NYS Council for Community Behavioral Healthcare

June 29, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2442-P
Submitted via regulations.gov

RE: Medicaid Program; Ensuring Access to Medicaid Services (CMS-2442-P)

On behalf of the NYS Council for Community Behavioral Healthcare, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on Ensuring Access to Medicaid Services ("the Proposed Rule").

The NYS Council is a statewide, non-profit, membership organization composed of 120 community-based organizations that provide recovery-focused mental health and/or substance abuse/chemical dependence and addiction treatment programs and services for New Yorkers in need. NYS Council members offer a broad array of behavioral health services designed to meet the unique needs of children and adolescents, individuals and families seeking our assistance. Our services are available in a variety of community settings including freestanding agencies, behavioral health divisions of general hospitals, and county mental hygiene programs.

Overall, the NYS Council is supportive of the goals in the Proposed Rule of streamlining standards for Medicaid fee-for-service (FFS) payment adequacy and strengthening requirements for safety and quality in the delivery of home and community-based services (HCBS). CMS is seeking in the proposal to clarify and reformulate the Medicaid access rules at 42 C.F.R. Part 447. CMS aptly concludes in the preamble to the Proposed Rule that, per Section 1902(a)(30)(A) of the Social Security Act, provider payment rates are key to ensuring that Medicaid services are "sufficient to enlist enough providers so that care and services are available under [the Medicaid state plan] at least to the extent that such care and services are available to the general population. . . ." Adequate provider payment, as CMS acknowledges in the preamble, is the linchpin to ensuring that every Medicaid beneficiary has access to needed care and services. In the wake of the Supreme Court's decision in *Armstrong v. Exceptional Child Ctr.,* 575 U.S. 320 (2015), which held that Medicaid providers do not have a cause of action to challenge a state's Medicaid payment rates under Section 1902(a)(30)(A), the need for meaningful CMS access rules became more pressing to provide guidance to states in the face of national mental health workforce shortage.

While supportive of CMS' rationale for the rulemaking generally, there are several concerns regarding CMS' approach that uniquely impact community mental health and substance use treatment providers (CMHSUTPs) that constitute the NYS Council membership. CMHSUTPs furnish a wide range of services which are both lifesaving for individuals experiencing behavioral health crises and closely linked with more effective management of complex conditions yet are in dire shortage for the more than 150 million individuals across the United States living in a mental health professional shortage area.[1]

[1] See HRSA, Health Workforce Shortage Areas (June 2023).

The NYS Council has several concerns relating to CMS' approach to provider payment adequacy, in CMS' proposed rewriting of 42 C.F.R. 447.203, which focuses primarily on services (1) furnished in practitioner settings, (2) paid for on a fee schedule basis and are covered under both the Medicare and Medicaid programs as evaluation and management services. These two limitations exclude much of the care furnished by CMHSUTPs. CMHSUTPs, in many states, are paid by Medicaid as facilities (often using a bundled or encounter-based payment model), rather than for discrete services furnished by individual clinicians. Further, CMHSUTPs typically provide a much broader range of behavioral health services than Medicare covers under its Physician Fee Schedule. CMHSUTPs also rely on a much broader range of behavioral health clinicians than the clinicians recognized under the Medicare program. For these reasons, CMS' approach, which relies on comparisons to Medicare payment by reference to Medicare-covered evaluation and management (E/M) code for services, is a poor lens to judge the adequacy of payment to many CMHSUTPs. We also have some concerns about CMS' "percentage threshold" approach to payment adequacy for HCBS, as described further below.

Additionally, the NYS Council is concerned by some of the methodological choices CMS has made in its overhaul of the access rules. CMS acknowledges in the preamble the critical role of behavioral health outpatient services for Medicaid beneficiaries, and the historical deficiency of Medicaid payments for these services. (See 88 *Federal Register* (FR) 28804.) Nonetheless, the proposed changes appear oriented toward chiefly reducing CMS' and states' administrative burdens, deleting and replacing a set of 2016 Medicaid access rules that were perceived by states as overly burdensome. The result of the revision is an oversimplified approach to evaluating Medicaid FFS provider payment. The approach does not focus sufficient scrutiny on payment levels for behavioral health services, because many Medicaid behavioral health services and provider types do not conform to the narrow parameters of CMS' proposed approach, and thus the approach does not support a comprehensive continuum of behavioral health care services to which minimally impeded access is vital.

Below, we have associated our comments with the numbered topic section used in the Proposed Rule, and we have placed our comments in the order in which topics appear in the Proposed Rule.

HCBS Payment Adequacy (Section II.B.5)

In this section, CMS proposes to assess states' payment adequacy for HCBS by focusing particularly on compensation paid to HCBS direct care workers. CMS notes that direct care workers typically earn low wages and receive limited benefits, "contributing to a shortage of direct care workers and high rates of turnover in this workforce, which can limit access to and impact the quality of HCBS." 88 FR 27982. In response to this shortage, which was exacerbated by the COVID-19 pandemic, CMS proposes to require that at least 80 percent of all state payments to HCBS providers (including both base payments and supplemental payments) with respect to three components of HCBS—homemaker services, home health aide services, and personal care services—be spent on compensation to direct care workers.

Generally, the NYS Council supports CMS' efforts to increase scrutiny of quality of care and of direct caregiver payment adequacy for HCBS. Access to HCBS as an alternative to inpatient or residential settings is a crucial resource for individuals with disabilities or behavioral health disorders. CMHSUTPs have had a growing role in furnishing Medicaid HCBS in recent years, and more and more states have used the authority under Section 1915(c) waivers or Section 1915(i) state plan amendments to add HCBS programs focused on persons with mental health disorders or substance use disorders (SUD). As of 2015, 25 states offered either a 1915(c) or 1915(i) HCBS option providing services to adults with serious mental illness, children with serious emotional disturbance, or individuals with SUD.[2]

[2] See Medicaid and CHIP Payment and Access Commission (MACPAC), Behavioral Health Services Covered Under HCBS Waivers and 1915(i) SPAs.

Further, at least with respect to HCBS programs that are focused on behavioral health, we do not believe that provider agencies are retaining an excessive portion of Medicaid payments for direct caregiver services. Instead, behavioral health-oriented HCBS is more likely to include a set of clinical (as opposed to home care support) services—for example, services provided by licensed counselors, peer specialists, etc.—in addition to a set of services less clinical in nature, equipping participants with life or career skills. To the extent that care providers for these HCBS services are in short supply, the challenges confronting provider agencies relate to complex and well-documented shortages of behavioral health clinicians to hire to perform these services. Taking a one-size-fits-all approach to the issue at hand may not produce the desired outcomes across the varied contexts across the country. The NYS Council recommends keeping a distinct focus on wage review and transparency as an important first step to advancing this issue.

CMS seeks comment on whether 80 percent is an appropriate minimum percentage expectation for the portion of payments for homemaker, home health aide, and personal care services expected to be expended on direct care workers' pay; or whether, instead, 75, 85, or 90 percent would be more appropriate. (88 FR 27984.) Based on the NYS Council members' experience in providing HCBS, we would urge CMS to further consider this threshold and potential negative impact for providers and access to services where the current percentage expectation is lower than 80 percent. For example, consider current scenarios in states where approximately 50 percent goes to direct care worker salary and the remaining portion goes to supervision, benefits, and housing expenses; thus, an increased minimum percentage requirement that does not consider the significant nuance associated with the provision of such services could result in a reduction in access to needed benefits and lower quality supervision in such jurisdictions.

Regarding CMS' proposed definition of "direct care workers," at 88 FR 27984, to include nurses and others providing nursing services, assisting with activities of daily living and providing "behavioral supports, employment supports, or other services to promote community integration," we would note that the distinction CMS is seeking to draw between direct care providers and other workers, may not be a clear distinction in the realms of habilitative and behavioral health services or supportive employment. The NYS Council strongly urges CMS to reconsider setting a "percentage threshold" requirement at this time due to the distinct nuance associated with the provision of HCBS services across states that may result in decidedly negative outcomes.

Additionally, CMS notes in the preamble that CMS considered whether to apply the percentage thresholds to other services listed in 42 C.F.R. § 440.180, such as adult day health, habilitation, day treatment/partial hospitalization, psychosocial rehabilitation, and clinic services for individuals with living with mental disorders. (88 FR 27984.) These services, which are more clinical in nature than homemaker and home health aide services and more likely to take place on the provider's premises rather than in homes, are likely to be associated with higher facility and indirect costs than the three services to which CMS has chosen to apply the percentage threshold. The NYS Council also recommends that the finalized regulation not apply the proposed percentage threshold to any additional HCBS services at this time.

Documentation of Access to Care and Service Payment Rates (Section II.C)

In this section of the regulations, CMS is proposing to delete in their entirety the requirements in 42 C.F.R. 447.203 relating to access monitoring review plans (AMRPs), and to replace them with a new approach to testing the adequacy of states' Medicaid FFS provider payment levels. For the reasons explained below, we are concerned that CMS' proposed approach, based exclusively on a comparison of Medicaid fee schedule payments to payments for analogous services under the Medicare Physician Fee Schedule, will result in effectively *no* access review for many of the behavioral health services furnished by CMHSUTPs, which have been historically subject to low reimbursement rates, and for which Medicaid

is the chief payor. CMS notes that payment adequacy is essential to ensuring that services are adequately available. And after the Supreme Court's decision *Armstrong v. Exceptional Child Center,* it is clear CMS is the primary entity responsible for the revised access to care proposals in Section II.C of the regulations in ensuring that states set payments high enough to meet that goal.

CMS' role in evaluating the level of Medicaid payments is especially important for CMHSUTPs. CMHSUTPs function as safety net providers in their communities; they are often the only behavioral health providers in the community serving Medicaid patients. As CMHSUTPs' primary payer, state Medicaid programs frequently pay CMHSUTPs under methodologies that result in reimbursement of only sixty to seventy percent of their allowable costs.[3]

Additionally, FFS payment rates have particular importance for CMHSUTPs. Whether or not states are held to rigorous standards on FFS payment methodologies may impact how CMHSUTPs are paid under managed care arrangements. Managed care organizations (MCOs) do generally, under the regulations, have discretion in negotiating payment arrangements with network providers. However, under the Certified Community Behavioral Health Clinic (CCBHC) demonstration, initially authorized under the Protecting Access to Medicare Act of 2014 and initiated in 2017, states must ensure—either via supplemental payments, or through contracting arrangements with MCOs—that CCBHCs receive payment for services rendered under managed care up to the same level as the required Prospective Payment System (PPS) amounts that would be guaranteed for FFS payments. Some states have replicated the CCBHC methodology under their state plans. Further, states that use cost-related payment methodologies for CMHSUTPs do, in many instances, seek to ensure that the providers ultimately receive similar cost-related payments for the services they render under contract with an MCO. The adequacy or inadequacy of Medicaid FFS payment standards and methodologies does, in many states, affect CMHSUTPs' Medicaid payment outlook and financial sustainability.

CMS acknowledges in the preamble: "Improving access to behavioral health is a critical, national issue facing all payors, particularly for Medicaid which plays a crucial role in mental health care access as the single largest payer of services and has a growing role in payment for substance use disorder services, in part due to Medicaid expansion and various efforts by Congress to improve access to mental health and substance use disorder services." 88 FR 28804. As described further below, CMS' proposed new access rules fail to take community behavioral health providers into account in the payment adequacy regulations, an issue which we implore CMS to further address.

II.C.1. Fully Fee-for-Service States

In a companion proposed rule on managed care (88 FR 28092) ("Managed Care Proposed Rule"), CMS has proposed to replace the network adequacy standards in the Medicaid managed care regulations, which currently require only that states use "a quantitative network adequacy standard," with specific appointment waiting times for the managed care network. For routine appointments for outpatient mental health and SUD services, the managed care Proposed Rule would require that appointments be available within the MCO network "no longer than 10 business days from the date of request." 88 FR 28243. In this Proposed Rule, CMS seeks comment on whether CMS should implement standards timeliness standards in fully FFS states (i.e., states with no MCO arrangements) that "closely mirror" the proposed appointment wait time standards in the managed care Proposed Rule.

As discussed further in the NYS Council comments on the Managed Care Proposed Rule, we have concerns about CMS' proposed shift in approach on managed care network adequacy. In its 2016 managed care rule, CMS required States to implement time-and-distance standards that would require MCO networks to include enough providers for members to conveniently access services. CMS'

[3] "The Solution to America's Mental Health Crisis Already Exists," New York Times (Oct. 4, 2022).

replacement of time-and-distance requirements with appointment wait time standards appears to us to shift the burden of MCO network adequacy from the states and MCOs, to individual network providers. Individual providers cannot compensate for gaps in an MCO's overall contracted network, and moreover, the appointment wait time standards CMS proposed in the Managed Care Proposed rule will be difficult for many CMHSUTPs to achieve, due to behavioral health clinician shortages in many States.

For these reasons, we urge CMS not to adopt similar appointment wait time standards in the Medicaid FFS regulations—either generally, or exclusively for fully FFS States. Instead, access goals should be achieved in Medicaid FFS through a focus on payment adequacy.

II.C.2. Payment Rate Transparency (42 C.F.R. § 447.203(b)(1))

CMS is proposing to replace the existing AMRP process with three overall requirements: for States to display payment rates on their websites; for States to conduct a comparison of Medicaid FFS payment rates with comparable Medicare rates; and for States to provide additional assurances relating to State plan amendments (SPAs) that would reduce rates or restructure them in a manner that could result in diminished access.

With respect to each of these three areas, the NYS Council is concerned that CMS' proposed new protections would not provide for adequate reform of payment to CMHSUTPs.

As to payment transparency, the Proposed Rule would appear to omit from consideration those rates that are not based on a fee schedule. This would prevent consideration of many States' payments to CMHSUTPs, which in some instances are organized as PPS methodologies or other cost-related payment methodologies. The Proposed Rule would at 42 C.F.R. 447.203(b)(1), require State agencies to publish all "Medicaid fee-for-service payment rates" on the agency's website, by January 1, 2026. CMS specifies that this requirement would "only include fee schedule payment rates made to providers delivering Medicaid services to Medicaid beneficiaries through a FFS delivery system." 85 FR 27999.

From CMS' later discussion in the preamble, it appears that the requirement to publish rates on the website—as well as the linked requirement to compare those rates with analogous Medicare rates—would apply to "bundled fee schedule" rates but would not apply to rates structured as "encounter rates," such as prospective payment rates often used for inpatient behavioral health facilities, federally qualified health centers, and some community behavioral health providers. 88 FR 27999, 28006, 28011-28012. With respect to the bundled encounter rates, the State would be required to identify the fee associated with each constituent service included in the bundled fee schedule payment. 88 FR 27999. With respect to PPS and similar methodologies, CMS determined that including these rate methodologies in the analysis "could frustrate comparisons between States and sometimes even within a single State" (88 FR 28006), and that "comparing cost between the Medicaid and Medicare program would require a different methodology, policies, and oversight than what is proposed in this rule due to differences within and between each program." 88 FR 28012.

The NYS Council urges CMS to include more comprehensively States' FFS payment rates and methodologies in the transparency requirements at 42 CFR 447.203(b)(1). We agree that it is not feasible or advisable to post individualized information about amounts paid to a provider under, for example with cost-related reimbursement, however, including information about payment under these methodologies would advance the goal of transparency. We recommend that CMS include in 42 CFR 447.203(b)(1) a provision requiring the State to include summaries of all its payment methodologies for FFS providers on the website alongside FFS payment rates—and to require the State to update those

summaries upon approval of a State plan amendment. We urge CMS to amend 42 CFR 447.203(b)(1) accordingly.

II.C.2. Comparative Payment Rate Analysis and Payment Rate Disclosure (42 CFR 447.203(b)(2))

CMS proposes at 42 C.F.R. 447.203(b)(2) and (3) to require States to develop and publish a comparative payment rate analysis of Medicaid FFS rates, based on comparison with Medicare payment rates. States would be required to update the analysis every two years. CMS proposes to focus this comparative analysis on primary care services, obstetrical and gynecological services, and outpatient behavioral health services. CMS has selected these services because "these categories of services are critical preventive, routine, and acute medical services in and of themselves, and that they often serve as gateways to access to other needed medical services." 88 FR 28002. CMS proposes that States would be required to compare the State agency's Medicaid FFS rates for these services to Medicare rates. 88 FR 28086.

Initially, CMS seeks comment on whether outpatient behavioral health services should be included in the finalized list of services subject to the comparative payment requirement. 88 FR 28004. The NYS Council strongly supports the inclusion of this service category in the analysis. We appreciate CMS' recognition in the preamble that "improving access to behavioral health services is a critical national issue facing all payors," 88 FR 28804, and CMS' further acknowledgement that low Medicaid payment rates are a key reason that many psychiatrists are unwilling to accept Medicaid patients.

The parameters for the comparative analysis, however, are inconsistent with CMS' recognition of the importance of behavioral health services in Medicaid and the imperative to improve Medicaid behavioral health payments. Whereas the current AMRP regulations allow states to take into account "actual or estimated levels of provider payment available from other payers, including other public and private payers," 42 CFR 447.203(b)(1)(v), the present proposal would require States to compare the Medicaid rates "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," by applicable HCPCS/CPT codes. 88 FR 28086. Because CMS is proposing to compare Medicaid rates with Medicare fee schedule rates, CMS plans to include in the comparison only those payment rates that are based on a fee schedule (either individually or through a bundled rate). CMS further proposes to exclude encounter rates used under cost-related payment methodologies from the analysis, because this "could complicated the proposed comparison to Medicare FFS rates." 88 FR 28006.

The lens of the proposed comparison shortchanges CMHSUTPs in two respects. First, States' community behavioral health benefits often include, and CMHSUTPs furnish, a wide variety of services that do not correspond to E/M codes, nor do they have an analog among covered services under the Medicare Physician Fee Schedule. These services range from peer support services to psychosocial rehabilitation services, to assertive community treatment, to name a few. Medicare covers a much more limited range of behavioral health services than most State Medicaid programs. CMS states its belief that Medicare payment rates "are likely to serve as a reliable benchmark" for the analysis, 88 FR 28002. However, we would suggest that is true only for primary care services and a limited range of mental health practitioner services.

Second, the exclusion from consideration of providers paid under encounter methodologies would result in the omission of CMHSUTP services from payment analysis in some States. For example, 12 states currently have Medicaid payment arrangements for CCBHCs and 10 will be added to the

demonstration every other year beginning in 2024 to which they will also have encounter-based rates.[4] CCBHCs in the Medicaid demonstration use a prospective payment system (PPS) that enables flexibility via encounter-based rate structure that is not determined by a statewide fee schedule.[5] Thus, with the passage of the Bipartisan Safer Communities Act encouraging all 50 states to have encounter-based payments for CCBHCs, such exclusion is concerning.

The NYS Council urges CMS to finalize 42 CFR 447.203(b) with new provisions requiring States to evaluate and submit to CMS information on payment adequacy for behavioral health services, taking into account Medicare's limited behavioral health coverage, the key role played by CMHSUTPs in furnishing Medicaid behavioral health services, and the prevalence of encounter payments to CMHSUTPs in Medicaid.

In the Proposed Rule, CMS acknowledges only one category of service—HCBS—as including primarily services that Medicare does not cover or pay for currently. 88 FR 28005. CMS accordingly requires state agencies to establish an "advisory group for interested parties," to assess the adequacy of services involving payments to HCBS direct care workers. 88 FR 28087.

The NYS Council urges CMS to provide a similar alternative form of payment oversight for outpatient behavioral health services that would not be included in CMS' analysis. A special additional rule is necessary given that many outpatient behavioral health services do not have E/M codes, and that many CMHSUTPs are paid on a basis other than a fee schedule. Omission of these services from the analysis is not acceptable given the acute shortage of behavioral health services and acknowledged historical underpayment of this provider sector.

CMS should amend Section 447.203 to include a new paragraph (b)(6) requiring States to submit to CMS a payment adequacy analysis for behavioral health services. The new provision could have two main components: comparison of payment under cost-related methodologies to providers' actual incurred costs; and CMS evaluation of States' implementation of their state plan methodologies for behavioral health. Specifically, CMS Regional Offices should be required to evaluate on a biennial basis State agencies' compliance with the payment methodologies for outpatient behavioral health services in their state plans. Additionally, the NYS Council recommends that the provision also include a comparison of payment to commercial payers' rates where feasible to better assess the landscape and implication of rate variation on access with the caveat that this information may be proprietary and difficult to obtain as recognized in the proposed rule.

II.C.3. State Analysis Procedures for Rate Reduction or Restructuring

CMS proposes to revise the procedures for additional scrutiny of state plan amendments that reduce provider payment or restructure provider payments in a manner that may result in diminished access to services. The present regulation, at 42 CFR 447.203(b)(6), requires States to submit an access review relating to any service affected by such a state plan amendment.

CMS explains in the preamble that in the original regulation, there was a lack of clarity surrounding precisely what provider payment "restructuring" may result in diminished access. CMS therefore proposes to include three criteria indicating state plan amendments are of concern: (1) if Medicaid

[4] See National Council for Mental Wellbeing, What is a CCBHC?
[5] See National Council for Mental Wellbeing, Certified Community Behavioral Health Clinics: A New Type of Prospective Payment System.

payment rates would not be at least 80 percent of the most recently published Medicare payment rates; (2) if the proposed reduction or restructuring resulted in more than a 4 percent reduction in aggregate FFS expenditures; or (3) if significant concerns were voiced by beneficiaries, providers, or other interested parties under the public process regarding rate restructuring plan amendments required under 42 CFR 447.204. For amendments that do not meet all three criteria, a heightened set of submissions would be required.

The NYS Council's concern is that, while CMS understandably seeks to clarify which State plan amendments are subject to heightened scrutiny, the criteria once more are skewed toward services that are paid for off a fee schedule, and which correspond to Medicare-covered services. Further, where States make changes to a cost-related payment methodology that may result in diminished access (e.g., by placing a new cap on administrative costs, requiring a "rebase," or otherwise altering cost reporting procedures), it may not be straightforward to determine based on the text of the amendment, whether the change would result in a 4 percent or more decrease in payment to an already underpaid and diminishing workforce.

Exercising additional vigilance in the review of state plan amendments that propose to change provider payments is a straightforward way for CMS to ensure that it does not unwittingly authorize states to implement payment reductions that compromise access to care, motivated solely by state budgetary concerns. The negative impact of such changes is not always apparent or quantifiable on the face of the amendment. The NYS Council urges CMS to remove the threshold criteria described in proposed 447.203(c)(1), and instead, to require states to meet the heightened submission criteria described in 447.203(c)(2) whenever they propose to change provider payment rates or methodologies.

The NYS Council appreciates the opportunity to provide these comments. We welcome any questions or further discussion about the recommendations described here. Please contact me at lauri@nyscouncil.org. Thank you for your time and consideration.

Sincerely,

Lauri Cole
Executive Director