Community Behavioral Healthcare Association of Illinois

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Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Notice of Proposed Rulemaking: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability (CMS-2390-P)

Dear Administrator Slavitt:

The Community Behavioral Healthcare Association of Illinois (CBHA) welcomes the opportunity to provide comments on CMS' notice of proposed rulemaking modernizing the Medicaid managed care regulations. CBHA is a statewide trade association that represents community-based mental health and substance use treatment providers who provide care, treatment and services to individuals with mental health and substance use disorders and conditions. We appreciate the opportunity to provide feedback on these important regulations.

Medicaid serves a diverse range of low income and medically vulnerable populations, many of whom are living with a mental illness or addiction, often co-occurring with one or more chronic physical health conditions. In recent years, states have continued to expand the use of managed care to include more Medicaid enrollees, with far-reaching effects on individuals living with these conditions. Given Medicaid's unique role in serving this complex population, it is crucial that managed care arrangements provide sufficient and appropriate protections for Americans in need of mental health or addiction care. Prior Medicaid managed care regulations have not kept pace with the fast-moving changes in our delivery system, and CMS' proposed updates to these regulations are a welcome step toward bringing our managed care delivery system into the 21st century.

We thank CMS for promulgating a proposed rule that updates and modernizes key managed care requirements. We offer our recommendations for preserving these positive elements and further strengthening the final rule below.

Institutes for Mental Disease Exclusion
The proposed rule (at section 483.3(u)) would permit managed care plans to cover within their capitated rate certain services for which payment would otherwise not be available under the Institutes for Mental Disease (IMD) exclusion. The IMD exclusion was put in place in the early days of the Medicaid program as a way to ensure that states would continue to bear the responsibility for covering inpatient mental health treatment; it also extends to facilities offering addiction care. However, as our nation's addiction treatment delivery system has evolved over recent decades, the IMD exclusion has proved detrimental to individuals in need of addiction treatment, as it restricts access to an important component of the full spectrum of addiction care.

Individuals in need of acute inpatient addiction treatment services, residential addiction care, or detoxification all too often find they cannot access such services through Medicaid because of the payment prohibition. The 16-bed limit keeps treatment facilities from expanding to meet community needs, creating long waiting lists and extended delays before patients are able to access treatment. In an era when comprehensive mental health and addiction parity regulations have been put in place, IMDs remain the only treatment setting subject to a coverage limitation based solely on the fact that they provide care to individuals with mental illness or addiction disorders.

The proposed rule takes a limited approach to addressing this issue, allowing managed care plans to cover within their capitated rate services provided in certain institutions for mental disease. We thank CMS for its attention to the important issue of expanding Medicaid enrollees' access to residential substance use treatment, detoxification, and acute inpatient addiction care. However, we are concerned about a discrepancy in the regulation that could inadvertently limit patients' access to much-needed services.

The preamble to the rule clearly states that the new proposal is inclusive of facilities "providing psychiatric ***or substance use disorder (SUD) inpatient care*** or sub-acute facility providing psychiatric ***or SUD crisis residential services*** and the stay in the IMD is for less than 15 days in that month" (emphasis added). Yet, the regulatory text itself (at section 483.3(u)) fails to identify substance use treatment facilities in its description of the types of IMDs that may be included in the capitated payment. It states only that these payments may be made "so long as the facility is an inpatient hospital facility or a sub-acute facility providing crisis residential services, and length of stay in the IMD is for a short-term stay of no more than 15 days during the period of the monthly capitation payment."

We are concerned that the discrepancy between the preamble and the regulatory text could lead to confusion among providers and managed care plans about the extent to which substance use treatment services may be covered when provided in an IMD setting. We strongly urge CMS to clarify and strengthen the proposed regulatory text to expressly include substance use disorder inpatient care and substance use disorder residential services in the description of types of IMD services that may be covered.

The proposed length of stay up to 15 days in one month with the average length of stay of 8.2 days is data from the Medicaid Emergency Psychiatric Demonstration. These lengths of stay are referring to acute inpatient psychiatric services, not substance abuse residential services. The sub-acute definition of "short-term stays" according to the *U.S. Department of Health and*

Human Services: Sub acute Care Review of Literature is 3-30 days. Medium stays are considered to be 31-90 days. If parity is applied, short-term care for medical/surgical equals short-term care of substance abuse residential. The 15-day parameter is not clinically appropriate when applied to non-hospital Substance Use Disorder (SUD) Institutes for Mental Disease IMDs, such as community-based residential substance abuse treatment programs.

The American Society of Addiction Medicine (ASAM) has developed patient placement criteria and principles that guide substance use treatment providers across the country. Many states require SUD providers to follow ASAM standards in providing services. The ASAM criteria "are the most widely-used and comprehensive set of guidelines for placement, continued stay and transfer/discharge for patients with addiction and co-occurring disorders," (ASAM.org) and "were developed as a consensus-based guide to 'best practices' by committees of experts and diverse stakeholders." (ASAM Principles of Addiction Medicine - 5th edition (2014).)

According to *ASAM Patient Placement Criteria, Second Edition-Revised*:

"[T]he duration of treatment always depends on an individual's progress. Nevertheless, the length of service in a clinically managed level III.5 program tends to be longer than in the more intensive medically monitored and medically managed levels of care [such as in a hospital]. Longer exposure to treatment interventions is necessary for residents to acquire the basic living skills and master the application and demonstration of coping and recovery skills" (pgs. 75-76).

Additionally, *ASAM Principles of Addiction Medicine - 5th edition (2014)* notes:

"…many naturalistic studies of substance abuse treatment have found longer stays in treatment to be associated with better outcomes, even a reduction in premature mortality" (pg. 421).

Thus, the proposed 15-day parameter, or any fixed parameter, for length of treatment or stay contradicts published ASAM criteria for residential substance abuse treatment.

In addition, the allowable billing days "per month" component of the Proposed Rule does not apply as readily to SUDs as it may to psychiatric care, and is not clinically appropriate. Although SUDs are a chronic condition often requiring multiple treatments (as do other chronic diseases), it is not typical to have residential treatment in multiple consecutive months, as may be the case for psychiatric disorders. The typical length of stay for SUD may occur within the course of one month, or run from one month into the next, but not on a repetitive cyclical basis. Typically, after residential treatment, care is provided in an outpatient setting, not in the IMD. A fixed number of days contradict ASAM criteria as artificial early discharge sets the individual with SUD up for a high probability of relapse.

Recommendations:

- CMS should clarify that this exception to the IMD payment prohibition applies to inpatient and residential substance use care by aligning the text of the proposed section 483.3(u) with the text of the preamble. Specifically, 483.3(u) should be revised to read: "The State may make a monthly capitation payment to a MCO or PIHP for an enrollee receiving inpatient psychiatric or substance use disorder (SUD) treatment in an Institution for Mental Diseases, as defined in §435.1010 of this chapter, so long as the facility is an inpatient hospital facility or a sub-acute facility providing psychiatric or SUD crisis residential services…"
- We encourage CMS to preserve the language in the proposed rule improving flexibility related to substitute providers under Medicaid managed care programs for CMS's "in lieu of" policy. The proposed clarification related to the "in lieu of" policy is important to ensure that MCOs can meet the range of mental health and substance use needs of their enrollees.
- We request that CMS clarify that the IMD payment exclusion does not apply to patients receiving covered mental health or substance use services in facilities considered IMDs under the "in lieu of" policy, and that MCOs can continue to receive payment for other appropriate covered services provided to enrollees while they are patients in those facilities.
- We urge CMS to reconsider the exception to the IMD rule: This obviously needed to be addressed as it was limiting care for many and/or payment for providers. The "15 day rule" will still result in problems, however. National averages for length of care are cited, but these averages are skewed dramatically by a number of relatively short stays. Often to complete a course of treatment will result in longer than 15 days of stay. If this eliminates the capitated payment for a MCO, they will do everything they can to limit care to 15 days or less to avoid paying for care that is uncompensated. Of course, there is a desire to limit expense regardless of what they get paid, but this would be an extreme case. So, those providers will get paid, but I believe the course of care will be cut short for potentially the most promising treatment candidates (i.e., those who haven't already dropped out).
- We recommend that CMS reconsider the "15 day limit" that is being proposed for substance use disorder treatment in-patient care. We urge CMS to use nationally recognized clinically appropriate substance use treatment guidelines that stress longer length of stays equals better outcomes.

Network Adequacy

At section 438.68, CMS proposes that states must establish network adequacy standards for specified provider types, including behavioral health professionals. In crafting these standards, states must consider, at a minimum, anticipated Medicaid enrollment and utilization of services, the characteristics and health care needs of specific Medicaid populations covered by the plan, the numbers and types of heath care professionals required to furnish the contracted Medicaid services, the numbers of these providers who are accepting new Medicaid patients, the geographic location of the health care professionals in relation to Medicaid enrollees (taking into account the distance, travel time, and means of transportation typically used by these Medicaid enrollees), the ability of health care professionals to communicate with limited-English-proficient enrollees in their preferred language, and more.

We appreciate CMS' attention to ensuring that beneficiaries have access to a sufficient selection of mental health and addiction treatment providers without unreasonable delay. We commend CMS for encouraging states to take into account the length of time and distance beneficiaries would have to travel to access services; however, we caution that time and distance are not the only important indicators of whether any given beneficiary has timely access to care. In the preamble to the proposed rule, CMS notes that "we believe time and distance standards present a more accurate measure of the enrollee's ability to have timely access to covered services than provider-to-enrollee ratios" such as those used in the Medicare Advantage program." We concur with this assessment, but note that network adequacy standards must also take into account the total number of local behavioral health providers in relation to beneficiaries' anticipated need for services. The ratio of providers to enrollees must be sufficient, within the reasonable time and distance standards established by the state, to ensure robust availability of behavioral health services for all beneficiaries.

Furthermore, we encourage CMS to take into account the geographic locations of the country in which there is simply an insufficient supply of behavioral health providers to meet all enrollees' needs. We encourage CMS to include language in this proposed rule clarifying that in areas where not enough providers are available to meet the state-established network adequacy standards, managed care plans may include within their capitated rate the costs of utilizing telehealth or telepsychiatry services to extend patients' access to care. Current practices in Medicaid coverage of telehealth services vary widely from state to state, meaning that beneficiaries' access to an adequate array of providers in remote or underserved areas depends in part upon whether and how their state has opted to cover telehealth services.

Additionally, we note that many important mental health and addiction treatment services are provided by a wide range of non-physician health care professionals such as licensed clinical social workers, licensed professional counselors, substance abuse counselors, and peer recovery specialists. These professionals play a critical role in the provision of routine health management as well as crisis care, care provided in intermediate care settings such as residential substance abuse treatment, and more. States' network adequacy standards must take into account the diversity of the behavioral health workforce and must ensure patients have access to masters-level or bachelors-level providers when necessary and appropriate. States should also ensure that their network adequacy standards are sufficient to provide patients with access to the full range of needed behavioral health treatment; for example, network adequacy standards should include sufficient physicians who are licensed to prescribe buprenorphine, naltrexone and naloxone so as to safeguard patients' access to medication-assisted treatment for opioid addiction.

Within the proposed rule's section on network adequacy standards, CMS adds that "given the large number of pediatric Medicaid enrollees, we believe it is important for states and plans to specifically include pediatric primary, specialty, and dental providers in their network adequacy standards." Given the severe shortage of pediatric mental health and addiction providers around the country, we support requiring that plans assess network adequacy separately for pediatric specialty providers than for adult providers.

The proposed regulation also outlines factors that must be considered in these standards' transparency. We strongly support transparency in disclosure of plans' network adequacy standards and urge CMS to preserve this provision in the final rule.

Recommendations:

- CMS should strengthen patients' access to behavioral health care services in the network adequacy standards by:
  - Requiring states to include within their network adequacy standards, appropriate standards to ensure patients have timely access to mental health and substance use crisis, emergency, urgent, and routine care.
  - Requiring states to give funding structures for providers who serve populations in the rural areas of a state so as not to make rural areas such an exception that the residents' access to care is virtually ignored.
  - Permitting managed care plans to include the cost of telehealth services in their capitated rates whenever needed to expand access to health care providers such as mental health and addiction treatment professionals.
  - Prohibiting managed care plans from excluding or discriminating against providers that serve high-risk populations such as individuals living with serious mental illness or addiction.
  - Requiring managed care plans to recognize the state's licensing standards for mental health and addiction services as necessary and sufficient to enter the network.
  - Requiring managed care plans, when appropriate for the service or populations, to develop efficient methods to credential masters-level clinicians not yet licensed or who have 3 years of experience, including substance abuse counselors, direct care, and peer/recovery staff.
  - Requiring managed care plans to include in their networks all willing physicians who are certified to administer buprenorphine, unless they do not meet other minimum standards.
- CMS should preserve the proposed rule's requirement that network adequacy standards be assessed separately for adult and pediatric specialty care providers such as pediatric behavioral health professionals.
- CMS should preserve the proposed rule's requirements in regards to transparency and disclosure of plans' network adequacy standards.

Formulary Requirements

In section 438.3(s)(1), CMS proposes to require MCOs to provide drug coverage that meets the standards imposed by the Medicaid rebate statute as outlined in section 1927 of the Social Security Act, if MCOs are contractually obligated by their state to provide prescription drug coverage and if the section 1927 standards apply directly to the MCO. However, at the same time, the proposed rule allows states to permit MCOs to maintain their "own formularies" without specifying whether those formularies must comply with the formulary requirements in section 1927, such as prior authorization requirements, or whether plans would have flexibility to limit their drug coverage in comparison to what is required in the Medicaid rebate statute.

The proposed rule also includes a new section 438.10 that modernizes formulary and other information standards in light of technological advances in electronic access to information. The revised 438.10(i) includes a new section on formulary information standards that would ensure all enrollees have electronic access to managed care plans' formulary drug lists. It also requires these lists to be machine-readable, facilitating the use of third-party sites that can quickly and easily aggregate and compare formulary data across plans, a useful tool in helping consumers make informed decisions about which health plan will best meet their health needs.

However, the requirements outlined in this section of the proposed rule could be strengthened by requiring disclosure of additional information. For example, the rule would require plans to disclose the formulary tier in which a particular drug is covered, but does not require the plan to identify the level of cost-sharing or the actual cost in dollars that the patient would incur for that particular drug in that formulary tier. Having information about the actual drug cost is a critical tool in informed decision-making and a vital element of the information patients need to compare the relative merits and drawbacks of their managed care plan options. Additionally, the proposed rule does not specify how frequently formulary lists must be updated and made available to patients. Formularies may change throughout the course of a year, and patients must always be able to access the most up-to-date information about which drugs are covered under their plan. Without specifying the frequency with which formulary lists must be updated, the rule fails to protect patients from making decisions based on incorrect or out-of-date information.

Recommendations:

- To maximize patients' access to medicines, CMS should clarify that permitting MCOs to maintain their "own formularies" does not permit them to offer more limited coverage than that outlined in the formulary rules in section 1927 of the Social Security Act.
- Given the importance of full access to medications for Medicaid beneficiaries, CMS should clarify patients' rights to obtain all medically necessary medications by adding clear protections for non-formulary medications to the *regulatory* text at 438.3(s)(6). Without clear regulatory protections and enforcement of these rules, it is not clear that patients will fully benefit from Section 1927's protections. This is particularly concerning since Medicaid fee-for-service programs that are governed by Section 1927 have imposed some significant restrictions on drug access in recent years.
- In section 438.3(s)(6) on prior authorization, CMS should address the process for obtaining medically necessary non-formulary medicines in ways that are simple for both the patient and provider. The ease of the process is vital to ensuring patients do not experience unnecessary complications and delays in accessing their medications.
- In section 438.10(i), CMS should clarify that formulary lists and any changes to formulary lists must be made available in real time in all required formats.
- In section 438.10(i)(2), CMS should require plans to identify both the level of cost-sharing required for drugs in that tier of coverage, as well as the actual cost the patient will incur for each drug.

Health Information Technology Incentive Payments

Under the subsection "Special Contract Provisions Related to Payment (438.6 (d)), the proposed rule adds paragraph 486.60 (c)(1)(i)-(iii), which provides an exception to the general rule for setting capitated payment rates. This proposed change would allow states to set parameters around the expenditures of managed care contracts to incentivize enhanced

delivery of care for Medicaid beneficiaries. Specifically, 483.60(c)(1)(ii) provides states the option to include in their managed care contracts participation in Medicaid-specific initiatives, including broad-based provider health information exchange projects which can include electronic health record (EHR) incentive payments for behavioral health providers.

We applaud this innovative initiative to allow states the opportunity to provide incentive payments to behavioral health providers who were previously not eligible to receive Meaningful Use incentive payments under the HITECH Act. Comorbidity between mental and medical conditions is the rule rather than the exception. Research shows that 70% of the populations served by behavioral health providers and settings in the public mental health system have co-occurring, chronic medical surgical conditions that mandate quick and quality coordinated care. Fully one-third of the nine million Americans dually eligible for both Medicare and Medicaid have a primary diagnosis of schizophrenia and a co-occurring, chronic medical condition.

True care coordination cannot take place when a crucial segment of providers lack EHRs. Health IT is the bedrock of any effort to coordinate and integrate care for all Americans. Yet, most behavioral health providers lack the resources to implement EHRs. Community mental health and substance use providers face significant financial challenges when trying to adopt comprehensive EHR systems, and fewer than 30% have successfully implemented full or partial EHR systems to date. If mental health and substance use providers cannot adopt health IT at a rate comparable to primary care facilities, hospitals and physicians' offices, it will soon become impossible to coordinate clinical care electronically.

In the final rule, we recommend that CMS clarify several items to ensure states can efficiently and effectively take advantage of this proposed initiative.

Recommendations:

- Behavioral health providers should be defined. To ensure clarity of the proposed rule, CMS should define behavioral health providers. Legislation pending in the Congress and Senate currently exists that defines these settings. For example, Congressman Tim Murphy's H.R. 2646 Helping Families in Mental Health Crisis' Title VII "Behavioral Health Information Technology", Senator Rob Portman's S. 1685 "Behavioral Health Information Technology Coordination Act", and Senator Sheldon Whitehouse's S. 1517 "Behavioral Health Information Technology Act" all define behavioral health providers and settings. These bills include the following definition:

  "(c) Medicaid providers.—

  "(iii) a public hospital that is principally a psychiatric hospital (as defined in section 1861(f));

  "(iv) a private hospital that is principally a psychiatric hospital (as defined in section 1861(f)) and that has at least 10 percent of its patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals receiving medical assistance under this title;

> *"(v) a community mental health center meeting the criteria specified in section 1913(c) of the Public Health Service Act; or*
>
> *"(vi) a residential or outpatient mental health or substance abuse treatment facility that—*
>
> *"(I) is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, or any other national accrediting agency recognized by the Secretary; and*
>
> *"(II) has at least 10 percent of its patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals receiving medical assistance under this title."; and*
>
> *"(vi) clinical psychologist providing qualified psychologist services (as defined in section 1861(ii)), if such clinical psychologist is practicing in an outpatient clinic that—*
>
> *"(I) is led by a clinical psychologist; and*
>
> *"(II) is not otherwise receiving payment under paragraph (1) as a Medicaid provider described in paragraph (2)(B)."." (Section III, S. 1685).*

- In addition to the above definition, licensed clinical social workers and mental health counselors should also be specifically listed as eligible providers.
- Payment parameters should be detailed to ensure payment efficiency. As with the HITECH Act, CMS should include payment parameters for incentive payments relevant to electronic health records. While recognizing that HIT reimbursements under Medicaid capitation arrangements to behavioral health providers will vary by state under CMS-2390-P, the BHIT Coalition nonetheless recommends payment plans similar to those utilized in the implementation of the HITECH Act's Meaningful Use incentive payments. For example, under Title IV, Eligible Professionals could receive $63,750 over 6 years, and Eligible Hospitals could receive a maximum of $2,000,000. In our view, psychiatric hospitals, CMHCs, community behavioral health organizations and substance use residential treatment centers should also be eligible for the higher hospital/facility payment.
- Compliance parameters should be defined to collaborate with primary care settings. The HITECH Act and the corresponding regulations detail the requirements for Meaningful Use incentive payments under the HITECH Act. To ensure all non-eligible providers permitted to receive incentive payments under this proposed rule can correctly collaborate with HITECH-eligible providers and settings, we recommend CMS require the same technical specifications, clinical indicators and quality requirements as mandated in Stage 1, Stage 2 and Stage 3 of the federal rules implementing the Meaningful Use incentive program. With five years of implementation experience, CMS/ONC may adopt modifications as needed including the possibility of adding to/building upon the behavioral quality indicators already required in the Meaningful Use regulations. Specifically with the behavioral health patients, it is essential for there to be interoperable and standardized electronic health records between behavioral health providers and settings and those in the primary care settings in order to provide quality and coordinated care. The Meaningful Use rules already specify interoperability requirements for medical/surgical providers, and CMS-2390-P provides an opportunity to think about broader interoperability parameters for providers currently ineligible for HITECH Act incentive payments.
- CMS should clarify whether other forms of technology will be permitted under the incentive payments. Finally, beyond Electronic Health Records, CMS 2390-P could play an enormously important role in specifying what other types of health technology could

be reimbursed in MCO capitated arrangements. With great advances in technology in the health field, such as telepsychiatry, mobile devices, and telemonitoring, there are a wide variety of opportunities for states to improve their care coordination efforts for Medicaid recipients with major mental health and addiction disorders.

Meaningful Consumer Choice in Plan Enrollment

The proposed rule points out that there are currently no federal regulations specifically governing enrollment of Medicaid beneficiaries into managed care plans. In the absence of specific guidance, state enrollment practices vary widely in how they address both voluntary and mandatory enrollment in managed care, revealing a need for consistency across programs. We concur with CMS' assessment that "beneficiaries are best served when they affirmatively exercise their right to make a choice of delivery system or plan enrollment" and have the time and information to effectively choose.

In both mandatory and voluntary enrollment processes (438.54(b)(2) and (d)(2)), the proposed rule would require states to give enrollees at least a 14-day window within which they may actively select to enroll in managed care (for voluntary programs) or select their managed care plan (for mandatory programs). We are concerned that 14 days is not sufficient for consumers with serious cognitive or mental impairments to fully understand their options and make an informed selection, particularly if the person is also experiencing homelessness or housing instability—a common challenge for low-income individuals with mental illness or addiction—which may result in a delay in receipt of the enrollment notice.

We support the information requirements outlined in section 438.10, particularly the requirement that information about plan enrollment and opt-out processes must be provided "in a manner and format that may be easily understood and readily accessible by such enrollees and potential enrollees." We support the provision that such information may be provided electronically and that it must include, at a minimum: provider directories, member handbooks, appeal and grievance notices and more. Because many people living with mental illness rely on specific, non-interchangeable medications to manage their condition, we encourage CMS to strengthen this list of required information by including formulary lists that provide information on the tier structure, cost sharing, and pricing of medications. For many consumers, medication coverage is among the most important criteria in making their plan selection.

Regarding default enrollment when the beneficiary does not actively select a plan, we commend CMS for highlighting the importance of preserving patient-provider relationships. We appreciate that CMS is proposing to apply this requirement to default plan selection for beneficiaries in both mandatory and voluntary enrollment processes. We also support the list of additional considerations that states may take into account when making default plan assignments, such as facility accessibility and quality performance.

Given that managed care plans are permitted to maintain their own formularies, we encourage CMS and states to also take into account managed care plans' coverage of any medications patients are using to manage their chronic conditions. Patients with mental health conditions respond differently to different antipsychotic medications, and it can often take several trials and many months to find an appropriate drug regimen that stabilizes an individual's condition. For

people with serious and persistent mental illness or those suffering from co-morbid conditions, it is critical that their plan covers these needed medications without unreasonably high cost-sharing or other barriers to access (such as fail-first requirements). States should make every possible effort to auto-enroll patients into plans that provide robust coverage of their medications.

Recommendations:

- In both mandatory and voluntary enrollment processes (as outlined in sections 438.54(b)(2) and (d)(2)), extend the plan selection or opt-out period from 14 days to 30 days.
- For both current and potential enrollees, CMS should add formulary information to the list of information managed care plans must provide under section 438.10 (subsections (d)(3) and (e)(2)). This formulary information should include a comprehensive list of covered drugs, tier placement of drugs, and required cost sharing for the patient.
- The final rule should preserve provisions requiring states to take existing patient-provider relationships into account when making default plan assignments in both voluntary and mandatory managed care enrollment.
- In section 438.54(c)(7)(ii) and (d)(7)(ii), CMS should add "plan coverage of patient's current medication needs" to the list of criteria states may consider in establishing their default enrollment processes.

Coverage and Authorization of Services

We are grateful for the inclusion in the proposed rule of language prohibiting plans from imposing utilization management requirements that would disproportionately harm individuals living with chronic conditions. We agree with CMS' proposed approach that the state "must ensure, through its contracts, that service authorization standards are appropriate for and do not disadvantage those individuals that have ongoing chronic conditions or needing [long-term services and supports (LTSS)]" and we support the establishment of a standard for states to use in monitoring utilization management.

These requirements align with the goals of the 2008 Mental Health Parity and Addiction Equity Act as well as the Affordable Care Act's non-discrimination standards. The proposed rule could be further strengthened by expressly stating that plans' utilization management requirements must comply with the terms of the 2008 parity law and subsequent final regulations.

Additionally, we support the definition of what constitutes "medically necessary" care in section 328.210(a)(5); specifically, we were pleased to see that plans' medical necessity criteria must meet the requirements for providing early and periodic screening, assessment and diagnosis (EPSDT) for beneficiaries under the age of 21.

Recommendations:

- CMS should preserve the proposed rule's requirements prohibiting utilization management requirements that would disproportionately harm individuals living with chronic conditions and imposing a standard for states to use in monitoring utilization management.
- In sections 328.210(a)(3)(ii) and (a)(4)(ii)(B), CMS should add language specifically establishing that these provisions must be applied in a manner consistent with the requirements of the 2008 parity law and subsequent implementing regulations.

Beneficiary Support Systems
We agree with CMS' acknowledgement that some beneficiaries may need additional assistance, beyond the typical plan information disclosures, when evaluating their choices and making their plan selection. Additional assistance will be especially beneficial to individuals living with serious mental illness or substance use disorders given the complex health needs, possible cognitive deficits, and low levels of health insurance literacy among this population. We fully support requiring states to develop and implement beneficiary support systems similar to and aligned with those already in place for Marketplace enrollees under the Affordable Care Act. We agree that such assistance should be available to beneficiaries both before and after they enroll in a managed care plan and that it should include factors to consider when selecting a plan, information on how managed care works, and help for beneficiaries who receive or would like long-term services and supports.

Risk Sharing
Section 438.6(c) of the proposed regulation describes allowable risk sharing and incentive arrangements between managed care entities and providers. Under this proposal, managed care plans would be permitted to implement value-based purchasing models for provider reimbursement, including pay for performance arrangements, bundled payments, "or other service payment models intended to recognize value or outcomes over volume of services." Notably, unlike prior subsections outlining safeguards for managed care entities engaging in risk sharing arrangements with the state, subsection (c) does not include safeguards for providers entering into such arrangements with managed care entities.

We recognize the importance of payment reforms that account for value in care delivery; however, we caution that such reforms must be carefully designed to avoid disincentivizing clinically appropriate, medically necessary care for patients with complex, chronic health conditions such as mental illness or addiction. Value-based purchasing arrangements, bundled payment, and other payment innovations must carefully consider how value, quality and outcomes are defined, taking into account the needs of individuals who require a high volume of services over time and whose health improvements are best measured in terms of functional outcomes rather than reduction in clinical symptoms. CMS should consider additional steps to ensure that risk sharing provides incentives for quality care.

Recommendations:
- CMS should require states to build in opportunities for comment on the quality measures used in future value-based arrangements. States should also be required to monitor and evaluate the impact of these arrangements on patient access. Risk sharing mechanisms should be carefully analyzed and monitored to ensure unintended and undesirable incentives are not created.
- CMS should require states to require MCOs to accept all members who seek to enroll, and prohibit MCOs from refusing to enroll individuals with an adverse change in their health status, utilization patterns, cost of care, missed appointments, inability to pay, submission of grievances or appeals, or behavior related to their special needs.

Quality Requirements
CMS proposes to update states' requirements related to quality improvement, measurement and reporting in their Medicaid managed care programs. States would have to establish a comprehensive quality strategy to encompass their quality-related activities; they must also require plans to establish performance improvement projects for the purpose of improving quality of care. States must publicly report via a website the specific quality measures that managed care plans report to them.

CMS suggests that it will provide direction for each of these quality requirements; however, it allows states to opt out and to create their own quality activities. While flexibility would let states design their activities to meet their own needs, it would also mean that there would be little, or no, alignment between states. CMS already has quality reporting programs for Medicare Part D plans (Star Ratings) and requirements for the Quality Rating System for plans sold on the Exchanges; this new Medicaid MCO quality rating system provides an opportunity for alignment so that quality can be compared between programs and can aid beneficiaries who move between programs to be able to select care options.

Quality improvement programs must be carefully designed to incentivize activities that will help individuals with serious mental illness or addiction maintain their health and functioning while living in the least restrictive setting. For example, we support states requiring managed care plans to: incorporate recovery strategies, person-centered planning, youth and family-driven care and evidence-based practices into their services for individuals living with these conditions; report on and improve access to community-based care and intermediate services, and to increase the time that members with serious mental illness or addiction spend living in the community, rather than restrictive inpatient settings, homelessness, or criminal justice system involvement; promote recovery goals such as stable housing and full employment for these individuals and report on goal attainment; carefully monitor the quality of behavioral and medical care delivered to individuals with serious mental illness or addiction by managed care plans; develop methods to identify and track individuals with these conditions in enrollment and utilization records, and in collecting recovery-related measures not found in claims; and set expectations for improvements to access to primary care and to manage chronic medical conditions among individuals with serious mental illness or addiction.

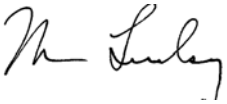
Recommendation:

- CMS should require states to engage in a public comment process during their managed care contract development activities. Stakeholders must have the opportunity to evaluate and comment on the state's proposed quality improvement plan as well as individual managed care plans' proposed activities to meet quality improvement requirements.

Thank you again for the opportunity to provide comments on the proposed rule governing Medicaid managed care plans.

Please let us know if you have any questions or if we can be helpful in any way as CMS moves forward with implementation.

Sincerely,



Marvin Lindsey, CEO