the early stages of implementation would provide the foundation necessary for long-term success of the model.

Finally, eliminating cost-sharing requirements for these services would reduce barriers to care. Reports from the field cite patient concerns about cost-sharing amounts as one of the reasons individuals choose not to engage in care or continue to receive care through the model. A 2022 report from the Assistant Secretary for Planning and Evaluation (ASPE) reported that millions of Americans have benefited from ACA coverage and the lack of cost-sharing associated with preventive services. The report noted the value

[8] Washington State Institute for Public Policy Benefit-Cost Results for Adult Mental Health. Retrieved from: https://www.wsipp.wa.gov/BenefitCost?topicId=8

[9] Carlo AD, Barnett BS, Unützer J. Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. JAMA Psychiatry. 2021;78(4):355-356. doi:10.1001/jamapsychiatry.2020.3216

[10] Melek SP, Norris DT, Paulus J, Matthews K, Weaver A, Davenport S. Milliman Research Report potential economic impact of integrated ... Milliman. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Milliman-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf. Published February 12, 2018. Accessed July 27, 2022.

[11] McBain RK., Eberhart N, Breslau J, Frank L, Burnam A, Kareddy V, and Simmons MM. How to Transform the U.S. Mental Health System: Evidence-Based Recommendations. Santa Monica, CA. RAND Corporation. 2021. https://www.rand.org/pubs/research_reports/RRA889-1.html.

of preventive care/screening for chronic conditions to prevent or reduce impacts on long-term health. It is widely understood that depression has been linked to increasing mortality and morbidity for individuals with chronic conditions (i.e., cardiovascular disease, diabetes). CoCM aids in identifying and treating depression and other mental health conditions sooner preventing illness and modifying the trajectory of other diseases, saving overall health care costs and improving the quality of life for patients. **APA recommends eliminating the cost-sharing requirement associated with the CoCM CPT® codes.**

APA recommends that MA plans also incentivize adoption of Measurement-Based Care (MBC) in primary and specialty care by providing financial support and technical assistance. MBC, has been shown to be effective in improving outcomes and patient and clinician satisfaction.[12,13,14.] In a 2022 report to Congress, SAMHSA's Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) highlighted the positive effects of MBC; accrediting organizations and payers have also begun to recognize its value. MBC increases screening and can improve early identification and prevention and is more effective in improving outcomes than screening alone.

As with CoCM, clinicians in both primary care and specialty care have been slow to adopt MBC. A 2020 JAMA Psychiatry article (Lewis et al) summarized several barriers faced by individual clinicians and organizations.[15] Implementation will require stakeholder buy-in to adapting to a change in practice.[16] Incentives, such as coverage of CPT® codes *99484 and G0323 (Care management services for behavioral health conditions*) provides a starting point however will not fully account for the costs to implement this model of care. The current valuation does little to incentivize MBC. As with CoCM, providing implementation funding and support through technical assistance in addition to reimbursement mechanisms that incentivize change could reduce the barriers to adoption. This is one way all primary care and specialty care practices can improve outcomes for their patients suffering from MH/SUD.

Continuous Access to Care

APA commends CMS for its efforts to ensure continuous access to care for people who are managing a MH/SUD, particularly those who are members of marginalized communities, or for whom English is not their primary language. APA supports many of the proposed changes including: requirements that

[12] Alter, C.L., Mathias, A., Zahniser, J., Shah, S., Schoenbaum, M., Harbin, H.T., McLaughlin, R, & Sieger-Walls, J. (2021, January). Measurement Based Care in the Treatment of Behavioral Health Disorders. Dallas, TX: Meadows Mental Health Policy Institute. mmhpi.org

[13] Hu J, Wu T, Damodaran S, Tabb KM, Bauer A, Huang H. The effectiveness of collaborative care on depression outcomes for racial/ethnic minority populations in primary care: a systematic review. Psychosomatics. 2020, online first.

[14] Snowber K, Ciolino JD, Clark CT, Grobman WA, Miller ES. Associations Between Implementation of the Collaborative Care Model and Disparities in Perinatal Depression Care. Obstet Gynecol. 2022;140(2):204-211. doi:10.1097/AOG.0000000000004859

[15] Lewis CC, Boyd M, Puspitasari A, et al. Implementing Measurement-Based Care in Behavioral Health: A Review. JAMA Psychiatry. 2019;76(3):324-335. doi:10.1001/jamapsychiatry.2018.3329

[16] Fortney, (J. C., Unützer, J., Wrenn, G., Pyne, J. M., Smith, G. R., Schoenbaum, M., & Harbin, H. T. (2017). A Tipping Point for Measurement-Based Care. Psychiatric Services (Washington, D.C.), 68(2), 179–188.

enrollees be notified by MA organizations when the enrollee's primary care or behavioral health clinician(s) are dropped midyear from networks; codifying *Part D transition requirements* intended to avoid interruptions in drug therapy; and clarifying that MA organizations must provide *culturally competent care* to people: (a) with limited English proficiency or reading skills; (b) of ethnic, cultural, racial, or religious minority groups; (c) with disabilities; (d) who identify as lesbian, gay, bisexual, or other diverse sexual orientations; (e) who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; (f) who live in rural areas and other areas with high levels of deprivation; and (g) otherwise adversely affected by persistent poverty or inequality.

While APA **s**upports CMS's proposal to codify data requirements for *provider directories*, including whether the clinician is accepting new patients, information on the clinician's cultural and linguistic capabilities, including languages (including American Sign Language (ASL)), and whether the clinician is offering medications for opioid use disorder (OUD), **more needs to be done to hold MA plans accountable for the accuracy of the information contained in the provider directory.** The recent report on "Ghost Networks" from the Office of the Inspector General affirmed previous studies that found significant inaccuracies in provider directories increases the challenges patients face in accessing timely care and lead to a higher percentage of patients seeking out of network care.[17,18] While APA appreciates CMS's efforts to expand networks and directory information to include clinicians qualified to prescribe buprenorphine, studies have found that prescribing of buprenorphine has remained limited even among waivered prescribers, with roughly half of all waivered clinicians choosing not to prescribe buprenorphine to treat OUD, and many of those who do prescribe seldom treat as many patients as allowed.[19,20] Failing to hold plans accountable for verifying clinician availability and the accuracy of all the information in the directory in ways that are not overly burdensome for the provider will be necessary to reduce barriers patients experience in connecting to care.

Shortages of Formulary Drug Products During a Plan Year

APA supports the proposed change that would require Part D sponsors to permit enrollees affected by a shortage to obtain coverage for the formulary alternative without requiring those enrollees to satisfy prior authorizations or step therapy requirements. CMS should provide administrative clarifications to Part D sponsors to ensure implementation that ensures there is no delay to any beneficiary accessing medications. APA has consistently opposed step therapy medication protocols specifically as applied to mental health and substance use disorder medications. Step therapy, like prior authorization, is harmful

[17] Busch, S. H., & Kyanko, K. A. (2020). Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills. Health affairs (Project Hope), 39(6), 975–983. https://doi.org/10.1377/hlthaff.2019.01501

[18] United States Government Accountability Office. Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts.; 2022. https://www.gao.gov/assets/gao-22-104597.pdf

[19] Duncan A, Anderman J, Deseran T, Reynolds I, Stein BD. Monthly Patient Volumes of Buprenorphine-Waivered Clinicians in the US. JAMA Netw Open. 2020;3(8):e2014045. doi:10.1001/jamanetworkopen.2020.14045

[20] Huhn AS, Dunn KE. Why aren't physicians prescribing more buprenorphine?. J Subst Abuse Treat. 2017;78:1-7. doi:10.1016/j.jsat.2017.04.005

to patients causing delays in care. To meet the goals of the administration around mental health treatment, APA advocates to further this proposal, removing any requirement for step therapy or prior authorization from the Medicare Program, as it pertains to mental illness, while maintaining the protections provided through Medicare Part D protected classes.

Technology and Interoperability in MA

APA appreciates CMS's work aligning MA standards and benefits to best practices in the use of technology to improve care. We applaud CMS's recognition of the role of technology in identifying and achieving health equity objectives. To further this goal, **we recommend some enhancements to this proposed rule:**

- **In addition to ensuring that MA plans cover the same telehealth services as traditional Medicare, include requirements for MA plans to cover the same modality as MA plans (e.g., coverage of audio-only mental health services equivalent to traditional Medicare). Ensuring that reimbursement rates are the same across modalities in MA plans also helps ensure that care is delivered based on patient need and clinical decision-making, not on reimbursement rates.**
- Digital literacy is a valuable component of a health equity strategy, but **we urge CMS to apply a population health lens to these efforts and include structural and policy strategies to advance digital inclusion.** These strategies may include:
    - Conducting community-level analyses to evaluate the root causes of inequitable access to technology in the plans' populations and communities and developing strategies to address these specific issues, rather than assuming knowledge of the population's technology needs based on age, language, or other characteristics;
    - Developing clinician training programs to help clinicians understand and communicate about technology with patients;
    - Incorporating digital navigation into existing care coordination structures as well as identifying peer and community champions; and
    - Coordinating with local and state entities to address determinants of digital access.
- Aligning around technology standards and certification criteria is a great step toward reducing administrative burden for practices associated with adopting technology, and we encourage CMS, ONC, and other federal partners to go beyond certification criteria. **The cost and burden associated with acquiring and implementing certified technology can be beyond the reach of practitioners, particularly those in rural or underserved communities and those that serve historically underrepresented groups, and certification efforts should be accompanied by funding and TA to help practices adopt technology that is consistent with HHS' quality standards.**

Protecting Beneficiaries

Marketing

APA members have been increasingly concerned about the marketing practices of Medicare Advantage plans. Medicare plans tout their benefits, like low copays or premiums, the inclusion of dental and vision

care, but fail to mention limitations or gaps in coverage (i.e., limited networks, limited formularies, absence of access to case management for seriously mentally ill patients) or clearly explain the challenges that could arise if they want to revert to a traditional Medicare plan, especially if they've never been enrolled in traditional Medicare. Individuals enroll with limited knowledge or understanding of the constraints of the coverage. APA members have expressed concerns about the "seamless conversion" process available to some MA plans, explaining that individuals may be unwittingly enrolled in an MA plan after failing to specifically opt out. The flood of marketing materials eligible individuals receive from various MA plans increases the likelihood that key information is being missed. MA is seen as a poor option for individuals with a MH/SUD that requires ongoing care.

Limitations as to health insurance literacy coupled with functional limitations/ impairments due to physical, MH/SUD make the process to choose the best coverage challenging. Consideration should be given to providing additional support to those with chronic conditions or those dually eligible for Medicare and Medicaid. Attention needs to be given to ensure that the coverage information is written concisely at a fourth-grade level with comparisons across plans of key information clearly outlined and available in multiple languages. Guidance from an impartial, knowledgeable individual, who can ideally converse in the individual's native language could help guide individuals to choose a plan that best meets their needs.

We applaud CMS for its efforts to ensure MA and Part D marketing to beneficiaries is not misleading, inaccurate, or confusing by proposing to prohibit certain marketing activities and requiring beneficiaries be provided with certain accurate information, including from brokers. These proposals may help to address some of the predatory marketing practices causing harm to beneficiaries. However, APA remains concerned these proposals do not go far enough given the widespread misleading practices in the MA industry and the lack of meaningful enforcement against the bad actors. CMS's proposed regulatory changes regarding D-SNP look-alike plans which are intended to extend protections for dually-eligible individuals, are a start. **We encourage CMS to continue to monitor and evaluate any non D-SNP plan where dually-eligible patients make up the majority of the covered lives to ensure the plan is not engaged in deceptive marketing practices.**

60 Day Reinstatement

APA is concerned that CMS's proposal to require disenrolled individuals to request reinstatement within 60 calendar days will be challenging for people who are managing an MH/SUD. We are not persuaded by CMS' rationale that infrequent complaints from beneficiaries about this 60-day deadline demonstrates that this new proposal will not adversely impact individuals disenrolled for nonpayment of premium. People struggling with MH/SUD often do not complain when they face administrative difficulties.

Dually Eligible Patients and Low-Income Patients

We support the proposed mechanisms that increase access to care, reduce the risk of gaps in coverage, and ensure that individuals have access to the full range of therapeutic interventions. This includes policies that support enrollment alignment across Parts A, B, C and D, and proposed mechanisms (i.e., LI

NET) to ensure coverage and open formularies under Part D for low-income individuals. **We strongly encourage CMS to monitor the impact of the proposed changes, particularly related to cost-sharing and recoupment policies to ensure access to care for individuals with MH/SUD is not adversely impacted by this approach.** Ensuring ongoing access to the full range of benefits, including the full continuum of care is important in maintaining the health of individuals, particularly those with chronic conditions.

Thank you for your review and consideration of these comments. If you have any questions or would like to discuss any of these comments, please contact Rebecca Yowell (byowell@psych.org) Director, Reimbursement Policy and Quality.

Sincerely,

Saul M. Levin, M.D., M.P.A., FRCP-E, FRCPsych
CEO and Medical Director
American Psychiatric Association