July 27, 2015

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-2390-P: Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

Dear Administrator Slavitt,

As the medical specialty society representing more than 36,000 psychiatrists, the American Psychiatric Association (APA) appreciates the opportunity to provide comments on the Proposed Rules (CMS-2390-P) titled “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability” as published in the June 1, 2015 Federal Register (the Proposed Rules). The APA’s physician members treat patients in all settings: inpatient, outpatient, nursing homes, and partial hospitalization programs, under Medicaid, CHIP, Medicare, and commercial insurance.

About the Proposed Rules

Noting that “the health care delivery landscape has changed substantially both within the Medicaid program and outside of it,” in the Preamble to the Proposed Rules, CMS aims “to modernize the Medicaid managed care regulatory structure to facilitate and support delivery system reform initiatives to improve health outcomes and the beneficiary experience, while effectively managing costs.” The agency additionally seeks to “align” Medicaid Managed Care “with other . . . sources of coverage,” explicitly identifying Medicare Advantage and Exchange plans. We at the APA applaud re-evaluation of a system, but it needs to also have as a priority that parity of services and payments is as important to the beneficiary experience and positive health outcomes.

CMS has provided multiple, direct purposes for the Proposed Rules: to improve “the accountability of rates paid in the Medicaid managed care program”; to “ensure beneficiary protections” in the areas of provider networks, coverage standards, and treatment of appeals; and to strengthen “program integrity safeguards.” In so doing, the Proposed Rules effectively seek to balance greater regulatory oversight and accountability of both State and industry practices with wider deference to states in
how they choose to design managed care and utilize contractors. We applaud CMS for this balance.

Given the many documented issues with Medicaid Managed Care and access to quality services, especially behavioral health services, these rules are an important and constructive step going forward. This is especially important for individuals with MH/SUD conditions as well as for the Medicaid program in achieving overall cost effectiveness.

It is also important to note at the outset that there is a significant interplay between these Proposed Rules and the Proposed Rule recently issued on Medicaid Parity (80 FR 19418). While the proposed changes to 42 CFR Part 438 subpart K are not within the scope of these rules, we will highlight Medicaid parity and the Proposed Rule on Medicaid Parity where appropriate.

As providers of critical clinical services to the Medicaid beneficiaries with mental health and substance use disorders (MH/SUDs), and the reality that we are the parties who invariably act on their behalf to secure needed medical services, our members have a vested interest in the outcome of these Proposed Rules. Our comments below span the major topics addressed in the rule that relate to the care we provide.

**Proposed payment changes for services provided in IMDs**

Federal Medicaid law at Section 1905 (a)(29)(B) of the Social Security Act excludes payments for adult beneficiaries ages 21-64 who are residents of Institutions for Mental Diseases (IMDs). This exclusion, which dates back to Medicaid’s enactment, has been repeatedly cited as outmoded and harmful to Medicaid beneficiaries, given the need for some patients to require certain forms of inpatient treatment and the move toward parity for MH/SUDs, including parity in Medicaid managed care.

To partially mitigate the exclusion, the Proposed Rules distinguish between short-term treatment and long-term care, permitting states to include short-term stays in their capitation payments to MCOs. Patient stays would be limited to fewer than 15 days in any month, with flexibility to create longer stays by aligning stays over two consecutive months (14 days in one month and 14 in the next). However mental illness and substance use disorders do not follow the calendar, so if someone were to enter treatment on the 2nd of the month, this would result in a system forced to discharge a patient with continuity of treatment being placed in jeopardy and the need for repeat admissions, which increase costs and morbidity. One would not do this with a primary care or surgical intervention. CMS would permit this short-term stay policy using IMDs if “the facility is a hospital providing psychiatric or substance use disorder (SUD) inpatient care or [a] subacute facility providing psychiatric or SUD crisis residential services and the stay in the IMD is for less than 15 days in that month.”

CMS estimates that 7.1 percent of adults in the 21-64 adult age category meet the criteria for serious mental illness, requiring at least some inpatient treatment and that 13.8 percent experience serious substance use disorders (SUD). CMS anticipates that the proposed loosening of Medicaid financing for short-term stays may help address widespread reports of the lack of availability of short-term inpatient mental health (MH) and SUD treatment, which could be alleviated through better financing options.

The foundation for the CMS proposal rests on clarification of what is known as the “in lieu of” standard. That is, “the flexibility that managed care plans have had historically to furnish care in
alternative settings (state plan coverage limits) that meet an enrollee’s needs.” CMS’s clarification emphasizes that “managed care plans have had the flexibility under risk contracts to provide alternative services or services in alternative settings in lieu of covered services or settings if cost-effective, on an optional basis, and to the extent the managed care plan and the enrollee agree that such setting or service would provide medically appropriate care.”

While we are supportive of the provisions of the Proposed Rules, since it takes a step forward, we must note at the outset that our support should not be construed as a departure from the official APA position on the IMD exclusion which states:

States should be offered the opportunity to receive a Federal exemption from the IMD Exclusion for State Hospitals and all Nonprofits over 16 beds, e.g., private hospitals, community residential programs, dual diagnosis residential treatment. To participate in the exemption a state must demonstrate a maintenance of effort (maintain its mental illness and substance abuse expenditures (excluding medication costs) from all sources, e.g., state’s DMH, DPH, DMA, DMR, DOC, DSS, DYS, other) at a level no less than the state’s average expenditure over the preceding five years.

The Proposed Rules’ provisions are a step forward toward achievement of parity in this regard, but are still incomplete.

We concur that CMS has the appropriate authority to permit managed care organizations (MCOs) and pre-paid inpatient health plans (PIHPs) to receive payment, and qualify as federally funded programs (FFPs) as “in lieu of services,” for short-term stays in an IMD for enrollees aged 21-64 and not contravene the coverage exclusion in 1905 (a) (29) (B) of the SSA for several compelling reasons:

- The policy rationale that drove the original coverage exclusion at enactment;
- The broad authority granted CMS under 1915(a) of the SSA; and
- The documented bed access shortage CMS notes for individuals with MH/SUD conditions, which makes fulfillment of the network adequacy regulatory standards MCOs must comply with unattainable

In Minnesota v Heckler, 718 F. 2d 852 (8th Cir., 1983), which focused on the legality of applying the IMD exclusion to private chemical dependency treatment facilities, the Court of Appeals noted that the basis for the exclusion lay in a 1963 House of Representatives report finding that state mental institutions were simply warehouses and furnished no treatment and thus, were inappropriate facilities for Medicaid coverage purposes. That is, that they were providing long-term custodial care rather than medical care.

However, as noted in a 1993 Congressional Research Service report:

This exclusion is sometimes described as representing a broad policy decision that the Federal Government would not assume overall responsibility for the care of the mentally ill, but would leave this responsibility with the States. However, the legislative history of the Act does not conclusively indicate that the exclusion stems from any abstract principles about appropriate Federal and State roles. (The Medicaid Source Book: Background Data and Analysis (a 1993Update), GPO, p. 917)

There are two inescapable conclusions that flow from this. First, the coverage exclusion was based on policy that was designed to pay for active treatment and not custodial care. Second, there is no
basis to assume that the Federal government does not have a policy and fiscal role respecting clinical treatment of the mentally ill. The Proposed Rules provide for short-term treatment (not custodial care) and acknowledge the need for access to medically necessary services.

CMS’s “in lieu of policy” is consistent with the need for short-term inpatient stays for MH/SUDs. The genesis of the “in lieu of” policy originates in CMS’s general authority as stated in section 1915(a) of the Social Security Act, which specifies that a State “shall not be deemed to be out of compliance... solely by reason of the fact that the State... has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance...” The legal authority supporting the ability of an MCO to offer services outside of a State plan is therefore clear. Non-provision of services that are otherwise available would contravene CMS’s network regulatory requirements. CMS has ample authority within and beyond section 1915 to both permit MCOs to offer coverage for services in addition to what is covered in a State plan, and to allow for payment by the MCO for these additional services provided “in lieu of” State plan services, so long as the coverage is consistent with its medically appropriate cost effective criteria for same.

The third basis for CMS authority rests in the documented bed shortage and network requirements for MCOs and PIHPs. As you know, Federal regulations require states, through their contracts, to ensure that each MCO and PIHP has a contracted provider network that is sufficient to provide access to all services covered under the state's plan. Here specialty inpatient psychiatric services/SUD are at issue.

Enrollees with special health care needs must have direct access to a specialist as appropriate for the individual’s health care condition (42 CFR § 438.208). If the MCO or PIHP is unable to provide any contracted services to its enrollees, it must adequately cover those services in an out-of-network and timely fashion, for as long as it is unable to provide them in network, at no additional cost to the enrollee. States must also ensure their contracts with MCOs and PIHPs comply with certain timely access requirements and ensure that their network providers comply with these requirements. Plans must meet state standards for timely access to care and services, considering the urgency of the service need. Contracted services must be made available 24 hours per day, seven days per week when medically necessary.

By operation of these requirements, if an MCO cannot provide needed inpatient services as in lieu of services, given the unavailability of beds for services otherwise covered through entities covered under the state plan, the MCO would be out of compliance with CMS requirements. Hence, the proposed payment/coverage policy for short term stays is essential. It could also be argued that CMS can use its general authority under 1902 (a)(4), which permits it to specify methods “necessary for the proper and efficient operation of the state plan,” to reconcile this conflict through this proposed policy.

We do, however, have concerns with parts of the proposed policy and how they interrelate with the newly proposed Medicaid parity regulations for Managed care arrangements. The first concerns utilizing a 15-day cap to define a short-term stay eligible for payment. On its face this has the potential to be a quantitative treatment limitation, which violates the parity requirements. Regardless of this fact, in response to CMS request for comments, we think it would be more appropriate to base limits on the average length of stay across a managed care plan’s enrollees. First, this is more likely to avoid the parity issue; and second, it is more reflective of the
heterogeneity of patient's medical needs and allows for needed clinical flexibility. There is no typical patient, and payment based on an average length of stay would be more appropriate in reflecting reality.

In addition, the notion of the 15-day number threshold as defining a short-term stay should be revisited. The Medicare statute defines long-term care hospitals (LTCHs) as having lengths of stay of greater than 25 days. Therefore, for consistency, short-term care (in both medical/surgical and psychiatric hospitals) should be defined in both Medicare and Medicaid policies as 25 days or fewer. **APA recommends that the Medicaid definition of short-term inpatient be in sync with existing federal definitions of short-term hospitalization.** Furthermore, adopting a facility-wide average length of stay of fewer than 25 days would align with CMS's existing standard for what constitutes the dividing line between short-term and long-term care in Medicare (section 1886(d)(1)(B)(iv)(I) of the Act defines an LTCH as “a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services) of greater than 25 days”). Consistency with CMS’s’ existing regulations is a benefit in and of itself; but this approach would also benefit from the fact that CMS has ample experience in calculating facility-wide averages and enforcing this standard.

An additional issue that has potential parity implications concerns the criteria whereby MCOs decide to offer/utilize in lieu of services in this regard. The medical management or other protocols utilized to determine when to place individuals in an alternate setting are a type of nonquantitative treatment limitation inasmuch as they directly affect the scope and/or duration of care. **This should be clarified.** The protocols used for MH/SUD are subject to the comparability and applied no more stringently tests set forth in the parity rule as compared to those used for medical/surgical in lieu of services.

**We would also note that the conditions for use of these services set forth in the Preamble should be translated into regulatory text.** That is, the state’s contract may not explicitly require the MCO or PIHP to use IMD facilities and the managed care plan may not make the enrollee receive services at an IMD facility versus the setting covered under the state plan. The preamble to the rule clearly states that it the new proposal is inclusive of facilities “providing psychiatric or substance use disorder (SUD) inpatient care or sub-acute facility providing psychiatric or SUD crisis residential services and the stay in the IMD is for less than 15 days in that month” (emphasis added). Yet, the regulatory text itself (at section 483.3(u)) fails to identify psychiatric and/or substance use treatment facilities in its description of the types of IMDs that may be included in the capitated payment. It states only that these payments may be made “so long as the facility is an inpatient hospital facility or a sub-acute facility providing crisis residential services, and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment.”

We are concerned that the discrepancy between the preamble and the regulatory text could lead to confusion among states and managed care plans about the extent to which both categories of treatment services may be covered when provided in an IMD setting. **We recommend CMS clarify and strengthen the proposed regulatory text to expressly include substance use disorder inpatient care and substance use disorder residential services in the description of types of IMD services that may be covered.**

**Should CMS determine it lacks the authority or is otherwise unable to adopt a facility-based average length of stay approach, a far more patient-centric approach would be to adopt a medical**
exceptions process alongside an otherwise firm day-per-patient cap. Such a policy would be consistent with other recent guidelines issued by CMS, including CMS’s proposal in the Hospital Outpatient PPS rule to modify the agency’s existing two-midnight policy to formalize a case-by-case medical exceptions policy. Similarly, in the TRICARE program, although patients are generally subject to a 30-day inpatient psychiatric care limit, day limitations may be waived if a longer stay is determined to be medically or psychologically necessary.

Adoption of an exceptions process for a strict day-per-patient cap is also much more patient-centric. As CMS recently emphasized in the FY 2016 Outpatient Prospective Payment System (OPPS) proposed rule, it is a clear priority of the agency to “not override the clinical judgment of the physician regarding the need to keep the beneficiary at the hospital, to order specific services, or to determine appropriate levels of nursing care or physical locations within the hospital.” Any strict day-limit will ultimately force a provider to compromise his or her medical judgment in the face of patient financial exposure.

This would also be consistent with the intent of the newly proposed provisions regarding coverage and authorization of services at 438.210. Many of the Medicaid patients to be served by Medicaid MCOs have chronic conditions with acute exacerbations and flexibility to ensure long term stability is essential. It is simply not appropriate to force clinicians to curve fit varied patient need with a fixed number.

Modifications to Regulations Governing the Appeals and Grievances System for Medicaid Managed Care Are Important.

The Proposed Rules modify the current regulations governing the grievance and appeals system for Medicaid managed care in order to align and increase uniformity between the regulations for Medicaid managed care and MA managed care plans and the regulations for private health insurance and group health plans. We agree that these changes will reduce confusion for beneficiaries who transition between private health coverage and MA or Medicaid managed care coverage and inefficiencies for health insurance issuers that participate in both private and public sectors.

We commend the changes that aim to:

• Include PAHPs among the types of entities subject to the standards of Subpart F;
• Provide access to records and plan documents;
• Provide timely and adequate notice of adverse benefit determinations;
• Establish a two-step process for appealing adverse benefit determinations; and,
• Align time frames in which MCOs, PAHPs, and PIHPs issue decisions on beneficiary appeals.

These changes give Medicaid beneficiaries the same important rights to disclosure of plan information and meaningful appeals that are afforded beneficiaries of private health plans.

State Fair Hearing (SFH) Decisions that Involve Medical Judgment Should Include MHPAEA Appeals.

Given CMS’s interest in aligning the grievance and appeal process of Medicaid Managed Care plans with the process of private health insurance plans, it would be important to provide provisions which allow Medicaid beneficiaries the right to appeal claims denials on the basis of MHPAEA compliance at the SFH level. It is important to note that the Internal Claims and Appeals and External Review Processes Interim Final Rules provide that a claimant can seek external review of a claim that involves an adverse benefit determination based on “medical judgment,” which includes
whether a plan is complying with the NQTL provisions of MHPAEA and the Final Rules. See 78 FR 68246. Medicaid beneficiaries should be afforded the same rights to independently appeal a denial based on plan provisions that violate MHPAEA.

Coverage and Authorization of Services

The Proposed Rules would bring new standards to coverage authorizations and the obligations of risk contractors and states in situations in which a plan proposes to reduce or eliminate treatment. As CMS notes, the right of plan members to maintain a current treatment level while appealing a reduction or termination depends on the level of treatment authorized. Reflecting Medicaid’s seminal requirement that treatments be reasonable in amount, duration, and scope and not arbitrarily discriminate based on condition, the Proposed Rules would require that managed care contracts adhere to the program’s reasonableness standards and use service authorization standards that are “appropriate for and do not disadvantage those individuals that have ongoing chronic conditions or needing [long term services and supports]. The expectation is that clinical services that support individuals with ongoing chronic conditions, as well as LTSS would be authorized in a manner that reflects the beneficiary’s continual need for such services and supports,” and that limits would be consistent with an “enrollee’s current needs assessment and . . . the person-centered service plan.” We concur with these changes as they address the ongoing and chronic needs of beneficiaries with MH/SUDs.

Hence, we agree with the modernization of the language in Section 438.210 that governs the coverage and authorization of services and establishes standards for states through the managed care contract to ensure that utilization management strategies properly support individuals with chronic conditions, like MH/SUDs. The proposed language permits limits on the basis of criteria applied under the state plan (like medical necessary or utilization control) as long as the services provided can reasonably achieve their purpose. However, it should be noted that any medical necessity criteria or utilization management strategies employed by a plan must comply with the provisions of MHPAEA. Specifically, the plans must meet the two-part non-quantitative treatment limitation tests of stringency and comparability.

We also support the concept that state’s are in the best position to decide whether or not plans may seek to recoup from an enrollee if the beneficiary’s claim for services is later upheld on appeal. Further, we support the definition of what constitutes “medically necessary” care in section 328.210(a)(5); specifically, we were pleased to see that plans’ medical necessity criteria must meet the requirements for providing early and periodic screening, assessment and diagnosis (EPSDT) for beneficiaries under the age of 21. These provisions would best protect the enrollee.

Network Adequacy

Network adequacy refers to the ability of a health plan to provide enrollees with timely access to a sufficient number of in-network providers, including specialty physicians such as psychiatrists, as well as other health care services which are included as part of the plan’s benefits. 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 (42 U.S.C § 1396a(a)(30)(A)). A state's
Medicaid plan state 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.” Social Security Act § 1932(c)(1)(A)(i); see also id. § 1932(b)(5).

Access to quality services, especially for behavioral health and for children, is a long standing and well documented problem. Two recent reports show this problem persists into the present. See for example the July 2015 GAO Report, “Medicaid: Overview of Key Issues Facing the Program” (GAO-15-746T) and “California Department of Health Care Service report 2014-134: "Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care.”

The problem has multiple consequences of significance. First, un- and undertreated MH/SUD disorders have, aside from enrollees not receiving needed medical care, manifold consequences a for all payors1. The access issue must be addressed to assure that the current patient-centered, quality and cost objectives of system delivery initiatives are realized.

Second, the lack of access to behavioral services has implications for primary care physician (PCP) participation in Medicaid programs. The lack of access to PCPs is a persistent problem as well. Limited referrals to behavioral health services were a factor noted by PCPs in deciding whether or not to participate in Medicaid and/or accept new patients in a recent study of Washington state physicians. (Health Affairs, Sept 2013 32:9 1563)

Extensive research suggests that many factors contribute to low physician participation: complex program requirements, cumbersome preauthorization, payment delays, and concerns about managing the care of patients with high levels of health and social risk. But research also shows that low fees play a key role and that substantial payment increases may be needed to alter physicians' behavior.

Specialty care arguably presents the more serious Medicaid access problem, especially since there is no obvious mitigation strategy for it comparable to that offered by community health centers. Public, teaching, and mission-driven hospitals play a critical role in access to specialty care, but their numbers and geographic reach are limited. The Commonwealth Fund reports that low payment rates are the principal cause of reduced specialist participation2. In a study pre ACA implementation, one third of psychiatrists who had opted out of Medicaid, said they would have returned to the system had they received the "Medicaid bump" provided to primary care specialties.

Under the proposed rule CMS seeks to update network adequacy requirements to modernize the regulatory framework and align MMC requirements, where feasible, with MA and QHP standards and to establish minimum standards while maintaining state flexibility. The Proposed Rule would ensure states’ ongoing assessment and certification of the networks of MMC entities, including managed care organizations (“MCOs”), prepaid inpatient health plans (“PIHPs”), prepaid ambulatory health plans (“PAHPs”), and Managed Long-Term Services and Supports (“MLTSS”) programs while moving states toward a time and distance-based approach like that employed under the MA program.

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1 See Economic Impact of Integrated Medical-Behavioral Healthcare, Milliman, April 2014

Overall, the provisions are a step forward to develop a beginning framework to ensure that the above noted statutory provisions are realized. Our comments below respond to the specific issues CMS raised regarding the new standards.

First, we concur with the proposed approach to require states to establish specific time and distance standards for behavioral health. **We recommend clarification in this regard that the term behavioral health be unbundled to reflect both the benefits classifications required by the propose parity rules and that the term encompasses two, often distinct delivery systems respecting both mental health and substance use disorders.** Therefore time and distance standards for both MH and SUD should be required across all relevant benefit classifications.

CMS has also asked for comment on whether states should be given more or less flexibility with respect to setting these standards. In order to correct the problem identified in the GAO report cited in the Preamble. **CMS should provide more binding requirements for the states as to what constitutes network adequacy.** Standards for network adequacy are rapidly evolving for both commercial and public payers and a more unified approach would be consistent with CMS's stated interest in better alignment between Medicaid MCOs and requirements in other ‘markets’. Also, more centrally defined network parameters would be consistent with the intent of the above noted statutory requirements.

CMS also requested comment on whether or not behavioral providers should be included in the list of those for which states must apply separate access standards for adult and pediatric providers. **We strongly recommend that CMS do include behavioral services in the list of required services.** The recent GAO report noted clearly suggests this is in order to address the chronic access problem experienced by children and adolescents.

**We are compelled to point out that under the proposed Medicaid parity rule,** which mirrors in most all key respects the Final Rule for commercial plans and exchange plans, network adequacy is a non-quantitative treatment limitation. Squaring its requirements with whatever final standards and dimension of state flexibility is adopted by CMS will be an essential task and based on experience guidance may be needed to definitively guide all parties.

**Formulary Requirements**

In states that require MCOs to provide drug benefit, CMS propose to require MCOs to provide drug coverage that “meets the standards...imposed by section 1927 of the Social Security Act as if such standards applied directly to the MCO.” However the proposed rule allows states to permit MCOs to maintain their own formularies without specifying that those formularies must comply with the formulary requirements in Section 1927. CMS does stipulate in the preamble that patients must be able to get non-formulary medicines through prior authorization” when there is a medical need.” **These are constructive provisions but do not go far enough to protect the interests of patients in need of critical drugs.**

**CMS should clarify that MCO formularies must satisfy the formulary rules in section 1927, and clarify patients’ rights to obtain an off-formulary drug in order to maximize access to same. CMS should also address the process for obtaining these medicines in ways that are not burdensome for patients and/or their physicians.** Given the importance of this issue for Medicaid beneficiaries CMS should add clear protections to the regulatory text. The full benefit of these protections will not be
realized without clear regulatory protections. In section 438.10(i), CMS should clarify that formulary lists and any changes to formulary lists must be made available in real time in all required formats. In section 438.10(i)(2), CMS should require plans to identify both the level of cost-sharing required for drugs in that tier of coverage, as well as the actual cost the patient will incur for each drug.

**Health Information Technology Incentive Payments**

Under the subsection “Special Contract Provisions Related to Payment (438.6 (d))”, the proposed rule adds paragraph 486.60 (c)(1)(i)-(iii), which provides an exception to the general rule for setting capitated payment rates. This proposed change would allow states to set parameters around the expenditures of managed care contracts to incentivize enhanced delivery of care for Medicaid beneficiaries. Specifically, 483.60(c)(1)(ii) provides states the option to include in their managed care contracts participation in Medicaid-specific initiatives, including broad-based provider health information exchange projects which can include electronic health record (EHR) incentive payments for behavioral health providers.

This is a positive and innovative initiative, which will allow states the opportunity to provide incentive payments to behavioral health providers who were previously not eligible to receive Meaningful Use incentive payments under the HITECH Act. Comorbidity between mental and medical conditions is the rule rather than the exception. Research shows that 70% of the populations served by behavioral health providers and settings in the public mental health system have co-occurring, chronic medical surgical conditions that mandate quick and quality coordinated care. Fully one-third of the nine million Americans dually eligible for both Medicare and Medicaid have a primary diagnosis of schizophrenia and a co-occurring, chronic medical condition.

True care coordination cannot take place when a crucial segment of providers lack EHRs. Health IT is the bedrock of any effort to coordinate and integrate care for all Americans. Yet, most behavioral health providers lack the resources to implement EHRs. Community mental health and substance use providers face significant financial challenges when trying to adopt comprehensive EHR systems, and fewer than 30% have successfully implemented full or partial EHR systems to date. If mental health and substance use providers cannot adopt health IT at a rate comparable to primary care facilities, hospitals, and physicians’ offices, it will soon become impossible to coordinate clinical care electronically.

In the final rule, we recommend that CMS clarify several items to ensure states can efficiently and effectively take advantage of this proposed initiative. To ensure clarity of the proposed rule, **CMS should define behavioral health providers**. Legislation pending in the Congress and Senate currently exists that defines these settings as follows:

**Medicaid providers**

- a public hospital that is principally a psychiatric hospital (as defined in section 1861(f));
- a private hospital that is principally a psychiatric hospital (as defined in section 1861(f)) and that has at least 10 percent of its patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals receiving medical assistance under this title;
a community mental health center meeting the criteria specified in section 1913(c) of the Public Health Service Act; or

a residential or outpatient mental health or substance abuse treatment facility that—

is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, or any other national accrediting agency recognized by the Secretary; and,

has at least 10 percent of its patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals receiving medical assistance under this title.

As with the HITECH Act, CMS should include payment parameters for incentive payments relevant to electronic health records. While recognizing that HIT reimbursements under Medicaid capitation arrangements to behavioral health providers will vary by state under the Proposed Rule, the BHIT Coalition nonetheless recommends payment plans similar to those utilized in the implementation of the HITECH Act’s Meaningful Use incentive payments. For example, under Title IV, Eligible Professionals could receive $63,750 over 6 years, and Eligible Hospitals could receive a maximum of $2,000,000. Psychiatric hospitals, CMHCs, community behavioral health organizations and substance use residential treatment centers should also be eligible for the higher hospital/facility payment.

CMS should clarify whether other forms of technology will be permitted under the incentive payments.

Finally, beyond Electronic Health Records, the Proposed Rule could play an enormously important role in specifying what other types of health technology could be reimbursed in MCO capitated arrangements. With great advances in technology in the health field, such as telepsychiatry, mobile devices, and telemonitoring, there are a wide variety of opportunities for States to improve their care coordination efforts for Medicaid recipients with major mental health and addiction disorders.

Beneficiary Support Systems

We agree with CMS’s acknowledgement that some beneficiaries may need additional assistance, beyond the typical plan information disclosures, when evaluating their choices and making their plan selection. Additional assistance will be especially beneficial to individuals living with serious mental illness or substance use disorders given the complex health needs, possible cognitive deficits, and low levels of health insurance literacy among this population. We fully support requiring states to develop and implement beneficiary support systems similar to and aligned with those already in place for Marketplace enrollees under the Affordable Care Act.

We agree that such assistance should be available to beneficiaries both before and after they enroll in a managed care plan and that it should include factors to consider when selecting a plan, information on how managed care works, and help for beneficiaries who receive or would like long-term services and supports

Meaningful Consumer Choice in Plan Enrollment
The Proposed Rule (for both mandatory and voluntary enrollment processes (438.54(b)(2) and (d)(2))) points out that there are currently no federal regulations specifically governing enrollment of Medicaid beneficiaries into managed care plans. In the absence of specific guidance, state enrollment practices vary widely in how they address both voluntary and mandatory enrollment in managed care, revealing a need for consistency across programs. **We concur with CMS’s assessment that “beneficiaries are best served when they affirmatively exercise their right to make a choice of delivery system or plan enrollment” and have the time and information to effectively choose.**

**State Direction of Expenditures**

CMS proposes to codify its long-standing policy that states may not direct expenditures by health plans under a risk contract. However, CMS also proposes ways that a state may set parameters on how plans make expenditures under the contract to promote delivery system and payment reform, performance improvements, and beneficiary access to care. Accordingly, CMS proposes to allow states to specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement, or to require plan participation in delivery system reform or performance improvement initiatives (including multi-payer or community-wide initiatives).

We recognize the importance of payment reforms that account for value in care delivery; however, we caution that such reforms must be carefully designed to avoid disincentivizing clinically appropriate, medically necessary care for patients with complex, chronic health conditions such as mental illness or addiction. Value based purchasing arrangements, bundled payment, and other payment innovations must carefully consider how value, quality and outcomes are defined, taking into account the needs of individuals who require a high volume of services over time and whose health improvements are best measured in terms of functional outcomes rather than reduction in clinical symptoms. CMS should consider additional steps to ensure that risk sharing provides incentives for quality care.

**CMS should require states to build in opportunities for comment on the quality measures used in future value-based arrangements.** States should also be required to monitor and evaluate the impact of these arrangements on patient access. Risk sharing mechanisms should be carefully analyzed and monitored to ensure unintended and undesirable incentives are not created. CMS should require states should require MCOs to accept all members who seek to enroll, and prohibit MCOs from refusing to enroll individuals with an adverse change in their health status, utilization patterns, cost of care, missed appointments, inability to pay, submission of grievances or appeals, or behavior related to their special needs.

The Proposed Rule also supports two state practices (438(c)(iii)) used to ensure timely access to high-quality, integrated care, specifically: (1) setting minimum reimbursement standards or fee schedules for providers that deliver a particular covered service, and (2) raising provider rates in an effort to enhance the accessibility or quality of covered services. Any contract arrangement that directs expenditures made by the plan for delivery system or payment provider initiatives must use a common set of performance measures across all payers and providers so that CMS can evaluate the degree to which multi-payer efforts achieve the stated goals of the collaboration. We strongly support these proposed changes.

**Transition of Care Policy**
The Proposed Rule would require states to have a transition of care policy for individuals switching from one delivery system to another within Medicaid or from FFS to managed care. Such policy would need to include, among other things, receipt of services for a period of time and assurance that medical records are transitioned. Care coordination activities would be expanded to cover coordination between care settings as well as with outside entities, such as community and social support agencies. Health risk assessments for new enrollees would be required to be performed within 90 days and shared with other providers thereafter. We strongly support the proposed provision. This is a frequently occurring issue in many states, especially where behavioral services are carved out and vendors change frequently.

**Primary Care Case Management (PCCM)**

CMS proposes to adopt the new term “PCCM Entities” to reflect the development of entities conducting more intensive case management and care coordination, measure of performance outcomes, and quality improvement activities, and who receive higher reimbursement. The activities of these entities have been referred to as an “enhanced” PCCM model, and the entities have been paid a more robust per member/per month fee, based on the activities covered under their contract. CMS proposes to recognize those PCCM programs that are truly managing care and to subject them to the same standards that apply to other MMC entities. Other health care delivery systems, such as integrated care models, patient-centered medical homes, and accountable care organizations, would remain unaffected by the changes in the Proposed Rule.

We support this proposal and request clarification as to how the Medicare Parity regulations for managed care organizations will apply.

Thank you in advance for your review and consideration of these comments. If you have any questions, or if you would like to discuss these matters further, please contact Irvin “Sam” Muszynski, Director of APA’s Office of Healthcare Systems and Financing, at hsf@psych.org or 703-907-7300.

Sincerely,

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CEO and Medical Director