ABHW

Advancing Health Care Policy
for Mental Health and Addiction

January 14, 2019

The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2408-P
P.O. Box 8016
Baltimore, MD 21244-8013

Dear Administrator Verma,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care proposed rule (proposed rule).

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, substance use disorders, and other behaviors that impact health and wellness.

ABHW's comments will focus on the following areas: Institutions for Mental Diseases (IMD); medical loss ratio (MLR), information requirements, network adequacy standards, Medicaid Managed Care Quality Rating System (QRS), adverse benefit determinations, the appeals process, and the privacy of substance use disorder records.

Institutions for Mental Diseases (IMD)
ABHW is appreciative of the efforts of the Centers for Medicare and Medicaid Services (CMS) in keeping the availability of IMDs as a treatment option via the acceptance of a 15-day stay or a state Medicaid waiver. However, we support eliminating the IMD exclusion completely. This would enhance the array of treatment options available to consumers. In some areas an IMD is the only available inpatient treatment and therefore Medicaid's recognition of, and

access to, these institutions is critical in order to provide appropriate treatment to enrollees. Fifteen days is an arbitrary limit to impose, decisions on length of stay should be based on medical necessity. In addition, there are some states that are providing more than a 15-day stay in an IMD and ABHW wants to make sure that a step backward isn't taken by somehow not allowing these states to continue with their current policies.

Medical Loss Ratio (MLR)
In general, ABHW is not in favor of imposing an MLR on the Medicaid program. The Medicaid program is very unique and has a high number of enrollees with behavioral health illnesses. The majority of these individuals benefit from social supports and connections to the community. Health plans are working to deliver a more comprehensive approach by addressing social determinants of health and other social needs by providing or connecting consumers with employment services, housing, social connections, etc. Unfortunately, these programs and the costs associated with connecting people with these useful benefits are often considered an administrative cost. Because of this, the imposition of an MLR can discourage innovation and the offering of programs that have a significant positive impact on quality, outcomes, and cost. If the MLR remains, we encourage CMS to consider moving some of these beneficial activities out of the administrative side of the MLR equation.

Information Requirements
ABHW appreciates the change in the timeline for notifying an enrollee of a provider's termination of the network from managed care plans issuing notices within 15 calendar days after receipt or issuance of the termination notice to the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after the receipt or issuance of the notice. This change in policy will be very beneficial as oftentimes a provider may indicate that they want to leave the network but when plans receive the providers notice they engage in negotiations to try and keep the provider in the plan's network. Frequently, these discussions have a favorable outcome and there is no need to send a notice to the enrollee alarming them of a situation that never materializes.

The change related to provider directories is also supported by ABHW. ABHW members frequently reach out to providers to ensure that they have accurate information on the provider. Obtaining updated information can be challenging at times but our member companies fully recognize the need for enrollees to

have accurate provider directories and plans are continuously working to supply correct information. Requiring the paper provider directory to have less than monthly updates if the managed care plan offers a mobile-enabled, electronic directory is both more efficient and will save on the unnecessary expenditure of valuable health care dollars.

Network Adequacy Standards
We support the flexibility granted to states in the proposed rule to set a quantitative minimum access standard for specified health care providers as opposed to requiring a time and distance standard. This allows states to develop network adequacy standards that more accurately reflect the market and the population in that state. ABHW also appreciates that the proposed policy recognizes the importance of the innovation that is taking place in the marketplace in areas such as telebehavioral health. ABHW is supportive of efforts to continue expanding telehealth services in order to make health care more accessible.

Medicaid Managed Care Quality Rating System (QRS)
ABHW recommends that if states establish a state specific QRS they are required to have their alternative measures be measures that are endorsed by a nationally recognized body like the National Quality Forum (NQF) or other similar organization. Alternatively, the states could be required to do a validity analysis of their measures. It is necessary to ensure that the measures used are accurately measuring what they intend to measure and are not overly burdensome to implement.

Adverse Benefit Determinations
ABHW believes that the proposed modification to when an adverse benefit determination is issued has the right intent but may have unintended consequences. We support not having to issue an adverse benefit determination when there isn't a clean claim. Since an enrollee has no financial burden in this scenario we agree that there is no need to confuse or upset the enrollee and there is no need to impose the administrative burden on the plan. Our concern is that some states may already have a policy that does not require the issuance of an adverse benefit determination in all, or most, cases were an enrollee does not have a financial burden, is held harmless, and is not impacted by the denial of payment for service. We do not want states to respond to the proposed CMS modification by changing their policy and requiring adverse benefit

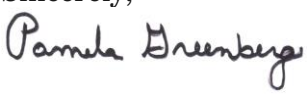
determinations to be issued in more cases, rather than fewer cases. We strongly suggest that CMS expand the proposed modification to not require adverse benefit determinations to be issued in all situations where the enrollee has no financial burden related to the denial.

Appeals
We support eliminating the requirement that enrollees must submit a written, signed appeal after an oral appeal is submitted. This will ease the burden on enrollees and allow for a faster appeals process to occur. We recommend that CMS consider what constitutes an oral appeal so that there is no confusion.

42 CFR Part 2
A topic not mentioned in the proposed rule that would also ease administrative burden, encourage integrated and coordinated care, and improve access to treatment under the Medicaid program is to align 42 CFR Part 2 (Part 2) with the Health Insurance Portability and Accountability Act (HIPAA). Part 2 is an outdated 1970s regulation that limits the use and disclosure of patients' substance use records from certain substance use treatment programs. This can prohibit plans from sharing substance use disorder (SUD) information with the health care providers on the front line caring for patients suffering from opioid and other SUDs. The outdated regulation severely constrains the health care community's efforts to coordinate care for persons with SUDs and ABHW members say Part 2 is one of the biggest – if not the biggest – barrier to fighting the opioid crisis. We urge the Department of Health and Human Services to issue regulations that align Part 2 with HIPAA for the purposes of treatment, payment, and health care operations.

Thank you for the opportunity to comment on this proposed rule. Please feel free to contact me at greenberg@abhw.org or (202) 449-7660 with any questions.

Sincerely,



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