April 10, 2014

Barbara Edwards
Director
Disabled and Elderly Health Programs Group
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244–8016

Dear Ms. Edwards,

On behalf of Medicaid Health Plans of America (MHPA), I thank you for your work to establish rules for applying the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 to Medicaid managed care. As your agency considers how this law applies specifically to the Medicaid program, MHPA would like to share some thoughts and concerns about how Medicaid behavioral health and substance use disorder services and supports differ from the commercial market.

MHPA is the leading national trade association solely representing Medicaid managed care plans, ranging from multi-state, for-profit plans to small, non-profit plans. MHPA's 117 health plan members serve the nation's poorest, most vulnerable population across 34 states and D.C. MHPA plans proudly manage the care of over 18 million Medicaid enrollees, through the use of innovative programs that keep individuals and families healthy, manage chronic diseases, and avoid expensive hospitals stays. Additionally, MHPA plans meet quality measures and deploy quality improvement projects that produce positive health outcomes. Through our health plans' partnership with state Medicaid agencies, MHPA health plans provide valuable cost savings and budget predictability to states in a time of sweeping changes to our health care system, uncertainty and tight budgets.

MHPA supports efforts to provide our nation's most vulnerable citizens with quality, value-based behavioral health benefits. MHPA plans have experience integrating both physical health and behavioral health benefits in many states and varied models of care. We strongly support the intent of the MHPAEA and the work that your agency is doing to ensure that our most vulnerable citizens with BH disorders are able to access quality and appropriate BH services at least as easily as they can access PH services. We do however note that the commercial insurance system does have distinctions from the Medicaid system, distinction that require a slightly different approach to the final rule interpretations for Medicaid plans. We'd like to discuss a few of those here.

While many behavioral health services are covered in the commercial market as well as by the Medicaid program (e.g. intensive outpatient (IOP), inpatient mental health and substance abuse detoxification services, etc.), the Medicaid program's behavioral health coverage includes a broader set of outpatient services and supports (e.g. case management, supportive housing, and peer support, etc.). The benefits available vary widely as do the providers who offer the services, such as psychiatrists, psychologists and case managers. Also, those with Severe Mental Illness (SMI), more prevalent in the Medicaid population, often require lifelong supportive services.

Variation in Service Models: The service models in Medicaid vary significantly from commercial behavioral health benefits, and the continuum of care can differ across states, making it difficult for members to navigate

treatment services, especially for members who move between states. For levels of intensive care that do not fall under the definition of inpatient care, the application of the Final Rule to Medicaid could present challenges. For example, case management and psychosocial rehabilitation services, which are common behavioral health benefits in Medicaid, help ensure access to high quality care and appropriate utilization; however, if these benefits are classified as outpatient care (OP), an MCO may have limited ability to manage these benefits. Additional subclassifications within the outpatient category would lead to mapping of the specific outpatient behavioral health services should be more closely aligned with the mapping in outpatient medical services (e.g., outpatient office visits, medication management visits and other brief non-scripted services which do not require a preauthorization currently and do not have specific guidelines for their use). Other, higher levels of care such as case management and peer support, which have specific guidelines for their use, should be mapped to an appropriate physical health service where possible. However, some behavioral health services may not have a corresponding physical health service that can be used for mapping purposes, and this complexity should be factored into how parity applies in Medicaid.

Care Coordination and Support: In the Medicaid behavioral health model, MCO's behavioral health care management team serves as the centralized support service and helps the member navigate an often complex array of providers, benefits and services. Medicaid members often lack a support system, such as a family member, to assist in accessing the scope of physical and behavioral health services. Unlike medical care, where a member's primary care provider (PCP) coordinates services, in behavioral health, the PCP often is unable to advise the member on the full scope of service options. In addition, providers are not incentivized to coordinate between several other providers since it is time consuming and they are not reimbursed for this. MCOs have the capacity to coordinate among providers and agencies, enabling the MCO to holistically manage the member's physical and behavioral health care. This is complimented by the MCO's knowledge of which services and providers are most appropriate, in different geographic areas.

The capacity MCOs have to coordinate services in the best interest of the members is cornerstone to the value managed care brings to members and the Medicaid program and should be maintained as parity applies to Medicaid. For behavioral health, there are a number of intensive, costly and time-consuming treatments that are classified as OP benefits because they are delivered for less than 24-hours a day. These services – such as intensive OP or partial hospitalization – have the potential to cost states significantly and lead to less-than-optimal health outcomes if they are not managed properly (and in some instances may not be in the best interests of the person who might need an even higher level of care). For example, a member with a SMI could remain in a partial hospitalization program (PHP) for an extended period, when the next course of treatment would be a wrap-around treatment plan involving more than one service listed under the unique public sector services. Not only could this be the best course of treatment for the member, but it also would be more cost efficient for the State and CMS.

Non-Quantitative Treatment Limitations (NQTL): The Final Rule also says that commercial health plans cannot impose NQTL on mental health or substance use disorder benefits based on factors or standards any more stringent than those used to impose NQTL to medical/surgical benefits. Unlike medical/surgical treatment, there are few objective standards for behavioral health treatment. Medical/surgical treatment follows its own course with a far lesser need for oversight; most patients do not seek repeated colonoscopies or chemotherapy unless there is a clear medical/surgical need.

Because Medicaid beneficiaries are more likely to have SMI or other severe mental and behavioral health issues than the commercially covered population, in some instances it may not be appropriate to manage behavioral health access the same way as medical services. Behavioral health patients may continue treatment unnecessarily because of psychodynamic issues and other reasons unrelated to medical necessity.

There may be a greater need among the Medicaid population for plans to manage behavioral health treatment using criteria such as medical necessity. For example, allowing MCOs to require prior authorization of IP benefits for psychiatric admissions directly from EDs ensures enrollees' access to alternative crisis stabilization options available to them. This would represent a more stringent requirement in assessing the need for behavioral health treatment than that placed on medical services, but may provide access to a more appropriate, less-costly setting for the member's needs. Also, it's important that as parity applies to Medicaid, the MCOs' ability to perform utilization review, including concurrent review, is maintained. This is particularly problematic in the outpatient category, as many MCOs perform only limited management of the medical benefits in this category. The ways in which these types of tools allow MCOs to manage patients' health and reduce costs is important to helping sustain the overall Medicaid program

Potential for Fraud, Waste and Abuse (FWA): MHPA remains committed to program integrity throughout Medicaid. Fraudulent behavior in Medicaid is often times identified through clinical intervention. For example, providers may bill the MCO separately for each individual family member in family treatment (e.g., bill six individual sessions for a single family session for a family of six). Clinically oriented care management helps to steer members to the more efficient model of care (i.e., in this case, family treatment), as well as to uncover related abuses. If the Centers for Medicare & Medicaid Services (CMS) limits the ability of Medicaid MCOs to properly manage behavioral health benefits, more members are likely to receive unnecessary or inappropriate care as part of fraudulent practices and, additionally, CMS and its state partners are likely to see more wasteful billing practices.

As the Medicaid program has evolved, it has become imperative to design programs that effectively manage both physical health and behavioral health services. Because many health conditions manifest with both physical and behavioral health symptoms, it becomes increasingly difficult to separate the cost impact; in addition, the co-morbidities that often exist as a result of one condition can and do impact the other when not addressed comprehensively and holistically. MCOs provide a unique benefit in their person-centered integration of physical and behavioral health services that relies often on innovation, flexibility and close and continuing partnership with state Medicaid agencies and enrollees.

MHPA applauds the U.S. Department of Health and Human Services, CMS, and related agencies in developing the commercial Mental Health Parity Final Rule with the goal of improving the delivery of behavioral health benefits. As you work to develop policies for Medicaid parity, MHPA believes that the organization and member health plans would serve as a valuable consultant in the development of meaningful standards that fulfill the spirit of Mental Health Parity while driving value in Medicaid through best practice, person-centered care and medical management. We look forward to a continued partnership with CMS as the agency develops further Mental Health Parity standards relevant to Medicaid and the members we serve.

Thank you, in advance, for your consideration. Please contact Amy Ingham at aingham@mhpa.org or (202) 857-5726 if you have any questions.

Sincerely,

Jeff Myers
President and CEO