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Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue , SW
Washington, DC 20201

RE: **CMS-2390-P: 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**

Dear Acting Administrator Slavitt,

As an association representing more than 800 behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on the proposed rule (CMS-2390-P) titled "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" as published in the June 1, 2015, *Federal Register*.

ABOUT NAPHS

Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 800 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care. Our members deliver all levels of care, including inpatient treatment, residential treatment, partial hospitalization, and outpatient services.

Significant numbers of the patients seen within our member facilities are Medicaid and Medicare beneficiaries. For example, according to our most recent NAPHS Annual Survey, Medicaid and Medicare patients, combined, accounted for 44% of all inpatient hospital admissions to NAPHS facilities in 2013.

COMMENT

In this letter, we have limited our comments to CMS' proposal to permit Medicaid managed care organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs) to receive Medicaid capitated funds and use those funds for enrollees receiving short-term treatment in an institution for mental disease (IMD). **NAPHS is supportive of the agency's proposal to permit Medicaid MCOs to cover short-term inpatient care in facilities providing psychiatric or substance use disorder services notwithstanding the IMD exclusion. We believe that the CMS proposal represents a major step forward in the care and treatment of those with mental illness and substance use disorders.** As discussed in detail below, NAPHS believes that, if the proposed rule is adopted, CMS has the legal authority to permit states to amend their state plans so that Medicaid MCOs may offer coverage (and receive payment) for short-term inpatient psychiatric care in an IMD.

1. **CMS has the authority to align Medicaid with the federal parity law.**

First, we would like to state that NAPHS has long taken the position that all Medicaid benefits – including managed Medicaid benefits – should, wherever possible, be provided on the principle of parity, as defined in the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) and as explicitly required by section 1932(b)(8) of the *Social Security Act*. Our comments below, therefore, should not be construed as a deviation from this longstanding position of our association. As noted below, we believe that the CMS proposal moves the agency's policy for Medicaid managed care plans closer to parity, although it does not fully achieve it.

Parity does not mean *unlimited*. It means that limitations placed on coverage for mental health/substance use disorders benefits should be no more restrictive than the "predominant" limitations as applied to "substantially all" medical/surgical benefits. Parity requirements generally apply on a plan-by-plan basis.

On April 10, 2015, CMS released a proposed rule (CMS-2333-P) addressing the application of the Federal parity law (and the 2013 regulations implementing parity) to Medicaid MCOs. CMS went on record to state that the proposed rule "…generally mirrors the policies set forth in the MHPAEA [*Mental Health Parity and Addiction Equity Act*] final regulations to implement the statutory provisions that require MCOs, ABPs and CHIP to comply with certain requirements of section 2726 of the PHS Act (mental health parity requirements)."

However, in the Medicaid managed care proposed rule being reviewed in this letter (CMS–2390–P), CMS is recommending a quantitative limit of 15 days of payment for stays in IMDs for short-term inpatient treatment. This limit is inconsistent with MHPAEA and its implementing regulations (as well as the April 10, 2015, proposed rule on parity in Medicaid) in that it imposes a strict treatment limitation (of 15 days) on mental health and substance use

disorder benefits that is in most cases more restrictive than the treatment limitations applied to medical and surgical benefits. In other words, under the Medicaid parity proposed rule, if a Medicaid MCO plan has no treatment limitations on inpatient medical and surgical benefits, parity prevents the plan from placing any treatment limits on inpatient mental health or substance use services.

We recommend – if at all possible – that CMS not use arbitrary, quantitative limits in the Medicaid managed care proposed rule. All wording should be consistent with the principle that mental health/substance use disorders are treated *substantially* the same as and *no more restrictively* than other medical conditions. We also recommend that CMS use the same regulatory structure and criteria being used in the proposed Medicaid/CHIP parity rule. Parity is the law of the land, and policymakers have agreed that it is the right direction for the future.

2. **CMS has the authority to permit Medicaid MCOs to offer coverage and payment for short-term stays in an IMD.**

We believe that CMS is well within the authority granted to it by Congress to permit states to amend their state plans so that Medicaid MCOs may offer coverage and payment for short-term stays in an IMD. As CMS notes in the proposed rule, the agency has in the past permitted MCOs to provide medically appropriate, cost-effective substitutes for (or "in lieu of") state plan services included within a contract.

The genesis of the "in lieu of" policy originates from CMS' general authority at section 1915(a) of the *Social Security Act* which specifies that a State "shall not be deemed to be out of compliance… solely by reason of the fact that the State… has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance…" The legal authority supporting the ability of an MCO to offer services outside of a state plan is therefore clear. CMS has ample authority within and beyond section 1915 to both permit MCOs to offer coverage for services in addition to what is covered in a state plan, and to allow for payment by the MCO for these additional services provided "in lieu of" State plan services.

That these services meet the agency's standard of "medically appropriate" and "cost-effective" is also clear. For example, hospital IMDs offer the same "medically appropriate" psychiatric services as currently offered to Medicaid beneficiaries in psychiatric units in general hospitals. IMDs and short-term acute care hospital psychiatric services treat similar patient populations. As outlined in Medicare data (June 2010 Medicare Payment Advisory Commission *Report to Congress*), the lengths of stay in both settings are generally the same (12.4 days in nongovernmental freestanding psychiatric hospitals, and 11.2 days in general hospital units). The patient populations are generally the same (as shown in the consistent percentages of patient diagnoses). Three-quarters (75%) of patients have a primary diagnosis of psychosis in both psychiatric units and freestanding psychiatric hospitals. Comorbities in both settings are also similar. Comorbities recognized by the IPF payment system are 19% in general hospital units and 16% in freestanding IPFs.

Freestanding psychiatric hospitals and acute-care psychiatric units are also both nationally accredited (e.g., by The Joint Commission), and are Medicare- and Medicaid-certified.

Medicare- and Medicaid-certified hospitals must meet all hospital Conditions of Participation, including those on staffing, medical records, and restraint/seclusion.

Making IMD beds available to the Medicaid population is critical to improving access to mental health/substance use treatment. Approximately 60% of Medicare-certified psychiatric inpatient beds are in freestanding psychiatric hospitals (IMDs), and 40% are in psychiatric units.

Freestanding psychiatric hospital IMDs are also cost-effective. In the original final rule creating the Medicare inpatient psychiatric prospective payment system (IPPPS) [(69 Fed. Reg. 66,922, 66,957 (November 15, 2004)], CMS noted that "the average per diem cost in psychiatric units ($615) was 37 percent higher than the average per diem cost in psychiatric hospitals ($444)."

Further, freestanding psychiatric hospital IMDs today are a vital component of the overall behavioral healthcare delivery system for all other payers (other than Medicaid, which is statutorily prohibited from paying IMDs for beneficiaries ages 21-64 due to the IMD exclusion). IMDs have a diverse payer mix (including commercial insurance, Medicare, and Medicaid (for populations other than the 21-64 age group). These freestanding psychiatric hospitals serve all age groups (including children, adolescents, adults, and older adults).

3. CMS has the authority to define short-term stays in an IMD.

As outlined by CMS, one of the central tasks at hand in this proposed rule is defining *short-term stays* for the purpose of permitting payments for short-term services provided in an IMD. As the proposed rule notes, CMS is proposing that services provided in IMDs would be covered *in lieu of* services already covered today in short-term, acute care general community hospitals. These general hospitals are (by definition) "short-term" (that is, the opposite of "long-term care").

The Medicare statute defines *long-term care hospitals* as having lengths of stay of greater than 25 days. Therefore, short-term care (in both medical/surgical and psychiatric hospitals) should be defined consistently in both Medicare and Medicaid policies as 25 days or fewer. NAPHS recommends that the Medicaid definition of *short-term inpatient* be in sync with existing federal definitions of *short-term hospitalization* NAPHS further believes that the definition of *short-term inpatient* be applied at the facility level.

Should CMS determine that a patient-level limit is necessary in order to comply with the statutory IMD exclusion, then we recommend CMS adopt a medical exceptions process, alongside an otherwise firm 25 day cap, consistent with other recent rulemaking by the agency that ensures care is "provider-directed." See the next section for further analysis.

4. CMS should define a short-term stay in the proposed rule as a stay in an IMD with a facility-wide average length of stay for all patients of less than 25 days.

NAPHS believes a facility-wide average length-of-stay is a far more appropriate methodology for determining what constitutes a short-term stay as defined in the proposed rule. To better align the proposed rule with existing CMS policies, NAPHS suggests CMS adopt a policy under which facilities that are IMDs with an average length of stay of less than 25 days are eligible to provide care and services to Medicaid MCO enrollees.

As part of CMS' proposal to permit payment for short-term services provided in an IMD, CMS proposes to limit payment of capitation rates for enrollees that receive services in an IMD to stays of fewer than 15 days per month. As a rationale for this 15-day policy, CMS cites estimates showing a growing need for short-term mental health and substance use disorder services and a decline in the number of beds in freestanding psychiatric facilities and in distinct part psychiatric units. CMS looks to the data coming out of the Medicaid Emergency Psychiatric Demonstration, authorized under the *Affordable Care Act*, as a basis for the 15-day figure (the Demonstration suggests an average length of state of 8.2 days). Because a short-term IMD stay is much more likely to result in an enrollee only receiving Medicaid-covered services and/or services that are medically appropriate and cost-effective, CMS justifies a 15-day-per-month cap on services received in an IMD.

As CMS notes, one interesting result of the 15-day-per-month cap is that an MCO enrollee could actually exceed this cap so long as the length of stay within any given month is less than 15 days. For example, under the CMS proposal, if an individual enters an IMD on June 17th, they could receive services in an IMD (and the MCO or PIHP would be eligible to receive a capitation payment) through July 15th, resulting in a total of 29 days of service in an IMD. This 15-day cap also means that individuals requiring short-term inpatient psychiatric care in an IMD but who were admitted in the first 15 days of the month may be denied medically necessary, appropriate care if their stay exceeds this 15-day cap. CMS relies on data showing an <u>average</u> length of stay of 8.2 days in an IMD. While a 15-day cap is thus likely to capture the majority of IMD stays, it is also likely to exclude from coverage more than an insignificant number of stays that exceed the cap (and yet still comprise the stays resulting in this average.) CMS has requested comments on this approach.

<u>NAPHS believes a far more patient-centric approach would be to adopt a policy that, instead of relying on a specific numerical days-of-stay cap, focuses on a facility-wide cap.</u> Such a policy would remain consistent with the "in lieu of policy" (as stays would still be provided in a short-term setting and thus unlikely to result in an enrollee receiving non-covered services and/or services that are not medically appropriate or cost-effective.)

In addition, adopting a facility-wide average length of stay of fewer than 25 days would align with CMS' existing standard for what constitutes the dividing line between short-term and long-term hospital care in Medicare (section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as "a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services) of greater than 25 days." Consistency with CMS' existing regulations is a benefit in and of itself; but this approach would also benefit from the fact that CMS has ample experience in calculating facility-wide averages and enforcing this standard.

The facility-wide length-of-stay model is also much more patient-centric. Under CMS' proposed model, not only are some beneficiaries requiring medically necessary short-term care in an IMD likely to have their service requests denied, but the number of days available to any given beneficiary will vary because the cap resets each month, resulting in unequal care solely on the basis of when in a month an individual enters an IMD.

A length-of-stay approach permits a facility to provide individuals with the medically necessary care they require, while still falling within the overall goal of short-term care. Essentially, this

approach favors patient-centered care over one general rule that is blind to a patient's medical needs. A facility-wide length-of-stay approach is better for the patients and more consistent with CMS' past rulemaking and policies. This is also the approach used in general health care. With all other medical conditions, short-term hospitalization does not equate to a specific number of days of treatment but to the need for the individual to be in a 24-hour acute-care setting for whatever length of stay is deemed appropriate for the medical condition.

The proposed rule on which we are commenting also specifically addresses only *managed* mental health and substance use care within Medicaid. The external processes used by managed care are intended to assure that stays are medically necessary and meet the short-term model that managed care pays for.

NAPHS recommends that the determination of a facility's "short-term" status (that is, having a facility-wide average length of stay of 25 days or fewer) be calculated on the basis of *all days* divided by *discharges*. It should not be based on a facility's Medicaid length of stay. The rationale for this is that CMS is trying to define a *short-term hospital* and not a specific payer designation. Looking at a facility-wide average LOS also provides a way of determining a facility's overall treatment approach and general emphasis on short-term treatment and crisis stabilization.

5. In the alternative, CMS should adopt a medical exceptions process.

Should CMS determine it lacks the authority or is otherwise unable to adopt a facility-based average length of stay approach, NAPHS believes a far more patient-centric approach would be to adopt a medical exceptions process, alongside an otherwise firm day-per-patient cap**.** Such a policy would be consistent with other recent guidelines issued by CMS, including CMS' recent proposal in the Hospital Outpatient PPS rule to modify the agency's existing two-midnight policy to formalize a case-by-case medical exceptions policy. Similarly, in the TRICARE program, although patients are generally subject to a 30-day inpatient psychiatric care day limit, day limitations may be waived if determined to be medically or psychologically necessary.

Adoption of an exceptions process to a strict day-per-patient cap is also much more patient-centric. As CMS recently emphasized in the FY 2016 OPPS proposed rule, it is a clear priority of the agency to "not override the clinical judgment of the physician regarding the need to keep the beneficiary at the hospital, to order specific services, or to determine appropriate levels of nursing care or physical locations within the hospital." Any strict day-limit will ultimately force a provider to compromise his or her medical judgment in the face of patient financial exposure.

CONCLUSION

We agree with CMS that Medicaid MCOs should be able to cover short-term inpatient care in a facility offering psychiatric or substance use disorder services notwithstanding the IMD exclusion.

In our comments, we discuss options that we believe would be more clinically appropriate and more cost-effective than a per-patient-specific cap.

Whatever direction is ultimately chosen to define short-term inpatient care, we strongly support the addition of a clinical exception to any type of cap/day limit to allow for clinical judgment. Because all entities affected by this rule are subject to managed care, there is already a strong external review process in place to ensure that Medicaid beneficiaries receive only short-term, medically necessary services.

We look forward to working with CMS and HHS to ensure that this important rule is implemented in a way that puts the patients first and achieves the agencies' goal of beginning to solve the longstanding access issues for short-term inpatient psychiatric treatment for Medicaid beneficiaries.

Sincerely,

/s/

Mark Covall
President/CEO
NAPHS