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The Honorable Chiquita Brooks-LaSure  
U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services (CMS)

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

Dear Administrator Brooks-LaSure:

The American Psychiatric Association (APA), the national medical specialty society representing over 38,000 psychiatric physicians and their patients, appreciates the opportunity to comment on the proposed rule: [Medicaid Program; Ensuring Access to Medicaid Services](#) (the “access NPRM”). APA supports the Administration’s desire to strengthen Medicaid and improve access to and the quality of care provided. We appreciate the Administration’s efforts to address access-related challenges that impact how beneficiaries are served by Medicaid across all its delivery systems.

APA supports applying timeliness standards to fully fee-for-service (FFS) States that closely mirrors the proposed appointment wait time standards, secret shopper survey requirements, and publication requirements (as applied to outpatient mental health and substance use disorder, adult and pediatric; primary care, adult and pediatric; obstetrics and gynecology; and an additional type of service determined by the State, as proposed in [Medicaid Program; Medicaid and Children's Health Insurance Program \(CHIP\) Managed Care Access, Finance, and Quality](#) “managed care proposals”).

APA also supports CMS’s efforts to improve access to services in Medicaid by rescinding the requirement that states submit and update access review monitoring plans (ARMP) and instead requiring States to make all FFS Medicaid payment rates public and accessible on a state website and, similar to the managed care proposals, requiring states to report their state Medicaid rates relative to Medicare FFS rates for certain services, including all outpatient behavioral health.

We are concerned that inpatient behavioral health services will not be included in the comparative payment rate analysis. While this topic is not being addressed here, payment rates for inpatient psychiatric services need more exploration. Access to inpatient psychiatric care is extremely difficult. Too often, psychiatric inpatient beds are not available when needed and people with mental illnesses end up boarding in emergency departments or being discharged prematurely. Many inpatient hospitals are struggling to stay in operation due to low reimbursement rates and costly

administrative burdens.<sup>1,2</sup> Medicaid fee for service rates rarely cover hospital costs for most services in most states. According to a study conducted by the Massachusetts Attorney General’s Office<sup>3</sup>:

Among 18 general acute care hospitals that reported inpatient behavioral health margins for commercial and government business from 2010 to 2013 - including academic medical centers, teaching hospitals, community hospitals, and disproportionate share hospitals across all geographies - the cumulative margin for all these hospitals over those four years was negative 39%.

**We recommend CMS reconsider and include inpatient behavioral health services in their comparative rate setting analysis. We urge CMS to look more closely at inpatient rates and their impact on access to care.**

As we noted in our comments on the managed care proposals, in the case of low rates, CMS should require states to take corrective action, especially when networks are determined to be inadequate. Reimbursement rates are a critical component of building a network and low rates can discourage clinicians from joining networks and ultimately harm access.<sup>4</sup> Reimbursement rates are, however, not the only factor that discourages psychiatrists from caring for Medicaid patients. As one of our members wrote to us:

*“Not accepting Medicaid in a solo practice is more complex than just reimbursement rates, and higher payment rates would not simply change my mind. These are typically complex and socially disadvantaged individuals that require a team approach to care. The amount of time required to manage social and disability matters, prior authorization items, and the high rates of no-shows for appointments all result in large amounts of un-reimbursed time.”*

Aligning Medicaid reimbursement rates so that they are at a minimum on par with Medicare rates and decreasing administrative burdens/paperwork could help to enlist and retain more clinicians. Clinicians should have streamlined access to State covered Care Management and Care Coordination services offering a functional equivalent of a “virtual back office”. The focus on clinician ease of network use and access should be as much a priority as corresponding ease of access for clients. For example, standardized and centralized credentialing for clinicians that agree to work within a State Medicaid system could simplify entry and retention even as plans enter and exit markets. Collecting payment should not be measured only by comparison to other plans – but to collecting a cash payment. Rates need to be

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<sup>1</sup> APA Report on “The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions”, May 2023. <https://www.psychiatry.org/getmedia/81f685f1-036e-4311-8dfc-e13ac425380f/APA-Psychiatric-Bed-Crisis-Report-Full.pdf>

<sup>2</sup> NABH Report on “The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities”, May 2023. DOI: <https://www.nabh.org/the-high-cost-of-compliance/>

<sup>3</sup> Examination of Health Care Cost Trends and Cost Drivers, Massachusetts Attorney General's Office, June 30, 2015.

<sup>4</sup> On average, Medicaid paid psychiatrists at 81% of the Medicare rates. Reimbursement For Psychiatric Services: Comparisons Across States And With Medicare. Health Affairs. April 2023. <https://doi.org/10.1377/hlthaff.2022.00805>. Accessed June 12, 2023.

equitable across settings and the full continuum of care must be available and reimbursed.<sup>5,6</sup> Psychiatrists in private practice report a reluctance to accept Medicaid patients in part because the patients may require additional support the clinician is not able to provide in their practices, such as case management, housing assistance, and wrap around services. Creation of novel programs to fill those gaps should be considered. We also urge CMS to adopt stronger prior authorization standards that reduce the demand for prior authorization, such as not requiring prior authorization until a clinician fails to meet clearly defined national standards. We also urge CMS to mandate the use of consistent medical necessity standards, such as LOCUS or ASAM, which will standardize practices and reduce administrative burden for the inpatient services – while still allowing for meaningful outcome-focused feedback from payers.

Recognizing that most individuals seek care in primary care, APA encourages CMS to incentivize State Medicaid programs to encourage adoption of the Collaborative Care Model (CoCM), the population-based approach that improves behavioral health outcomes in primary care settings including in FQHCs and RHCs. Supporting sustainable levels of Medicaid reimbursement for this model of care within primary care could not only improve access but also the quality of care and serve to prevent long-term costs through prevention and early intervention. Incentivizing adoption of the model through enhanced reimbursement and implementation support has been shown to be an effective strategy available to payers as noted in a 2020 Psychiatric News article on Blue Cross Blue Shield of Michigan’s approach to improving access and quality of care and a May 2023 report from Meadows Mental Health Policy Institute, Improving Behavioral Health Care for Youth Through Collaborative Care Expansion, that features ongoing initiatives to incentivize adoption of CoCM in the adolescent population in New York, North Carolina, Texas and Washington.<sup>7,8</sup>

CMS should also assist the States in developing more effective and state-to-state consistent methods of primary care attribution to behavioral health clinicians that readily demonstrates prospective value of closer integration of behavioral health services into care continuum. Doing so would promote a “seat at the table” and an appropriate share of shared savings from innovative value-based contracts. This requirement could be included in the upcoming RFA on Making Care Primary (MCP) Initiatives that is said to promote better integration of social and behavioral health services in the primary care continuum. (<https://innovation.cms.gov/innovation-models/making-care-primary>)

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<sup>5</sup> In 2017, commercial insurance reimbursement rates for primary care were 23.8% higher than that for behavioral health, which is an increase from 20.8% higher in 2015.

Melek, Steve, Davenport, Stoddard, Gray, T.J. “Addiction and Mental Health vs Physician Health: Widening Disparities in Network Use and Provider Reimbursement.” October 2019. <https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p> . Accessed June 12, 2023.

<sup>6</sup> Battling The Mental Health Crisis Among The Underserved Through State Medicaid Reforms, Health Affairs. February 10, 2020. <https://www.healthaffairs.org/doi/10.1377/forefront.20200205.346125>. Accessed June 11, 2023.

<sup>7</sup> Richmond, Linda. “Payors Train PCPs to Treat Mental Health in House.” Psychiatric News, 30 November 2021, <https://doi.org/10.1176/appi.pn.2021.11.4> . Accessed June 15, 2023.

<sup>8</sup> Meadows Mental Health Policy Institute. “Improving Behavioral Health Care for Youth Through Collaborative Care Expansion” [https://mmhpi.org/wp-content/uploads/2023/05/Improving-Behavioral-Health-Care-for-Youth\\_CoCM-Expansion.pdf](https://mmhpi.org/wp-content/uploads/2023/05/Improving-Behavioral-Health-Care-for-Youth_CoCM-Expansion.pdf). May 2023. Accessed June 14.

## **Standardized reporting for Home and Community Based Standards (HCBS)**

CMS has excluded 1905(a) services from several of the proposed policy changes related to home and community-based services. **We urge CMS to remedy that by revising the requirements to include 1905(a) services that serve people with mental health and substance use conditions.** This includes:

- Requiring person-centered planning requirements to case management services.
- Allowing beneficiaries to access the grievance system for concerns about person-centered planning.
- Require incident management and reporting to case management services for any incident that occurred while receiving any 1905(a) service.

We urge CMS to work closely with the ONC around interoperability from a user-centered perspective. This is especially important to improve continuity of care and care transitions. For example, Medicaid beneficiaries and programs that serve them would benefit from standardized flags to be included in data sets and dictionaries that transfer between settings and insurers to help efficiently match individuals to services. Plans and clinicians often need to wait for 12-18 months to accumulate sufficient claims history or rely on self-reports of variable accuracy to stratify risk and allocate appropriate supportive services to patients. Once a plan changes, all the detailed understanding of a person's needs are reset. Suicide risk does not disappear when a plan changes, nor should the corresponding risk score. This ends up creating multiple lost opportunities to prevent the worst possible outcomes, especially with statistically relatively rare but dire events such as suicide attempt risk. The exclusion of any data would only make such work more challenging. Crypto keys or other tools can be used to allow individual to "own" their own data but inability to match need to resources can also explain underutilization of some more specialized HCBS services for example.

## **Medicaid Advisory Committee/Beneficiary Advisory Group**

APA supports CMS's proposed changes to the Medical Care Advisory Committee. **We urge CMS to encourage the inclusion of psychiatrists, their patients, and family/caregivers on the state Medicaid Advisory Committee given the large number of Medicaid patients with mental health and substance use orders.** Inclusion of these parties is critical to ensuring beneficiaries' access to quality healthcare. We support CMS' proposals to ensure beneficiary engagement with and annual reporting/transparency of both the Medicaid Advisory Committee and the Beneficiary Advisory Group.

## **Health Equity**

If finalized, this rule will strengthen the implementation and enforcement of necessary services across all eligible groups in every state. APA applauds CMS's commitment to addressing health equity across its programs. Identifying health disparities and addressing gaps in care are important goals. In recent decades, research has made clear that social factors are the dominant contributors to mental illness and morbidity and drive enormous inequities in health and mental health. The prevalence of COVID-19, has disproportionately impacted individuals from marginalized communities and those with serious mental

illnesses (SMI) or substance use disorder (SUD) who are at greater risk of infection due to social determinants of health (SDOH) factors,<sup>9</sup> and has exacerbated these same determinants,<sup>10</sup> and worsened them in populations where racism is endemic.<sup>11</sup>

APA urges CMS to support increased funding for research to better understand the mechanisms by which long term structural and social determinants, as well as emerging and more immediate disaster and climate emergency related factors, affect mental illness and recovery and to develop and disseminate evidence-based and interventions to promote mental health equity and address the social and mental health needs of patients and their families. This includes identifying and testing screening tools/assessments used for data collection; further refining the list of SDOH; as well as exploring innovative models integrating SDOH and resiliency-vulnerability factors impacting specific communities such as newly displaced, culturally and socially isolated or disproportionately impacted.

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

Sincerely,

A handwritten signature in blue ink that reads "Saul Levin" with "M.D., M.P.A." written in smaller text below it.

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

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<sup>9</sup> Shim, Ruth S, and Steven M Starks. "COVID-19, Structural Racism, and Mental Health Inequities: Policy Implications for an Emerging Syndemic." *Psychiatric services (Washington, D.C.)* vol. 72,10 (2021): 1193-1198. doi:10.1176/appi.ps.202000725

<sup>10</sup> Bernardini, Francesco et al. "Social Determinants of Mental Health As Mediators and Moderators of the Mental Health Impacts of the COVID-19 Pandemic." *Psychiatric services (Washington, D.C.)* vol. 72,5 (2021): 598-601. doi:10.1176/appi.ps.202000393

<sup>11</sup> Jeste, Dilip V, and Vivian B Pender. "Social Determinants of Mental Health: Recommendations for Research, Training, Practice, and Policy." *JAMA psychiatry* vol. 79,4 (2022): 283-284. doi:10.1001/jamapsychiatry.2021.4385