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Breaking Barriers. Defending Dignity.

May 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Request for Information on Medicare Advantage Data (CMS-4207-NC)

Dear Administrator Brooks-LaSure,

The Legal Action Center and the 22 undersigned organizations thank you for the opportunity to respond to the request for information on Medicare Advantage data collection (CMS-4207-NC). The Legal Action Center (LAC) is a non-profit law and policy organization that fights discrimination, builds health equity, and restores opportunities for people with substance use disorders, arrest and conviction records, and HIV/AIDS. LAC convenes the Medicare Addiction Parity Project, which seeks to improve access to substance use disorder services in Medicare comprehensively and equitably.

Approximately 5.7 million Medicare beneficiaries have a substance use disorder (SUD), though less than 1 in 4 received treatment in 2022.[1] Tragically, the rate of overdose deaths among adults ages 65 and older has quadrupled over the past two decades,[2] and Black men over the age of 65 are 7 times more likely to die from an overdose than their white peers.[3] Yet, even with progress in recent years, Medicare's coverage of SUD treatment is still inadequate, and legislative and regulatory changes are needed to close the outstanding gaps that prevent older adults and people with disabilities from getting the care they need. We are grateful to the Centers for Medicare & Medicaid Services (CMS) for continuing to engage with stakeholders to guide policymaking around Medicare Advantage (MA) plans, and we urge CMS to take this opportunity to improve data collection on access to SUD treatment and providers, and to use this data to continue to improve access to SUD treatment in both MA and traditional Medicare.

LAC engaged RTI International to conduct a claims analysis of SUD benefits in traditional Medicare and MA to better understand the extent to which traditional Medicare and MA plans

[1] "Medicare's Expanded Coverage of Substance Use Disorder Treatment: Important Progress and Recommendations to Fill Remaining Gaps," Legal Action Center (May 2024), https://www.lac.org/assets/files/2024-MAPP-Updates-Issue-Brief-share_Updated.pdf.
[2] Keith Humphreys & Chelsea L. Shover, "Twenty-Year Trends in Drug Overdose Fatalities Among Older Adults in the US," JAMA Psychiatry (Mar. 29, 2023), https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2802945.
[3] "Overdose Death Rates Increased Significantly for Black, American Indian/Alaska Native People in 2020," Centers for Disease Control and Prevention (July 2022), https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html.

are paying for specific SUD services.[4] The data showed that 3,750,809 Medicare beneficiaries had a primary or secondary SUD diagnosis recorded on their claims in 2020. This difference from the 5.7 million Medicare beneficiaries with a SUD according to the most recent National Survey of Drug Use and Health (2022) indicates that about 35% of beneficiaries with a SUD were undiagnosed, emphasizing the need for Congress and CMS to continue to expand Medicare's coverage of and access to SUD treatment. For calendar year 2020 (the most recent data available), more than half of Medicare beneficiaries with a diagnosed SUD (55.5%) were enrolled in MA plans, but beneficiaries in traditional Medicare were more likely to access SUD treatment for almost all types of services:

- More beneficiaries in traditional Medicare accessed hospital inpatient SUD treatment than MA enrollees (2% compared to 1.54%).
- More beneficiaries in traditional Medicare accessed hospital outpatient SUD treatment than MA enrollees (6.02% compared to 3.95%).
- More beneficiaries in traditional Medicare accessed partial hospitalization services than MA enrollees (0.23% compared to 0.10%).
- More beneficiaries in traditional Medicare accessed treatment in community mental health centers (CMHCs) than MA enrollees (0.2% compared to .06%).

For services covered under both traditional Medicare and MA plans, beneficiaries with SUD diagnoses accessed services at a higher rate than those with MA. In contrast, beneficiaries in MA were more likely to access intensive outpatient treatment (0.06% in MA compared to .01% in traditional Medicare), which was not covered in traditional Medicare until 2024; and residential SUD treatment (0.06% in MA compared to 0.03% in traditional Medicare), which still is not covered in traditional Medicare. This suggests that some MA plans may be offering some supplemental SUD benefits. The data also show that SUD treatment in Medicare is more skewed toward hospital settings (inpatient and outpatient) than community-based settings.

In addition to addressing the coverage limitations for SUD treatment in Medicare, collecting additional data from MA plans will be necessary to identify the causes behind these disparities. We therefore recommend CMS collect data on (1) network adequacy, (2) reimbursement rates and practices, (3) utilization management, (4) cost-sharing, and (5) supplemental benefits.

I. Network Adequacy

LAC appreciates CMS's commitment to improving network adequacy standards for mental health (MH) and SUD treatment in recent years, including the new categories for clinical psychology, clinical social work, and outpatient behavioral health. As we have noted in previous comments, we remain concerned that these categories collapse MH and SUD services into a single category, when these conditions – and their treatment – are not interchangeable. The lack of discrete data on network adequacy for each of these conditions is especially problematic given

[4] Tami Mark et al., "Gaps in Medicare Coverage of Substance Use Disorder Treatment: Medicare Fee-for-service and Medicare Advantage Claims Analysis Report," RTI International (Apr. 29, 2024), on file with the Legal Action Center.

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the U.S. Department of Health & Human Services Office of Inspector General's recent report,[5] finding abysmal rates of behavioral health provider participation and access to treatment in Medicare:

- Only about 1 in 3 behavioral health providers are actively participating in Medicare (29% in traditional Medicare and 33% in MA).
- There are fewer than 5 active behavioral health providers per 1,000 enrollees (2.9 in traditional Medicare and 4.7 in Medicare Advantage), and fewer than 2 who could prescribe medication (0.8 in traditional Medicare and 1.4 in MA).
- Rural counties have less than half of the number of active behavioral health providers as urban counties.
- Less than 5% of Medicare beneficiaries receive treatment from a behavioral health provider (4% in traditional Medicare and 3% in MA).

CMS also considered, but elected not to adopt, network adequacy standards for prescribers of medications for opioid use disorder (MOUD) in the CY24 MA rule. However, findings from another U.S. Department of Health & Human Services Office of Inspector General report reveal that access to MOUD remains consistently low, and disproportionate among beneficiaries of color:[6]

- Of the 1.1 million Medicare beneficiaries with an opioid use disorder (OUD) in 2022, only 18% received MOUD.
- Approximately 19% of white beneficiaries with an OUD received MOUD, compared to 15% of Black beneficiaries, 15% of Hispanic beneficiaries, and 11% of Asian/Pacific Islander beneficiaries.
- Black and Hispanic beneficiaries were more likely to receive methadone (7%) - which is only available at opioid treatment programs (OTPs) for OUD treatment - than white beneficiaries (5%) and Asian/Pacific Islander (4%) beneficiaries.
- Medicare beneficiaries without financial assistance for their Part D drug coverage were almost three times less likely to receive MOUD than those with financial assistance (9% compared to 26%).

LAC encourages CMS to adopt the recommendations outlined in these reports to improve network adequacy for SUD treatment, several of which could be incorporated into data collection requirements for MA plans. Recognizing these ongoing concerns and disparities in access, we recommend CMS collect discrete data on the networks of SUD providers in MA plans, specifically:

- Identify the number of active providers (those who submitted claims in the past six months) who prescribe MOUD per 1,000 enrollees, and the percentage of enrollees with an OUD who received MOUD (methadone, buprenorphine, and naltrexone);

[5] U.S. Department of Health & Human Services, Office of Inspector General, "A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care" (Mar. 2024), https://oig.hhs.gov/documents/evaluation/9844/OEI-02-22-00050.pdf.

[6] U.S. Department of Health & Human Services, Office of Inspector General, "The Consistently Low Percentage of Medicare Enrollees Receiving Medication to Treat Their Opioid Use Disorder Remains a Concern" (Dec. 2023), https://oig.hhs.gov/oei/reports/OEI-02-23-00250.pdf.

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- Identify the number of active providers who deliver outpatient SUD treatment per 1,000 enrollees, and the percentage of enrollees with an SUD who received outpatient SUD treatment;
- Identify the number of active facilities that deliver inpatient SUD treatment per 1,000 enrollees, and the percentage of enrollees with an SUD who received inpatient SUD treatment;
- Identify the number of active programs that deliver intensive outpatient (IOP) treatment for beneficiaries with a primary SUD diagnosis per 1,000 enrollees, and the percentage of enrollees with an SUD who received IOP;
- Identify the number of active programs that deliver partial hospitalization (PHP) treatment for beneficiaries with a primary SUD diagnosis per 1,000 enrollees, and the percentage of enrollees with an SUD who received PHP; and
- Identify the number of out-of-network claims for SUD treatment, by service type and provider/setting.

We believe this data will inform CMS on the adequacy of SUD networks in MA plans, and we encourage CMS to use this data to develop stronger network adequacy standards that ensure meaningful access to SUD treatment – separate and apart from MH treatment – for MA enrollees. The data will also inform CMS whether there are certain levels of care that are essentially unavailable to MA enrollees due to the lack of participating programs, which could help CMS identify ways to improve the benefit structure. This data may also provide insight into regions of the country where access to SUD providers is particularly lacking, such that CMS can identify appropriate incentives and opportunities to improve access where needed. We also encourage CMS to compare the adequacy of SUD networks – including comparing the rates at which enrollees need to go out-of-network[7] – to the adequacy of medical/surgical networks, which may suggest discriminatory plan design features that either need to be remedied under Section 1557, or which may require application of the Mental Health Parity and Addiction Equity Act to Medicare to fully resolve.

II. Reimbursement Rates and Practices

In its recent report, the U.S. Department of Health & Human Services Office of Inspector General noted that low payment rates, lengthy credentialing process, or a slow reimbursement process could be some of the reasons for the low rate of provider participation in both Medicare and Medicaid.[8] Accordingly, the report recommended CMS take steps to more accurately value and pay for MH and SUD services, increase payments to MH and SUD providers, and institute new requirements to increase transparency of payment rates.[9] LAC encourages CMS to adopt these recommendations, the latter of which could also be added to the data collection requirements for MA plans.

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[7] *See, e.g.*, Tami Mark & William Parish, "Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue," RTI International 11 (Apr. 17, 2024), https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf.

[8] *See* U.S. Department of Health & Human Services, Office of Inspector General, "A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care," *supra* note 5, at 10, 16.

[9] *Id.* at 16.

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Specifically, we recommend CMS collect the following data from MA plans:

- Identify the average, median, and lower and upper range of reimbursement rates, reported separately for different types of practitioners (or at least for physicians, non-physician medical practitioners (including physician assistants and nurse practitioners), psychiatrists, addiction medicine physicians, and non-physician MH/SUD practitioners (including psychologists, clinical social workers, MH counselors, and marriage and family therapists) as applicable) to the extent the rates differ, for the following services:[10]
    - CPT Code 99204 (E/M new patient office visit, 45-59 minutes)
    - CPT Code 99213 (E/M low-level established patient office visit, 20-29 minutes)
    - CPT Code 99214 (E/M mid-level established patient office visit, 30-39 minutes)
    - CPT Code 99215 (E/M high-level established patient office visit, 40-54 minutes)
    - CPT Code 90834 (psychotherapy, 45 minutes with patient)
    - CPT Code 90837 (psychotherapy, 60 minutes with patient)
    - OTP weekly bundled payment
    - IOP
    - PHP
- Identify the average, median, and lower and upper range of time between practitioners' initial request to join the MA plan and the completed contract, reported separately for different types of practitioners (or at least for physicians, non-physician medical practitioners, psychiatrists, addiction medicine physicians, and non-physician MH/SUD practitioners); and
- Identify the average, median, and lower and upper range of time between practitioners' submission of a claim and the issued reimbursement, reported separately for different types of practitioners (or at least for physicians, non-physician medical practitioners, psychiatrists, addiction medicine physicians, and non-physician MH/SUD practitioners).

We believe this data will provide valuable information to CMS on how reimbursement rates and administrative practices related to reimbursement affect access to SUD treatment for MA enrollees. We encourage CMS to compare these data points to the reimbursement rates, timeframe for credentialing, and timeframe for reimbursement in traditional Medicare. This data and the comparative analysis can be used to guide future rulemaking – both in traditional Medicare and in MA – to improve SUD provider participation, some of which may also require Congressional action to ensure that reimbursement rates are sufficient for all licensure and certification. The comparisons between addiction medicine physicians and psychiatrists to other types of physicians, and non-physician medical practitioners to non-physician MH and SUD practitioners, may suggest discriminatory plan design features that either need to be remedied under Section 1557, or which may require application of the Mental Health Parity and Addiction Equity Act to Medicare to fully resolve.

[10] Consistent with recent research on commercial health insurance disparities, we recommend evaluating reimbursement disparities by specific provider type, using a sufficient number of billing codes to capture the aggregate reimbursement paid to medical/surgical providers, and analyzing reimbursement at different percentiles to capture the incentives offered by carriers to some providers. *See* Tami Mark & William Parish, "Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue," *supra* note 7.

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III. Utilization Management

LAC commends CMS for its recent final rules to reduce the burdens of prior authorization in MA and to streamline prior authorization processes across health care financing systems. Nonetheless, prior authorizations and other utilization management practices are still a significant problem that prevent beneficiaries from getting the SUD treatment they need, and very few beneficiaries appeal when their treatment is initially denied. A report from the U.S. Department of Health & Human Services Office of Inspector General in 2022 found that 13% of MA plan denials of prior authorization requests actually met the Medicare coverage rules, meaning that those services would have been covered if the beneficiaries were enrolled in traditional Medicare.[11] Such denials prevent beneficiaries from getting medically necessary care or lead to significant delays as beneficiaries are forced to appeal. Another report from the U.S. Department of Health & Human Services Office of the Inspector General in 2018 found that few individuals (just 1%) take advantage of this opportunity to appeal, even though the vast majority of appeals (75%) result in the plan's initial decision being overturned in favor of the beneficiary.[12] A more recent report from KFF found that over 2 million prior authorization requests submitted to MA plans in 2021 (out of 35 million) were fully or partially denied, and only 11% of those denials were appealed, even though 82% of those appeals were at least partially overturned.[13]

In 2022, almost all MA enrollees (99%) were in plans that require prior authorizations for at least some SUD services, including 94% for inpatient stays in a psychiatric hospital, 92% for PHP, 85% for OTP services, 85% for MH therapy, and 83% for outpatient SUD services.[14] Another study found that 15% of MA formularies in 2021 required prior authorization for any immediate-release buprenorphine product and 17% required prior authorization for any extended-release buprenorphine.[15] Additionally, RTI International's claims analysis of SUD benefits in traditional Medicare and MA for calendar year 2020 found high rates of denials among MA plans for SUD treatment.[16] This analysis revealed that 45% of hospital inpatient settings claims with a primary SUD diagnosis billed to MA plans were denied, compared to 3% of traditional Medicare claims. There were also significantly more denials for hospital outpatient department claims with a primary SUD diagnosis in MA plans (11%) compared to traditional Medicare (2%). These

[11] U.S. Department of Health & Human Services, Office of Inspector General, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (Apr. 2022), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.
[12] U.S. Department of Health & Human Services, Office of Inspector General, "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials" (Sept. 2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.
[13] Jeannie Fuglesten Biniek, Meredith Freed & Tricia Neuman, "Gaps in Medicare Advantage Data Remain Despite CMS Actions to Increase Transparency," KFF (Apr. 10, 2024), https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-remain-despite-cms-actions-to-increase-transparency/.
[14] Meredith Freed, Juliette Cubanski & Tricia Neuman, "FAQs on Mental Health and Substance Use Disorder Coverage in Medicare," KFF (Jan. 18, 2023), https://www.kff.org/mental-health/issue-brief/faqs-on-mental-health-and-substance-use-disorder-coverage-in-medicare/.
[15] Emma E. McGinty et al., "US Payment Policy for Medications to Treat Opioid Use Disorder: Landscape and Opportunities," Health Affairs Scholar (Mar. 2024), https://doi.org/10.1093/haschl/qxae024.
[16] Tami Mark et al., "Gaps in Medicare Coverage of Substance Use Disorder Treatment: Medicare Fee-for-service and Medicare Advantage Claims Analysis Report," *supra* note 4.

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findings suggest a very troubling pattern of excessive utilization management practices for SUD treatment among MA plans, which we urge CMS to closely examine for future rulemaking.

Specifically, we recommend CMS collect the following data from MA plans:

- Identify the utilization management practices the plan uses for each SUD service or medication, including prior authorization, concurrent authorization, and retrospective review;
- Identify the number of denials, and the three most common reasons for denials, by SUD service and medication;
- Identify the number of appeals, by SUD service and medication;
- Identify the number of peer-to-peer reviews, by SUD service and medication; and
- Identify the number of overturned and partially overturned denials, by SUD service and medication.

We believe this data will provide valuable information to CMS on administrative barriers to SUD treatment in MA, and could be compared to denial, appeal, and outcome rates in traditional Medicare to guide future rulemaking on other processes that should be eliminated or streamlined to remove these unnecessary treatment barriers. Additionally, the reasons for the denials of SUD treatment may help inform future rulemaking or opportunities to work with Congress to improve access to care. For example, if treatment is frequently denied as a non-covered benefit (such as residential treatment) or a non-covered setting (such as community-based SUD treatment facilities other than OTPs), CMS can leverage this information to encourage Congress to expand Medicare coverage to meet the needs of older adults and people with disabilities with SUD. Alternatively, if treatment is most frequently denied due to lack of medical necessity, then CMS may need to reevaluate how its traditional Medicare coverage criteria align with the American Society of Addiction Medicine (ASAM) Criteria, or impose stronger guardrails on the internal criteria that MA plans use when coverage criteria in traditional Medicare are not fully established. *See* 42 C.F.R. 422.101(b). We also encourage CMS to compare the utilization management practices and related outcome data for SUD benefits to those for medical/surgical benefits, which may suggest discriminatory plan design features that either need to be remedied under Section 1557, or which may require application of the Mental Health Parity and Addiction Equity Act to Medicare to fully resolve.

IV. Cost Sharing

While beneficiaries in traditional Medicare are exempt from cost-sharing requirements for OTP services, a recent study found that 57% of MA enrollees were in plans that required a co-pay for OTP-based MOUD.[17] These weekly costs add up quickly for enrollees, especially when compounded by the financial burden of transportation and other costs associated with accessing regular treatment. As a result, LAC has heard from OTP providers that Medicare beneficiaries with OUD may be forced to make an impossible "choice" between getting affordable OUD treatment (in traditional Medicare) or getting affordable dental, vision, and other supplemental benefits (in MA plans). Moreover, to the extent that MA enrollees have to get more of their SUD treatment out-of-network due to the low rates of provider participation and network adequacy

[17] *See* Emma E. McGinty et al., *supra* note 15.

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issues described in Section I, we encourage CMS to collect additional data to measure the financial burden this imposes on beneficiaries.

To analyze and meaningfully address these disparities, we recommend CMS collect the following data from MA plans:

- Identify the cost-sharing requirements (co-pay and coinsurance) by SUD service and medication;
- Identify the average, median, and lower and upper range of annual out-of-pocket spending on SUD benefits; and
- Identify the average, median, and range of the difference in beneficiary cost-sharing between out-of-network claims for SUD treatment and what the cost-sharing would have been if the service were provided in-network, by service type and provider/setting, for plans with out-of-network coverage.

We believe this data will help CMS understand the financial burdens imposed on MA enrollees who need SUD treatment. We encourage CMS to compare these cost-sharing amounts to those in traditional Medicare, and to use those disparities to guide future rule-making and MA plan guidance to make SUD treatment more affordable and accessible. For example, data may support anecdotal reports that the cost-sharing requirements for OTPs make treatment unaffordable for enrollees without supplemental coverage or the low-income subsidy. To remedy this problem, CMS should consider requiring MA plans to remove all cost-sharing for OTPs, aligning MA requirements with traditional Medicare for OTPs. If the data suggests that office-based SUD treatment or medications require high out-of-pocket costs that interfere with access to care, then CMS should work with Congress to remove cost-sharing requirements for such benefits. We also encourage CMS to compare the cost sharing for SUD benefits to that for medical/surgical benefits, which may suggest discriminatory plan design features that either need to be remedied under Section 1557 or which may require application of the Mental Health Parity and Addiction Equity Act to Medicare to fully resolve.

V. Supplemental Benefits

LAC appreciates CMS's efforts in recent years to collect new data from MA plans on the use of and spending for supplemental benefits. We encourage CMS to collect demographic data (such as race and ethnicity, gender, gender identity, age, disability status, dual-eligibility status, and receipt of low-income subsidy) related to the use of these supplemental benefits, to ensure that all enrollees have equitable access to these benefits, consistent with CMS's health equity goals. To the extent that certain benefits are widely utilized and improve health outcomes, we encourage CMS to identify ways to make them more meaningfully available to all enrollees, as well as beneficiaries enrolled in traditional Medicare.

* * * * *

Thank you for considering our recommendations to improve data collection for MA plans. We look forward to continuing to work with you to improve access to SUD treatment for Medicare beneficiaries. Please contact Deborah Steinberg at the Legal Action Center, dsteinberg@lac.org with any questions.

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Sincerely,

Legal Action Center
American Association for the Treatment of Opioid Dependence (AATOD)
American Counseling Association
American Society of Addiction Medicine (ASAM)
Camden Treatment Associates
Edwin C Chapman MD PC
Families USA
FOR-NY
JSAS HealthCare Inc.
Justice in Aging
The Kennedy Forum
National Association for Behavioral Healthcare (NABH)
National Association of Addiction Treatment Providers (NAATP)
National Association of Social Workers (NASW)
National Health Law Program
National Rural Health Association
New Jersey Association of Mental Health and Addiction Agencies, Inc.
Partnership to End Addiction
RCCD Inc. DBA Morris and Sussex County Aftercare Centers
Resource Center for the Chemically Dependent
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