ABHW

Advancing Health Care Policy
for Mental Health and Addiction

May 31, 2019

Erin McMullen
Medicaid and CHIP Payment and Access Commission
1800 M St, NW
Suite 650 South
Washington, DC 20036

Re: Public Comment on the Medicaid IMD ADDITIONAL INFO Act

Dear Ms. McMullen,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on section 5012 of the SUPPORT for Patients and Communities Act (SUPPORT Act), known as the Medicaid IMD ADDITIONAL INFO Act. The provision requires the Medicaid and CHIP Payment and Access Commission (MACPAC) to conduct a study on institutions for mental diseases (IMDs) receiving Medicaid payment under fee for service or managed care.

ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness.

MACPAC released a notice asking for additional information on a number of topics set forth in the Medicaid IMD ADDITIONAL INFO Act, including state requirements and standards, a description of IMDs in each state and the types of services provided, and a description of Medicaid funding authorities. ABHW member companies' provision of IMD services and requirements of IMD providers is highly state-dependent. Each state Medicaid program is different, including treatment of IMD services.

The Medicaid IMD ADDITIONAL INFO Act also allows MACPAC to make recommendations to Congress. We have the following recommendations:

- **Repeal the Medicaid IMD Exclusion.** Medicaid beneficiaries should receive medically necessary care for as long as is needed, and the exclusion is contrary to MH and SUD parity requirements.

- **Provide further guidance on IMD exceptions to the exclusion.** While we appreciate that the Centers for Medicare and Medicaid Services (CMS) has already provided guidance on exceptions to the IMD exclusion, further clarity would help to reduce confusion about how to provide IMD services, pending repeal of the exclusion

Our detailed comments are as follows:

1. **Responses to specific questions set forth in MACPAC's notice**

Plans' delivery of Medicaid IMD services and IMD provider requirements varies based on each state. Each state's Medicaid program is unique, from financing, coverage of IMD benefits, and provider standards and requirements. This diversity requires plan flexibility state by state when providing IMD services for Medicaid beneficiaries.

Medicaid financing affects a plan's ability to provide IMD services, and is different in each state. Under federal law, Medicaid funds cannot be used to pay for services for an adult in an IMD (known as the "Medicaid IMD exclusion"). There is limited flexibility to the IMD exclusion. States can allow Medicaid managed care organizations (MCOs) to provide up to 15 days of care in a month in an IMD "in lieu of" other services covered under the state's Medicaid plan, per the Medicaid Managed Care Final Rule from 2016 (and codified in section 1013 of the SUPPORT Act). States can also apply for Section 1115 SUD and MH[1] waivers, and sections 5051-5052 of the SUPPORT Act allows states to elect, through a state plan amendment, to use Medicaid funds to pay for up to 30 days of IMD coverage in a 12-month period for eligible individuals with at least one SUD.

States' standards, regulations, and coverage of Medicaid IMD benefits also affects plans' delivery of services. Some states "carve in" (i.e., providing services through

[1] For adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).

Medicaid MCOs) or "carve out" (provide services outside of managed care) Medicaid behavioral health care services, including IMD services. Some states may allow IMD services without restrictions, and some may require prior authorization. ABHW member plans have evidence-based level of care guidelines for IMD providers, but the plan guidelines are superseded by state guidelines.

2. **Recommendations for Congress**

- **Eliminate the IMD exclusion**

There is some flexibility to the Medicaid IMD exclusion, as explained above. However, this flexibility only provides a narrow exception process from the exclusion for a number of reasons. Some of the exceptions have time limits (such as 15 days or 30 days). Time limits are not based on individual care needs. Medicaid beneficiaries should receive medically necessary care as needed, not based on arbitrary limits. In addition, the 15 day "in lieu of" time frame limited states that were providing IMD "in lieu of" services for longer periods of time.

Some of the exceptions also apply only to specific populations. For example, the provision in the SUPPORT Act allowing 30 days of treatment in a year is only for individuals with at least one SUD, and does not include MH conditions. While states can apply for MH waivers, this option is limited to adults with SMI and children with SED. Currently only one state, Vermont, has a waiver that covers MH services. This also demonstrates that not all states may choose to use an exception to the Medicaid IMD exclusion.

In addition, 1115 waivers may not include community-based services, such as community mental health centers, assertive community treatment, and vocational support. IMD services are part of the continuum of care, and wrap around community-based services and supports help to maximize successful recovery.

The Medicaid IMD exclusion also makes it difficult for states and plans to meet SUD and MH parity requirements. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires insurers that offer MH and SUD benefits to provide coverage that is comparable to coverage for general medical and surgical care. The Medicaid IMD exclusion prohibits payments for medically necessary care, restricting MH/SUD benefits. Medicaid does not have a similar restriction with respect to medical/surgical benefits. This makes it hard for states and plans to comply with MHPAEA if they cannot offer MH/SUD benefits that are comparable to medical/surgical benefits.

- **Provide additional clarity about IMD exclusion exceptions**

CMS has issued guidance (through state Medicaid director letters and informational bulletins) about exceptions from the Medicaid IMD exclusion, but there remain questions and confusion about how to implement permitted exceptions. For example, some states have interpreted the 15 day "in lieu of" exception to mean that if 15 days in a month is exceeded, the member loses Medicaid eligibility for that month. This is not supported by guidance. Also, our members have experienced different interpretations about what happens to the managed care capitation payment when a beneficiary exceeds the 15 days. For example, if 15 days is exceeded, is the capitation payment lost for the month, even though the beneficiary remains Medicaid eligible? If a 20 day stay occurs, is the capitation payment to be pro-rated over the month so that 10 days of capitation is permitted? Or, are the first 15 days plus the final 10 days included in the capitation for that month?

While we appreciate that CMS has provided guidance, we encourage CMS to provide additional clarity to reduce confusion and encourage consistent implementation of the exceptions until the Medicaid IMD exclusion is repealed. This additional guidance could include technical assistance and FAQs, and CMS could also host stakeholder meetings to solicit feedback on what kind of additional clarity is needed.

Thank you for the opportunity to comment on the Medicaid IMD ADDITIONAL INFO Act. Please feel free to contact Kate Romanow, Director of Regulatory Affairs, at romanow@abhw.org or (202) 449-7659 with any questions.

Sincerely,

Pamela Greenberg, MPP
President and CEO