

May 20, 2024

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services (CMS)  
7500 Security Boulevard  
Baltimore, MD 21244

Re: Medicare Advantage Quality Bonus Payment Program

Dear Administrator Brooks-LaSure:

Mental Health America (MHA) – founded in 1909 – is the nation’s leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the mental health of all. With nearly 200 affiliate organizations in 41 states, our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services, early identification, integrated care, behavioral health services, and supports.

We urge CMS to modify the Medicare Advantage Quality Bonus Payment Program and the underlying star ratings measures that are the basis for the bonuses received by Medicare Advantage (MA) organizations. Currently, the Part C domains and measures provide no scoring and no insight on enrollees’ ability to access mental health and substance use disorder care in their MA plans. Further, the underlying methodologies that underpin the scores are clearly leading to score inflation that far too frequently results in every plan being graded as above average. CMS must fundamentally rework both the measures in the Part C domains and the way scores are calculated.

### **Background**

Access to mental health and substance use disorder care is of paramount importance given the country’s worsening mental health crisis and dire opioid epidemic. Prospective MA enrollees should have some way of evaluating their ability to access mental health and substance use disorder care in an MA plan, particularly those with serious mental illness who are under 65 and enrolled in Medicare due to disability status. Many of these individuals are eligible for MA special needs plans (SNPs) but have no way of knowing if any plan in question has meaningful access to mental health providers and facilities, and neither do enrollees ages 65 and above selecting from the many MA plan offerings.

There is clear evidence that many MA plans do not have adequate access to mental health care. A [recent study](#) found that almost two-thirds of MA plans had fewer than 25 percent of available psychiatrists in the network service area. This was significantly lower than what was found in Medicaid managed care and ACA plans. Further, this trend was not observed with any other physician specialty type in MA plans indicating that access to mental health treatment was substantially worse than access to other medical care.

And this only tells part of the story. A [secret shopper survey](#) conducted last year by the Senate Finance Committee found that over 80% of mental health providers listed in MA plans’ networks were not actually available. Some could not be reached due to inaccurate phone numbers or unresponsiveness. Some were not accepting new patients. And some were not actually participating in the network despite being listed in the plan directory. Regardless, this indicates that these networks exist largely on paper only and in reality are ghost networks.

While these statistics reflect a need for broad improvement across the entire landscape of MA plans, clearly there are some MA plans that do have better access to mental health care than most MA plans. For example, the Senate Finance report found a wide range of performance with some plan directories at 80% accuracy and others with 20%. Consumers should have some way of knowing which plans do have better access to care and that is exactly the kind of information one would hope could be reflected in the Part C star ratings measures. In addition, bonus payments should reward the better plans instead of treating them the same.

### **New Part C Domain**

We propose that CMS add a new Part C domain that addresses access to mental health and substance use disorder treatment. While there are many distinct measures that could be included in this new domain, there are several concepts that should be contemplated, all exclusive to mental health and substance use disorder providers.

The first area for measurement is the accuracy of MA plans' mental health and substance use disorder provider directories. At the very least, there should be a measure that evaluates whether the providers listed actually participate in the network and if the contact information provided is correct. This is a foundational component of being able to access care. If many or most mental health and substance use disorder providers listed in an MA plan's network aren't reachable or aren't really in the plan's network, it will be very difficult for enrollees to access care. This is especially the case for the roughly 60% of MA enrollees whose plans [don't cover](#) out-of-network services.

A related metric would be the percentage of providers listed in the network that had submitted zero claims in the previous six months. A high percentage would demonstrate that an MA plan had a misleading network and poorer access to care than what would appear by looking at the directory.

Average wait times for appointments with providers is another key metric that may be the very best measure of enrollees' ability to access mental health and substance use disorder care. Even if most providers in the network are reachable and they do in fact participate in the MH plan's network, long average wait times would indicate that the network's performance is poor, regardless of the on-paper appearances.

Another metric to consider is the percentage of providers who are accepting new patients or clients. While this may seem to overlap with some of the previous metrics, it is a distinct indicator of access to care within an MA plan network. A plan could have a very low percentage of inaccuracy in its directory. The plan could also have very few providers who have not submitted any claims in the previous six months. The average wait times for the plan could be relatively reasonable and not unduly lengthy. However, those circumstances could exist under scenarios where many of the providers are not taking new patients. Given that the demand for mental health and substance use disorder services is so great, and many providers do not take Medicare, there could be a considerable number of providers in an MA network who are accessible to their existing patient or clients but who simply do not have the capacity to take on any new patients or clients. This could be measured by examining the percentage of providers who had not submitted claims with new patients in the most recent six months compared to claims submitted in the six months prior to that.

Access to follow-up care after an initial appointment could be a final key indicator of whether an MA plan's network has the capacity necessary to meet the mental health and substance use disorder treatment needs of its enrollees. Access to initial care is of course vital, but if screening and diagnosis take place, or just screening alone, and there is no additional treatment that likely indicates that enrollees are not getting the services they need. Yes, there will be instances when this is enrollee-driven, but this should remain

constant across plans so if a plan has a high percentage of enrollees receiving no follow-up care compared to others, poor network performance and capacity are a likely culprit.

### **Score Inflation**

Others [have examined](#) the issue of score inflation within the Quality Bonus Payment Program and its underlying star rating measures in much greater depth so we will not go into great detail on this point other than to vigorously agree with their conclusions. Any “bonus” program is fundamentally skewed when the vast majority of enrollees (85%) are in plans that receive a bonus.

Further, the total amount of bonus payments has [more than quadrupled](#) in the last 8 years, going from \$3 billion in 2015 to (projected) \$12.8 billion in 2023. Have patient outcomes and experiences also improved four-fold in that time? That would seem to be the only logical reason why “quality” bonuses would increase by that amount.

Additionally, in the history of the program, no plans have ever received a score below 2 and a vanishingly small number have received scores below 2.5. A score of 2.5 is the supposed midpoint in the rating system, but everyone is above that point. In other words, every plan is above average. Any scoring system that rates everyone as being above average likely needs substantial rethinking.

### **Prior Authorization Appeal Overturn Rates**

Finally, we strongly agree with the proposed change recommended by the Federation of American Hospitals that suggests that the star ratings should have metrics based upon the frequency with which MA plans’ initial prior authorization denials are overturned on appeal. High appeal overturn rates on prior authorization denials likely indicate that there were underlying errors or misapplied processes in place during either the design of the prior authorization protocols or in their operationalization. Regardless of why, this can be a huge problem for consumer access to care and one that will not be rectified for most as very few individuals actually appeal denials under any payer. Incorrectly denying prior authorizations for medically necessary care undermines “quality”. This absolutely should be part of the equation in determining the star ratings and the associated bonuses.

Thank you for considering these recommendations to economically incentivize better access to mental healthcare in the Medicare Advantage program. For questions or further information, please contact Tim Clement at [tclement@mhanational.org](mailto:tclement@mhanational.org) or Mary Giliberti at [mgiliberti@mhanational.org](mailto:mgiliberti@mhanational.org).

Sincerely,

A handwritten signature in black ink that reads "Mary Giliberti". The signature is written in a cursive, flowing style.

Mary Giliberti

Chief Public Policy Officer  
Mental Health America  
[mgiliberti@mhanational.org](mailto:mgiliberti@mhanational.org)



*Tim Clement*

Tim Clement

Vice President of Federal Government Affairs  
Mental Health America  
[tclement@mhanational.org](mailto:tclement@mhanational.org)