AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

October 18, 2019

Gabe Roberts, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

RE: Notice of Change in TennCare II Demonstration: Amendment 42

Dear Mr. Roberts,

On behalf of the Tennessee Psychiatric Association, the medical specialty society representing 320 psychiatric physicians in the state, and the American Psychiatric Association (APA), the national medical specialty society representing more than 38,500 psychiatric physicians nationwide, we write with concern about the proposed amendment to the TennCare II Demonstration (Amendment 42). We are especially concerned that the Director's intention to convert the bulk of TennCare's federal funding to a block grant will limit access to quality care for Medicaid patients, particularly those with mental health and substance use disorders (MH/SUDs). ***The APA has historically opposed Medicaid block grants, and we strongly urge you to withdraw the proposal.***

Parity Compliance and Program Integrity Concerns for Medicaid Managed Care Programs

Among our major concerns is Amendment 42's proposal to provide the state with "relief from the federal requirements at 42 CFR Part 438 (concerning Medicaid managed care programs) in order to have the flexibility necessary to structure its managed care service delivery system in a manner that meets the needs of state residents and optimizes effectiveness and efficiency of operation." The proposal delineates a non-exhaustive list of what are characterized as unnecessary federal requirements that Tennessee wants waived, including "arbitrary restrictions on the ability of managed care contractors operating fully at-risk to provide a full continuum of care for members with mental health or substance use disorder treatment needs." ***We strongly oppose allowing TennCare to waive compliance with 42 CFR Part 438, which has operationalized the statutory requirements for the Medicaid program in a number of ways that are especially significant for patients with MH/SUD conditions.***

42 CFR Part 438 Subpart K explicitly applies the Mental Health Parity and Addiction Equity Act (MHPAEA) compliance regulations to Medicaid managed care organizations (MCOs) and its nondiscrimination protections for patients with mental

health and/or substance use disorder conditions.[1] The regulations explicitly require that key program features, such as capitation rates and the scope of covered benefits, be MHPAEA compliant. These can indirectly be discriminatory and affect the scope and duration of services available for this population. Additionally, it is worrisome that the state is also asking for the flexibility to make changes to its benefits package. ***Without the requirements of parity compliance, we are concerned that services for the most chronically ill and complex patients would be scaled back.*** It is unclear from the text whether Subpart K is deemed an unnecessary federal requirement and within the scope of the contemplated provisions under 42 CFR Part 438 that Tennessee seeks relief.

These patient protections are essential since the very nature of treatment for this patient population is complicated by chronic needs and the stigma surrounding their illness. For example, addiction is a complex brain disease and seeking treatment can take several attempts. According to the National Survey on Drug Use and Health, only 12 percent of the nearly 20 million adults in America who needed SUD treatment received treatment in 2018.[2] These very complications have served as the basis of the historically discriminatory policies and practices of MCOs, which have unduly limited treatment for these populations and the very reason MHPAEA was enacted. To undermine its requirements would be an incomprehensible undermining of federally guaranteed patient access protections.

An additional area of fundamental concern is the 438 requirements concerning network adequacy and how they fit within the context of the proposal. ***Network adequacy is foundational for the Medicaid program and is reflective of a key federal law requirement, the so-called "equal access provision."*** This provision requires states to reimburse health care providers at a rate that is low enough to ensure efficiency and economy, yet high enough to attract a sufficient number of providers to ensure enrollees have access to health care services to the same extent they are available to the general public in the same geographic area.[3] A state's Medicaid plan must provide such assurances in writing. The Medicaid statute also requires that MCOs comply with "[s]tandards for access to care so that covered services are available within reasonable time frames and in a manner that ensures continuity of care and adequate primary care and specialized services capacity".[4] ***How these required protections would be assured remains opaque under the proposal, and a key basis for our recommendation that it be withdrawn.***

The fact that the proposal's non-exhaustive listing in this section is not definitive is a major source of concern for us, given the scope and content of 42 CFR 438. ***Regardless of the lack of waiver clarity, we oppose any approach whereby the state would be granted sole authority to determine if it is in***

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[1] Code of Federal Regulations: Part 438 – Managed Care. Centers for Medicaid and Medicare Studies, October 1, 2017. https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol4/xml/CFR-2017-title42-vol4-part438.xml

[2] Substance Abuse and Mental Health Services Administration. (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/ http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FFR2-2016.htm

[3] (42 U.S.C § 1396a(a)(30)(A)) - The Public Health and Welfare Chapter 7 - Social Security Subchapter Xix - Grants To States For Medical Assistance Programs.

[4] Social Security Act § 1932(c)(1)(A)(i); see also id. § 1932(b)(5

compliance with federal law. There is a defined statutory basis for the current regulations. 42 CFR Part 438 is grounded in the directive of Section 1902(a)(4) and other sections of the Social Security Act. It requires that states provide for methods of administration that the Secretary finds necessary for proper and efficient operation of the State plan and for which the Secretary is ultimately responsible, given that federal expenditures are at issue. The Amendment text does not delineate how the state would ensure compliance with the range of essential Part 438 requirements. To cede the federal responsibility and required oversight codified in federal law is unwarranted in our view.

Lastly, we are concerned that the state's request to eliminate federal oversight on healthcare delivery may have the unintended consequence of weakening patient safeguards and health standards. Under the current TennCare Managed Care program, contractors and providers are expected to meet certain standards to protect patient access. However, Amendment 42 outlines that the state could choose to alter its delivery system in the future without needing to submit an amendment to CMS for approval. For example, in an effort to save money, the state could decide that TennCare will limit the number of days an individual can receive inpatient care, which may not be in a patient's best interest or in line with clinical guidelines. Additionally, in attempting to control costs, MCOs often create new issues of access by imposing burdensome prior authorization requirements, implementing utilization limitations, and creating limited provider networks. Not only could these policy decisions impact patient outcomes and result in poor care, but they often raise costs by placing the burden of care elsewhere. Currently, due to the limited number of inpatient psychiatric beds, more psychiatric care is taking place in emergency departments that are often ill-equipped to handle mentally ill patients.[5] ***Eliminating these protections would represent a significant and unwarranted undermining of federal law, which was designed to eliminate discriminatory benefit access practices, and could have a catastrophic impact on an already vulnerable patient population.*** If this is not the intent, it needs unequivocal clarification and an exact delineation of the protocols and policies utilized that will ensure consistency with MHPAEA compliance.

Drug Formulary Impacts on Patients with Mental Illness and Substance Use Disorders

Amendment 42 seeks to give the state authority to implement drug formulary management tools in an effort to manage prescription drug spending without federal oversight. "The state proposes that it have the flexibility under this demonstration to adopt a commercial-style closed formulary with at least one drug available per therapeutic class." This proposal would mean that the drug formulary would not need to comply with Section 1927(d)(4) of the Social Security Act and would be particularly harmful for our patients. ***The drug formulary could no longer be required to have clinical input or all necessary medications.*** It is essential to acknowledge that individual drugs within the therapeutic classes used to treat psychiatrically ill patients have very different clinical indications, mechanisms of action, and side effect profiles. Drug prescribing is therefore complicated, given the nature of drug in the classes for the treatment of psychiatric disorders. These drugs are not clinically interchangeable. No two psychotropic medications have the same therapeutic effect or identical duration and intensity characteristics.

[5] Nordstrom, Kimberly et al. "Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document." Western Journal of Emergency Medicine, September 2019. https://escholarship.org/uc/item/71z0q1n8

Many mental illnesses are chronic, lifelong conditions with both acute and stable phases characterized by a broad array of symptoms, even among patients who have the same or similar diagnoses. If these mental illnesses go untreated, or are inappropriately treated, a patient's risk of hospitalization, persistent or significant disability, or death is heightened. Although this is particularly true when a patient needs treatment for acute symptoms like suicidality or psychosis, it is also of concern during his/her ongoing "maintenance" treatment. Clinical evidence from population-based studies clearly indicates that the risk of suicide attempts and completed suicide increases for patients with any psychiatric disorder, and this risk can increase exponentially for patients who suffer from disorders like depression and anxiety, who are unable to access the antidepressants that can control their symptoms. It has been widely recognized that doctors need to have complete discretion to prescribe the most appropriate medicines for patients with these and other conditions addressed by the protected classes. Removing these critical protections may have dire health consequences for beneficiaries.

A 2011 study by the American Psychiatric Institute for Research and Education studied how limited access to preferred medications impacted Medicaid patients receiving Medicare prescription drug benefits (dual eligibles).[6] These patients, who were previously stable on their medications, had to switch medications because clinically-indicated refills were not covered or approved. They also experienced significantly higher adverse events (62% versus 37%), including emergency department visits, hospitalizations, homelessness, and incarceration. ***The potential savings Medicaid could realize by limiting its drug formulary would be offset by the increased costs in other areas of the program and for society in general that are created by the clinical harms that will result from delaying, limiting, or denying vulnerable patients' access to these medications.***

The Direct Impact of the Block Grant on Tennessee Residents

Amendment 42 highlights the opportunities for cost savings to the state and the federal government as its signature goal, but it is not clear how the savings would be achieved. As written, the proposal mandates no reductions in who is eligible for TennCare, meaning that the state would likely rely on scaling back the amount of care and services enrollees are eligible to receive through the mechanisms we previously outlined to achieve Governor Lee's projected savings of $2 billion in a year.

TennCare currently covers 1.4 million of Tennessee's most vulnerable citizens, including half of the state's children.[7] These proposed changes in Medicaid financing are especially troubling, as we consider their potential impact on individuals with mental health and substance use disorders. Due to the nature of their illness, these patients already face several barriers to care, such as not having stable housing, shortages in inpatient hospital beds, or living in rural areas with limited providers.[8] They also often have co-occurring

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[6] Clinically Unintended Medication Switches and Inability to Prescribe Preferred Medications Under Medicare Part D. West JC, Rae DS, Mojtabai R, Rubio MS, Kreyenbuhl JA, Alter CL, Crystal S. Journal of Psychopharmacology; 2011, June 21.

[7] https://www.tn.gov/tenncare/information-statistics/tenncare-overview.html

[8] "The Doctor is Out: Continuing Disparities in Access to Mental and Physical Health Care." National Alliance on Mental Illness, November 2017. https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut.pdf

physical conditions, and research shows that patients with serious mental illnesses die years earlier than the general population, with the majority of them dying due to physical health conditions.[9] ***Ensuring patients have access to the treatment their doctors recommend and protecting patient safety should be a top priority for TennCare enrollees.***

The block grant proposal will further harm individuals already experiencing hardship. Across the country, the combined death rate for alcohol, drug, and suicide increased from 43.9% to 46.6% deaths per 100,000 people from 2016 to 2017.[10] In Tennessee, the Tennessee Suicide Prevention Network found that suicide rates have increased every year since 2014 and is now the ninth-leading cause of death. According to a SAMHSA report on Tennessee's behavioral health access, only 43.2% of adults with mental illness in Tennessee receive any form of treatment from either the public system or private providers, while the remaining 56.8% receive no mental health treatment.[11] In 2017, Tennessee's drug overdose deaths were among the highest in the nation, with 1,776 people dying of an opioid overdose.[12] Enabling limited patient access to care as a way of cutting TennCare costs would worsen the current rates of the crisis. Lastly, we highlight that Tennessee currently faces the highest number of hospital closures per capita.[13] Scaling back TennCare funding would not only adversely affect patients access, but would also impact the vital economic support needed by rural hospitals, physicians, and drug stores to remain open. Potential closures and loss of services to recipients will be particularly significant to rural populations.

We urge you to rescind Amendment 42 and instead work on policies that enable vulnerable patients to get the care they need. We thank you for the opportunity to respond to Tennessee's proposal. If you have questions, please contact Kathy Orellana, Associate Director of Practice Management and Delivery Systems Policy, at korellana@psych.org. We welcome the opportunity to further continue this conversation, so please feel free to reach out if you have any questions.

Sincerely,

Saul Levin, MD, MPA, FRCP-E
CEO and Medical Director
American Psychiatric Association

Valerie Arnold, MD, DFAPA
President
Tennessee Psychiatric Association

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[9] Ben Druss et al. "Psychiatry's Role in Improving the Physical Health of Patients with Serious Mental Illness." December 2017. https://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201700359

[10] "Pain in the Nation: Healthcare Systems Brief." Trust for America's Health and Well Being Trust. May 17, 2018. Available at http://allh.us/nq6X.

[11] "Behavioral Health Barometer – Tennessee, 2015." Substance Abuse and Mental Health Services Administration, 2015. https://www.samhsa.gov/data/sites/default/files/2015_Tennessee_BHBarometer.pdf

[12] Centers for Disease Control and Prevention. (2017). [Interactive map showing number and age-adjusted rates of overdose deaths, by state]. *2017 Drug Overdose Death Rates*. Retrieved from https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2017.html

[13] Alex Kent, Anna Walton. Mckenzie Regional Hospital Closure and Tennessee's Silent Epidemic. December 2018. https://www.tnjustice.org/mckenzie-regional-hospital-closure-rural-tennessee/