National Association for Behavioral Healthcare

Access. Care. Recovery.

18 April 2022

Daniel Tsai
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for Information: Access to Coverage and Care in Medicaid & CHIP

Dear Director Tsai:

The National Association for Behavioral Healthcare (NABH) respectfully submits the following recommendations in response to the Request for Information: Access to Coverage and Care in Medicaid and the Children's Health Insurance Program (CHIP).

NABH represents behavioral healthcare systems that provide mental health and addiction treatment across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility-based outpatient programs, including medication assisted treatment (MAT) centers. Our membership includes behavioral healthcare providers in all 50 states and Washington, D.C. We appreciate this opportunity to provide recommendations on how CMCS can support increased access to mental health and addiction treatment for Medicaid and CHIP beneficiaries.

As the single largest payor of behavioral healthcare services, Medicaid plays a pivotal role affecting the availability of mental health and addiction services. Unfortunately, the exclusion of specialized inpatient psychiatric settings (i.e., Institutions for Mental Diseases) from Medicaid coverage has contributed to a rapid decline in availability of acute care for individuals with serious mental illness or severe addiction. Since 1970, five years after Medicaid was established, the number of inpatient and residential treatments beds has decreased by at least 64%.[i]

This decline in availability of acute care has resulted in tragic outcomes for many individuals with serious behavioral health conditions, including high rates of incarceration. The book *Insane: America's Criminal Treatment of Mental Illness"*[ii] estimates that about half the inmates in U.S. jails and prisons have mental illnesses. Millions of individuals with serious mental illness (SMI) and/or addiction are booked into jail every year; many for minor crimes such as loitering or vagrancy.[iii] They tend to stay in jail far longer than other individuals and often do not receive needed behavioral health treatment.

Another result of inadequate access to acute care is an increasing reliance on emergency rooms to care for individuals with SMI or addiction, even though these settings are generally not well-suited to address these patients' needs.[iv] In 2018, almost 20 years after the start of the opioid crisis, the most common type of addiction treatment provided to Medicaid beneficiaries was emergency care.[v] In many cases, and increasingly during the Covid-19 pandemic, as the supply of psychiatric beds has declined, the wait for a transfer from emergency departments to specialized inpatient or other treatment setting has increased[vi] with frequent reports of people waiting for weeks for a bed to become available. [vii]

Furthermore, the Covid-19 pandemic has highlighted and amplified the need for mental health and addiction treatment. Studies have consistently found significantly higher levels of anxiety and depression and suicidal ideation since 2020.[viii, ix] In addition, alcohol consumption has increased significantly, [x] and drug overdose deaths continue to accelerate, reaching about 100,000 deaths during the 12-month period ending in June 2021.[xi] Suicide rates have

remained high, with troubling increases among certain groups, including Black Americans and adolescent girls. [xii] Moreover, experience with past epidemics indicates that the impact on behavioral health may continue for years to come.[xiii] The number of people needing behavioral healthcare following the pandemic is predicted to increase by 50% compared with pre-pandemic levels.[xiv]

Recommendations

Strengthen network adequacy standards for the full continuum of mental health and addiction treatment.

NABH appreciates CMCS' interest in increasing mental health and addiction treatment providers' participation in Medicaid and CHIP. As highlighted in recent rulemakings by the Center for Consumer Information and Insurance Oversight (CCIIO) and the Center for Medicare (CM), managed care networks generally do not include sufficient behavioral healthcare providers. CM has codified network adequacy standards for Medicare Advantage (MA) plans, including time and distance standards for psychiatry and inpatient psychiatric facilities. It has also encouraged coverage for telehealth including for psychiatry. Nonetheless, the most recent MA proposed rule highlighted continued difficulties regarding network adequacy for behavioral health.[xv] CCIIO recently proposed to re-establish time-and-distance standards for qualified health plans (QHPs) and to expand the types of behavioral health providers assessed under these network adequacy standards to include outpatient clinical behavioral health and residential treatment.[xvi] Furthermore, in these MA and QHP proposals, managed care plans would be required to demonstrate compliance with network adequacy requirements prior to approval for participation in Medicare or the federal marketplaces.

We urge CMCS likewise to strengthen network adequacy standards for Medicaid fee-for-service and Medicaid managed care. We recommend that CMCS expand the types of providers included in these network adequacy assessments beyond the categories that have traditionally been used, i.e., psychiatry and inpatient psychiatric facility services. We urge CMCS to establish network adequacy standards for behavioral healthcare providers across the full continuum of behavioral healthcare, including outpatient, intensive outpatient, partial hospitalization, residential, and inpatient care. These levels of care have been specified in leading practice guidelines for addiction treatment and mental health treatment, e.g., the ASAM Criteria from the American Society for Addiction Medicine[xvii] and Level of Care Utilization System (LOCUS) from the American Association of Community Psychiatrists.[xviii] Network adequacy standards should apply to each of these levels of care that are widely recognized as critical components of the continuum of care that individuals with mental illness or addiction may need.

In addition, we urge CMCS to establish separate network adequacy standards for mental health and addiction treatment providers instead of combining them. This action would help to improve access to both types of providers, especially during this time when so many people are struggling with mental health conditions and/or addiction. We encourage CMCS to follow the lead of those states that have recognized the need to improve access to both types of providers and thus have established network adequacy standards for addiction treatment that are distinct from mental health treatment.[xix] We also recommend establishing separate standards for child and adolescent behavioral health providers.

Enhance monitoring and enforcement of network adequacy.

CMCS should ensure states are requiring their Medicaid and CHIP managed care plans meet network adequacy standards for mental health and addiction treatment providers prior to approval of contracts with these plans to participate in state Medicaid and CHIP. CMCS and states should only permit exemptions from network adequacy requirements for plans that demonstrate their reimbursement rates meet the Medicare rates or are comparable to rates for similar medical/surgical services as already required by the federal parity rules that apply to these plans.[xx]

In addition, CMCS should incorporate reporting on network adequacy standards for fee-for-service and Medicaid managed care into the core set of behavioral health measures states are required to report on starting in 2024 for the children's core set[xxi] and in 2025 for the behavioral health measures in the adult core set.[xxii]

Require Medicaid programs and plans to implement parity compliance documentation requirements in Medicaid and CHIP.

The *Consolidated Appropriations Act, 2021* (CAA of 2021, Pub L 116-260)[xxiii] established new requirements for commercial health insurance plans and issuers to document compliance with the *Mental Health Parity and Addiction Equity Act* (MHPAEA) requirements regarding non-quantitative treatment limitations (NQTLs) for mental health and addiction treatment benefits. CCIIO also extended these documentation requirements to QHPs through a recent rulemaking.[xxiv]

Although the Medicaid and CHIP parity regulations include requirements that states and MCOs document compliance with parity in their Medicaid and CHIP programs, these requirements are far less detailed than the new documentation requirements included in the CAA of 2021. As the Departments of Labor (DOL), Treasury, and Health and Human Services (HHS) implement the new CAA of 2021 documentation requirements in federal parity regulations for commercial plans, we urge CMCS to follow suit and incorporate this same approach in the Medicaid managed care regulations. As CMS stated in the rulemaking implementing federal parity regulations for Medicaid managed care arrangements, the approach to applying parity to Medicaid and CHIP generally "mirrors the policy set forth in MHPAEA final regulations."[xxv] Furthermore, MHPAEA requirements apply to Medicaid managed care plans through a cross-reference to Title XXVII of the *Public Health Service Act* in section 1932(b)(8) of the *Social Security Act.* Thus, the requirements of MHPAEA apply to the Medicaid program and any changes to MHPAEA should carry over into Medicaid managed care arrangements.

Require Medicaid managed care plans to base utilization management on generally accepted standards of care under existing parity law.

Ensuring compliance with parity requirements for NQTLs has proven to be very challenging in commercial plans as well as in Medicaid and CHIP benefits.[xxvi] A helpful step would be to clarify that Medicaid programs and plans must base mental health and addiction treatment medical necessity determinations and other utilization management practices on generally accepted standards of care. CMCS should follow the lead of states that are incorporating this standard for utilization management into their requirements for state-regulated health plans as in California, Illinois, Georgia, and Oregon.[xxvii] Moreover, we appreciate that this proposal was included in the President's Budget for FY 2023 to require "Medicaid behavioral Health services, whether provided under fee-for-service or managed care, be consistent with current and clinically appropriate treatment guidelines."[xxviii] This policy should not require legislation because it is fundamentally consistent with existing parity requirements that apply to Medicaid managed care arrangements. Because utilization management and medical necessity determinations for medical/surgical benefits are generally based on clinical standards of care, a comparable approach must be used in applying utilization management and medical necessity determinations to mental health and addiction treatment benefits in Medicaid managed care arrangements to which parity requirements apply. However, coverage for mental health and addiction treatment by managed care plans is often not based on generally accepted standards of care, and therefore CMS should clarify this policy in regulations.

Establish additional benefit classification in parity rules for intermediate level of care.

Partial hospitalization, intensive outpatient, and residential treatment programs are critical for helping people with serious behavioral health conditions transition out of acute inpatient settings when they no longer require that level of care. These treatment settings in the intermediate level of care can also serve as alternatives to inpatient care for those who require intensive services but do not need acute care. However, capacity of these treatment settings is very limited, and managed care plans and issuers often place strict limits on receiving care in these settings.

The MHPAEA regulations designated six classifications of benefits to determine compliance with parity rules: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescriptions drugs, and emergency care. The MHPAEA final rule clarified that managed care plans and issuers should categorize intermediate level of care treatment settings in either the outpatient or inpatient benefit classifications for purposes of a parity analysis. However, partial hospitalization, intensive outpatient, and residential treatment programs clearly belong in a separate intermediate level of care comparable to skilled nursing facilities and rehabilitation programs for medical conditions. Designating a separate intermediate level of care classification would help to clarify how parity applies to these services. In addition, it could improve health plan coverage of partial hospitalization, intensive outpatient, and residential programs. Under the federal parity rules, if treatment is covered in a benefit classification for medical/surgical purposes, then plans and issuers must cover treatment for mental health and substance use disorders in that classification. We urge you to revise the parity rules to add an intermediate level of care benefit classification for purposes of compliance with parity.

Improve Medicaid reimbursement for mental health and addiction treatment providers.

Behavioral healthcare providers at all levels of care struggle with low reimbursement rates; for example, average in-network reimbursement rates in Medicare Advantage and commercial plans for primary care were almost 24% higher than reimbursements for behavioral healthcare office visits in 2014.[xxix] Another study found that MA and commercial plans paid 13% to 14% less than the Medicare fee-for-service (FFS) rate for in-network mental health services while paying significantly more than Medicare FFS rates for the same services when provided by non-behavioral healthcare providers.[xxx] This study also found that lower in-network reimbursement for mental health services did not reduce costs for patients because they had to access treatment so often out of network. These findings are consistent with other research showing that psychiatrists receive between 13% and 20% less in reimbursement for the same in-network services compared with other physicians.[xxxi]

Furthermore, hospitals in rural areas, which often qualify as critical access hospitals in the Medicare program, provide a crucial source of behavioral healthcare to their communities where access to care is generally in very short supply. These facilities can include inpatient psychiatric units, and they also assist in developing community-based services and recruiting mental health practitioners.[xxxii] These small independent institutions in remote, rural areas incur higher operating costs than their urban counterparts. Furthermore, the populations they serve are generally made up of older and sicker patients with lower incomes than individuals living in urban areas.[xxxiii]

According to our members, low reimbursement by managed care plans combined with increasing enrollment of beneficiaries in these plans are causing hospitals to close in rural areas. Currently 46% of rural hospitals operate at a loss—an increase from 40% in 2017.[xxxiv] It has been estimated that 21% of all rural hospitals are in danger of imminent closure.[xxxv] We urge you to work with state Medicaid agencies to improve reimbursement policies for hospitals in rural areas that are critical for maintaining access to inpatient behavioral healthcare. Improving availability of services in rural communities can help prevent out-of-state placement of beneficiaries in facilities that are far away from families and support systems that are so critical to recovery especially for young people experiencing serious behavioral health conditions.

CMCS should encourage states to reexamine and improve their Medicaid rates for behavioral healthcare to

encourage greater participation by mental health and addiction treatment providers in those programs and improve access to care for beneficiaries. In particular, we urge CMCS to require Medicaid managed care plans to demonstrate that their reimbursement rates for mental health and addiction treatment are comparable to the rates for similar medical/surgical services as part of the application process for participating in Medicaid. Federal parity rules that are incorporated into the Medicaid managed care rules identify reimbursement policies as NQTLs. Therefore, this requirement already applies to Medicaid managed care plans. However, as a recent report from the DOL, Treasury, and HHS noted, there is widespread lack of compliance with parity rules for NQTLs.[xxxvi] Furthermore, demonstration of comparable reimbursement rates should be a prerequisite for any exception that may be allowed for Medicaid managed care plans to network adequacy requirements.

Other potentially helpful steps would be to publicize findings from the Demonstration to Increase Substance Use Provider Capacity in Medicaid[xxxvii] and to develop best practices guidance—particularly regarding reimbursement policies and reducing administrative burden. Disincentives for participation by mental health and addiction treatment providers in coverage programs include excessive prior authorization and other utilization management requirements that vary by program as well as other administratively burdensome requirements such as excessive credentialing requirements for mental health and addiction treatment providers. Best practices from states may be instructive as, for example, a number of states have implemented uniform prior authorization forms.[xxxviii]

CMCS could consider promulgating payment regulations as the Center does for outpatient drugs or establish guidelines for states on setting Medicaid reimbursement rates for mental health and addiction treatment. These guidelines could incorporate instructions to eliminate state restrictions on same-day billing and allow providers to be reimbursed for more than one behavioral health services or both behavioral health and physical health services on the same day as proposed in the President's Budget for FY 2023.

Finally, CMCS should increase transparency in the reimbursement rates offered by each state Medicaid program and Medicaid managed care organizations for mental health and addiction treatment services. These rates should be published on the CMCS website to raise awareness regarding the inadequacy of these rates that prevent participation in Medicaid and CHIP by more mental health and addiction treatment providers. In addition, this transparency would help identify where payment for the same services provided by behavioral health providers is often significantly lower than payment for those same services when provided by physical healthcare providers.[xxxix]

Encourage continued Medicaid coverage of telehealth for mental health and addiction treatment including audio-only.

One positive outcome of the pandemic has been broader awareness of how helpful telehealth can be for increasing access to mental health and addiction treatment. This is especially true in communities without local providers and for individuals who have difficulty attending in-person appointments. Telehealth is particularly effective in behavioral healthcare delivery, especially psychiatric and psychological services.[xl] Examples of behavioral health services that can be delivered effectively via telehealth include depression screening, follow-up care after hospitalization, behavioral counseling for substance use disorders, medication management, and psychotherapy for mood disorders and partial hospitalization.[xli, xlii] Furthermore, telehealth has also been found to increase retention for addiction treatment, including MAT, especially when treatment is not otherwise available or requires lengthy travel to treatment.[xliii]

Telehealth can also facilitate collaboration and consultation between behavioral healthcare specialists and primary care and emergency department clinicians to expand capacity to provide care for mental health and substance use disorders.[xliv] In addition, there is evidence of reduced utilization of higher-cost services associated with providing

access to behavioral healthcare services via telehealth technologies.[xlv] The experience of our members in delivering behavioral healthcare during this pandemic is consistent with these research findings.

We urge CMCS to use its authority to encourage continued coverage of behavioral healthcare services via telehealth by Medicaid and CHIP programs and plans. This continued coverage of telehealth should include coverage of audio-only telehealth for mental health and addiction treatment. Coverage of services provided via audio-only technology is particularly important for certain vulnerable populations, including Medicaid beneficiaries who are older and/or challenged with disabilities. These individuals often face additional barriers to accessing care through the video-based technologies and platforms. A recent study found that among telehealth users, individuals who are older, Black, American Indian, male, or non-native English speakers have been significantly less likely to use video technology. [xlvi] Our members are concerned that many of their more vulnerable patients are unemployed or under-employed and sometimes homeless and simply do not have access to internet service to support video technology.

One way to incentivize Medicaid coverage of telehealth may be to recognize access to behavioral health providers via telehealth as helping to achieve network adequacy standards. However, telehealth services should not be counted as equivalent to in-person services for purposes of determining network adequacy. Medicaid and CHIP programs and plans should receive some credit toward network adequacy standards for making treatment via telehealth available, but it should not entirely replace availability of in-person care in terms of network adequacy. Network adequacy standards should support availability of mental health and addiction services both in-person and via telehealth. Treating telehealth as equivalent to in-person care in terms of network adequacy would undercut the utility of network adequacy requirements and likely undermine policies designed to improve availability of behavioral healthcare services, particularly in rural areas.

Encourage states to support implementation of electronic health records by mental health and addiction treatment providers.

As discussed in detail at the Medicaid and CHIP Payment and Access Commission (MACPAC) meeting on Sept. 24, 2021, mental health and addiction treatment providers trail far behind other types of providers in implementing electronic health records (EHRs) that are critical for improving integration and coordination of care for individuals with mental health and/or substance use disorders. Less than half of psychiatric hospitals have implemented certified electronic health record technology compared with 96% of general hospitals.[xlvii]

This discrepancy is due to the exclusion of psychiatric hospitals from the $35 billion in subsidies for EHR implementation provided by the *Health Information Technology for Economic and Clinical Health Act* of 2009 (*HITECH Act*) (Pub. L. 111-5), as well as low operating margins at these facilities that make it impossible to absorb these additional costs.[xlviii] As the rest of healthcare is moving toward increased interoperability and electronic communication, behavioral healthcare providers are being increasingly left behind which inhibits integration and coordination of care.

According to a State Medicaid Director Letter (SMDL) issued by CMCS in 2018 regarding Opportunities to Design Innovative Service Delivery Systems for Adults with Serious Mental Illness or Children with a Serious Emotional Disorder, “[s]tates may be able to access enhanced federal Medicaid matching funds for costs to state Medicaid agencies of implementing and operating technology to improve data-sharing capabilities as part of the MITA, the Medicaid Information Technology Architecture (MITA)”.[xlix] The SMDL goes on to point out that “[s]tates could use this authority and enhanced match to develop connections between mental healthcare providers and schools, hospitals, primary care, criminal justice, and faith communities.”

MACPAC commissioners have discussed the need to support implementing EHRs in behavioral healthcare settings multiple times, most recently on April 7,

2022— when MACPAC staff said the MITA guidance has not been updated in 15 years. In addition, MACPAC staff

highlighted that there are Medicaid authorities that can cover EHR hardware and software costs for providers including with directed payments through managed care and section 1115 demonstrations. We recommend issuing guidance on the availability of MITA with enhanced federal Medicaid match as well as any other Medicaid authorities including managed care directed payments that can be used to support broader implementation of EHRs among behavioral healthcare providers.

Support implementation of crisis stabilization programs and systems.

Establishment of 988 as a nationwide, toll-free mental health crisis and suicide prevention hotline[i] presents a game-changing new opportunity to improve access to behavioral healthcare while decreasing boarding in emergency rooms and incarceration of people struggling with mental illness or addiction. Congress has recently provided significant new grant funding through the Substance Abuse and Mental Health Services Administration (SAMHSA) to increase the capacity of call centers that will receive calls from the hotline. In addition, Congress established a new set-aside in the Community Mental Health Services Block Grant for crisis stabilization programs while significantly increasing funding for the block grant overall.[ii] Congress also clarified Medicaid coverage of services provided by mobile crisis teams,[iii] and the guidance from CMCS on these provisions should encourage states to consider how Medicaid can support crisis stabilization programs and systems.

We urge CMCS to continue encouraging state Medicaid agencies to engage in developing crisis stabilization programs and systems in their states. There are a number of Medicaid authorities as outlined in the recent CMCS guidance on mobile crisis services and the recently increased home and community-based care authorities that states can use to provide Medicaid support for crisis stabilization services. However, without Medicaid agency involvement in the planning and implementation, states may not consider these opportunities and will instead rely on available grant funding today that may not be available in the future.

Furthermore, we urge CMCS to encourage state agencies involved in developing crisis stabilization programs and systems to coordinate with existing behavioral healthcare providers who must be an essential part of this work on improving access to crisis stabilization services. Many psychiatric health systems and addiction treatment providers that are NABH members provide crisis stabilization services. According to SAMHSA's National Mental Health Services Survey data for 2020, most private psychiatric hospitals (59%) have a crisis intervention team within the facility and/or offsite and a significant portion of partial hospitalization programs do as well.

Moreover, mental healthcare and addiction treatment workforce shortages are significantly limiting provider capacity across the nation. Given the need to expand the availability of crisis stabilization services quickly, we recommend working with the existing behavioral healthcare providers, including psychiatric health systems and addiction treatment centers, to extend their existing capacity to provide crisis stabilization programs. It will also be important to ensure that states and localities— as well as any new crisis stabilization programs that are developed— coordinate closely with those existing providers to connect people who call 988 with on-going care if they need it.

Thank you for considering our concerns and recommendations. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100.

Sincerely,

Shawn Coughlin
President and CEO

National Association for Behavioral Healthcare

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About NABH

The National Association for Behavioral Healthcare (NABH) represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in all 50 states and Washington, D.C.. The association was founded in 1933.

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