January 5, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program

Dear Administrator Brooks-LaSure:

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 7,000 physicians and associated health professionals who specialize in the prevention and treatment of addiction, thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) Notice of Proposed Rulemaking (NPRM) regarding policy changes for 2025 Medicare Advantage (MA) plans.

ASAM welcomes the proposals set forth in this proposed rule to address network adequacy requirements for mental health (MH) and substance use disorder (SUD) services. These proposals build on other policy changes that CMS has finalized under previous rulemaking to bolster Medicare enrollees' access to quality MA plans and services, such as changes that limit medical necessity determinations, define the appropriate use of prior authorization, and increase transparency requirements for MA plans. Taken together, ASAM believes that these are important guardrails that will continue to raise the benchmark of quality, accessible care for Medicare beneficiaries with a MH or SUD. ASAM's recommendations herein will focus on the proposal set forth in CMS' rule to expand network adequacy requirements for SUD services.

Expanding Network Adequacy Requirements for SUD Services

Under the proposed rule, CMS proposes to add "Outpatient Behavioral Health" as a new facility-specialty category to evaluate network adequacy. Those in this category would include marriage and family therapists (MFTs), mental health counselors (MHCs), opioid treatment programs (OTPs), community mental health centers (CMHCs), or those of the following who regularly furnish or will regularly furnish behavioral health counseling or therapy services, including, but not limited to, psychotherapy or prescription of medication for SUD: physician assistants, nurse practitioners, and clinical nurse specialists; addiction medicine physicians; or outpatient mental health and substance use treatment facilities. CMS is also proposing to add the Outpatient Behavioral Health category to the time and distance standards that CMS has previously finalized. CMS notes that it is proposing to combine these categories of clinicians/facilities to create a meaningful access standard.

While ASAM supports the aims of this proposal, ASAM reiterates, as it has through comments on other proposed rules, that behavioral health as a category is too broad to evaluate network adequacy for MH benefits and SUD benefits. Although some MA beneficiaries may have MH/SUD comorbidities, it is vital that network adequacy standards evaluate these benefits separately.

By way of example, consider the case of a MA beneficiary with an opioid use disorder (OUD). Under ASAM's National Practice Guidelines for the Treatment of Opioid Use Disorder, the established treatment protocol includes the use of one of three Food and Drug Administration (FDA) approved medications in combination with psychotherapy. If the beneficiary is in an MA network that can provide psychotherapy but is without a clinician who prescribes/dispenses medication for OUD, then that network is not truly adequate to meet the needs of the patient population it serves. The same would be true of an MA beneficiary who resides in a network with clinicians to meet biomedical needs, but without clinicians in-network to meet the beneficiary's psychological/psychiatric needs.

In essence, while grouping these professionals together to create a meaningful access standard is well-intentioned, it ultimately distorts the fact that people with a MH or SUD may have vastly different treatment needs. Additionally, it may create the false impression that MA networks have enough clinicians to treat both MH and SUD when research has shown that the United States has a shortage of both MH and SUD professionals.

Instead, ASAM recommends that, at a minimum, CMS separate the proposed Outpatient Behavioral Health category into two categories: one focused on Outpatient MH and the other focused on Outpatient SUD. In short, putting MH/SUD facilities into one "Outpatient Behavioral Health" category and not creating separate, outpatient MH and SUD categories could cover up shortages of critical MH and SUD providers and much-needed expertise. Furthermore, this is especially concerning in the context of MA plans since federal parity law does not apply to them.

In addition, to the extent CMS includes *individual* professionals in an Outpatient SUD/Behavioral Health "facility-specialty type" category, it needs to be more specific as to the skills, training, and expertise of those professionals by requiring their inclusion being contingent upon them regularly furnishing and submitting claims for SUD counseling or therapy services, including, but not limited to, psychotherapy or prescription of medication for SUD and them being specifically "licensed, accredited, or certified" to furnish SUD services.

Finally, ASAM finds it concerning that the proposal includes *individual* addiction medicine physicians in the proposed new "facility-specialty type" category, along with a wide variety of clinicians and facilities that may not provide essential biomedical services for SUD, including addiction medications (not limited to medications for opioid use disorder). Thus, ASAM urges CMS to track separately a "provider-specialty type" category of "Addiction Specialists" or "Addiction Medicine" that is defined as follows:

- Physicians who have one of the following medical subspecialty certifications that demonstrate and define expertise in addiction treatment:
    - Subspecialty board certification in addiction medicine by the American Board of Preventive Medicine (ABPM);
    - Subspecialty board certification in addiction medicine by the American Osteopathic Association (AOA);
    - Certification by the American Board of Addiction Medicine (ABAM); or
    - Subspecialty board certification in addiction psychiatry by the American Board of Psychiatry and Neurology (ABPN).

Time and Distance Standard for SUD

ASAM recommends shortening the time and distance standards for SUD to align with the corresponding qualified health plan (QHP) standards. Addiction is a chronic condition requiring ongoing treatment and monitoring. Last year, CMS established shorter (by approximately half) QHP time and distance standards for "Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)." ASAM encourages CMS to ensure that consistent time and distance standards apply across financing systems. The shorter time and distance standards for QHPs are more fitting for the frequent visits typically required of patients with SUD and especially considering transportation challenges faced by older and disabled Medicare beneficiaries. Finally, ASAM urges CMS to revisit the current 30-business day appointment wait time standard in MA plans for SUD, which also differs from the corresponding standard for QHPs and proposed for Medicaid managed care plans.

Thank you for the opportunity to provide comments and for the continued focus on bolstering treatment for mental health and substance use disorders for millions of Medicare beneficiaries. If you have any questions, please do not hesitate to contact Corey Barton, Director of Advocacy at cbarton@asam.org.

Sincerely,

Brian Hurley, MD

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