



**Association for Behavioral
Health and Wellness**

*Advancing benefits and services
in mental health, substance use
and behavior change.*

July 27, 2015

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

Re: Medicaid and CHIP Managed Care Proposed Rule (CMS-2390-P)

Dear Acting Administrator Slavitt:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Proposed Rule. ABHW is the national voice for specialty behavioral health and wellness companies. Our member companies provide specialty services, in both the public and private sector, to treat mental health, substance use, and other behaviors that impact health and wellness to nearly 150 million people. The comments below focus on areas of particular importance to ABHW and its member companies.

Network Adequacy

ABHW would like to see any network adequacy standards that are set be consistent with similar requirements that have already been set for the Medicare and commercial markets. Uniformity is important, as adhering to multiple network adequacy standards becomes confusing and burdensome. However, states should have some flexibility to align the standards with particular circumstances that may exist in their state.

We support standards for behavioral health providers being distinguished between adult and pediatric providers. ABHW members would like to see flexibility in the network adequacy standards for pediatric providers; it should take into account the existing shortage and lack of availability of child and adolescent psychiatrists in most, if not all, parts of the country.

Additionally, ABHW would like to see network adequacy standards address telemedicine. A shortage of behavioral health providers limits access to mental health services, and making telemental services available in a variety of settings is one way to optimize the psychiatric workforce and increase access for consumers.

Medical Loss Ratio (MLR)

We appreciate that the proposed rule seeks consistency in the MLR rules for Medicaid managed care plans that were imposed for Medicare Advantage and commercial health plans in the Affordable Care Act (ACA). We suggest that the final rule align with the ACA requirements for commercial health plans and allow for the MLR to be calculated over a three-year rolling average as opposed to a 12-month

period. A rolling three-year time period will allow the rates to capture some aspects that are unique to Medicaid, like retroactive settlements, and will provide for a more accurate calculation. This will also help have a smoothing effect in the MLR of newer programs that do not have a stable population and are subject to ups and downs over a one-year time frame.

We were pleased to see the recognition that case management/care coordination is likely to be more intensive and costly for Medicaid and an understanding that these services as well as community integration activities are important and should be included in the numerator of the MLR calculation. We believe this should include services such as the use of peer providers, Assertive Community Treatment, and supported housing.

Depending on the population mix of each state's program, i.e. the percentage of Temporary Assistance for Needy Families (TANF), CHIP and other subpopulations, an 85% MLR may not be the right number; and the final rule should permit states to establish a lower MLR where appropriate.

Institutions for Mental Disease (IMD)

ABHW supports eliminating the existing IMD exclusion. In some areas ABHW members have found that IMDs are the only hospitals available, and the inability to get reimbursed for patients receiving care in these settings has been problematic. We support and appreciate the flexibility in the proposed rule allowing plans to receive a capitation payment from the state for care provided to a patient in an IMD and believe that the provision included in the proposed rule is a helpful step in the right direction. Our support of this proposal does not diminish our interest in providing consumers with treatment in the community when it is preferred by the consumer and is available and appropriate.

Actuarially Sound Capitation Rates for Medicaid Managed Care Programs

ABHW is pleased this regulation encourages states to offer enhanced incentive payments to providers who were previously ineligible for electronic health record (EHR) incentive payments. Fewer than half of behavioral health providers possess fully implemented EHR systems; because when Congress passed the HITECH Act in 2009, it left out behavioral health providers. On average, IT spending in behavioral health organizations represents 1.8% of total operating budgets – compared with 3.5% of total operating budgets for general health care services. ABHW member companies coordinate behavioral health care with an individual's medical care and use clinical outcomes to help measure the effectiveness of the consumer's treatment. EHRs help facilitate integrated care, enhance e-prescribing, and track clinical outcomes. These benefits are hard to achieve if behavioral health providers are behind on EHR implementation.

Beneficiary Enrollment Protections

The requirement that all states must provide a period of time of at least 14 calendar days of fee-for-service coverage for potential enrollees to make an active choice of their managed care plan seems unnecessary, as it may delay identification of medical or behavioral health problems and also may delay patient engagement in care. Individuals should be directly enrolled in their managed care plan either by their choice or by assignment depending on the state's policy, while still having the 90-day window to change Medicaid managed care (MMC) plans. We believe a consumer's care management should begin as soon as possible, and a 14-day choice period moves in the wrong direction by slowing down the patient engagement process.

Furthermore, we seek clarification on the proposal to require “any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate expertise in addressing the enrollee’s medical, behavioral health, or long-term services and support needs.” Since a diversity of providers treat mental illness, it is critical that the definition of “appropriate expertise” is not too narrow. ABHW suggests language that specifies the health care professional authorizing or denying a request is one “who is operating under his or her scope of licensure”, rather than simply requiring that the health care professional “has appropriate expertise”. This will ensure appropriate attention to authorization requests.

Additionally, we believe the requirement that plans make their best effort to have new enrollees complete a health risk assessment within 90 days is a misdirection of resources. It is ABHW’s opinion that there are better screening tools and surveys available to determine an individual’s health status. Also, there may be information available from programs/providers that have previously treated the enrollee; this data can be used to identify individuals for whom a broader assessment is appropriate. If the health risk assessment requirement remains in the final rule, we strongly suggest that the time period in which to administer the requirement be extended beyond 90 days. It is also important to note that under 42 CFR Part 2 any information gleaned from the assessment about an individual’s substance use disorder will not be able to be shared with other providers or the state unless the patient signs a consent for each of the individuals to whom the information is disclosed. 42 CFR Part 2 is an enormous road block to integrated, whole person care; and this is just one example of the barriers of this outdated law.

In addition to 42 CFR Part 2, other federal and state laws exist that restrict and limit the use of behavioral health information, which impede the coordinated care of an individual. The final rule should require access to additional information in this area for purposes such as quality assessment, quality rating, care coordination, external quality review, continuity of care, and performance improvement.

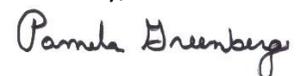
Information Standards

ABHW has concerns with the proposed regulation’s requirements for updating provider directories. The additional elements and provider types that would need to be included in a provider directory impose an added burden on plans that are at the mercy of the providers to give them updated and accurate information. We suggest language be included in the final rule that encourages providers to communicate their network status monthly with the plan. This proposal provides us with a unique opportunity to harmonize the provider directory requirements that exist under this rule with the requirements for Medicare Advantage Plans and Qualified Health Plans. Having different requirements for each market creates unnecessary work and confusion. A basic set of overarching rules for all programs would be very helpful, with exceptions if necessary, rather than a different set of standards for each market.

Additionally, to require monthly paper updates is of questionable value and is onerous and costly. By the time the paper directory is printed, it is out of date. Semi-annual or annual updates would be more practical. Also, requiring that updates to the directory be made three business days after new information is received is too short of a time frame, arduous, and unrealistic. We encourage CMS to reconsider this proposal and lengthen the time frame.

We appreciate your consideration of our requests. If you have any questions about our comments and recommendations, please feel free to contact either Pamela Greenberg or Rebecca Klein at (202) 449-7660.

Sincerely,

A handwritten signature in cursive script that reads "Pamela Greenberg".

Pamela Greenberg
President and CEO