NASMHPD

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January 29, 2016

Hon. Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Hon. Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Hon. Johnny Isakson
131 Russell Senate Office Bldg.
Washington, D.C. 20510

Hon. Mark Warner
475 Russell Senate Office Bldg.
Washington, D.C. 20510

Re: Comments Submitted on the Senate Finance Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

The National Association of Mental Health Program Directors (NASMHPD)—the member organization representing the state executives responsible for the $41 billion public mental health service delivery systems serving 7.3 million people annually in 50 states, 4 territories, and the District of Columbia—appreciates the opportunity to comment on the Senate Finance Bipartisan Chronic Care Working Group Policy Options Document issued in late December 2015.

First, NASMHPD wants to express its appreciation to the Working Group in assembling a compilation of options that address some of the most significant issues confronting the coordination of care for individuals with multiple chronic conditions, including the need for greater integration of care for behavioral health and chronic medical conditions, the need to broaden coverage for telehealth services, the need to eliminate limitations on supplemental benefits that can be provided by Medicare Advantage plans, the need to eliminate barriers and provide adequate incentives for care coordination in Medicare fee-for-service and accountable care organizations (ACOs), and the need for beneficiaries to access and remain compliant with wellness service regimens such as smoking cessation and obesity control.

To that list, NASMHPD would recommend (1) adding incentives for behavioral health providers to adopt, implement, and utilize health information technology that further enables the integration of behavioral health and physical health care, and (2) authorizing coverage for peer support services as partial hospitalization services under fee-for-service Medicare, and under Medicare Advantage as supplemental benefits.

***Expanding Innovation and Technology*: Need for Incentives to Enable Behavioral Health Providers to Adopt Health Information Technology**

As we know you are aware, behavioral health providers—many of whom are solo practitioners or practice in small practice groups with limited financial resources—were not included under the HI-TECH Act in the categories of providers eligible to receive Medicaid and Medicare meaningful use incentives. Those incentives were primarily limited to hospitals and practitioners falling within the definition of "physician" under 42 U.S.C. § 1395x(r).

Although the HITECH Act provided about $20 billion in Medicaid and Medicare incentive payments to health providers to subsidize and reward their implementation of electronic health records, psychiatric hospitals and community mental health centers were not designated as eligible to receive federal funds. And although the Department of Health and Human services has funded Health Information Technology (HIT) Regional Extension Centers to work with providers on the implementation and utilization of electronic health records (EHRs), in many states State Behavioral Health Agencies (SBHAs) do not appear to be a focus of those Centers.

As a result, behavioral health providers have been less able than those practitioners and hospitals who received incentives to fully adopt and implement the HIT which the Working Group acknowledges is so essential to the Working Group's goal of *Address[ing] the Need for Behavioral Health Benefits among Chronically Ill Beneficiaries*. Behavioral health entities have been largely unable to effectively utilize electronic personal health data that might help them to coordinate care between and among hospitals and community mental health centers (CMHCs), hospitals and emergency departments, CMHCs and primary care physicians, mental health and substance use disorder treatment providers, or any other of the complex linkages critical to increasing integration and improving care.

While we recognize that Centers for Medicare and Medicaid Services (CMS) Acting Administrator Andrew Slavitt has indicated it is the intent of CMS to wind down the meaningful use program for those practitioners and hospitals currently covered, we believe there is still a critical need to make available to behavioral health practitioners and providers incentives analogous to the HI-TECH Act meaningful use incentives. Without full participation of behavioral health providers in health information networks and the use of electronic health records, all attempts to integrate behavioral health and physical health will likely fall far short of full integration.

***Increasing Convenience for Medicare Advantage Enrollees through Telehealth*: Removing Limits to Telehealth Behavioral Health Services**

There is an additional significant reason for incentivizing the increased use of HIT by behavioral health providers: the ever-growing behavioral health workforce shortages in rural, frontier, and highly urban areas. Telehealth has made significant advances in the mental health arena, providing needed services to consumers in geographic areas where services would not otherwise be readily accessible. We agree with the suggestions of the Working Group under *Increasing Convenience for Medicare Advantage Enrollees through Telehealth* that payment limitations for telehealth services should be modified or eliminated.

However, we also believe that there should be a modification of those limitations in the fee-for-service program, so that telehealth services can be provided in community settings more easily. It has been the official policy of this country since the *Olmstead decision* to provide services to individuals with disabilities in the least restrictive settings. Mandating that telehealth services be conducted from an "originating site" and defining "originating site" under 42 CFR 410.78(b)(3) largely in terms of institutional settings—with the exceptions of a physician's office, an Federally Qualified Health Center, or a Community Mental Health Center—unduly restricts the use of telehealth behavioral health services, particularly substance use disorder treatment services, in an array of community settings. Such restrictions make no sense in a time when almost every personal computer is equipped with an inexpensive video camera and remote video applications such as Skype that make electronic face-to-face communications simple and easy.

***Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees:* Behavioral Health Peer Support Services as Medicare and Medicare Advantage Services**

NASMHPD is pleased to see the option *Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees* proposing to allow Medicare Advantage plans to offer a wider array of supplemental benefits than they do today. This option contemplates allowing not only supplemental medical services, but also non-medical social services that improve the overall health of individuals with chronic disease.

One very important category of non-medical behavioral health services now reimbursable either directly or indirectly under the Medicaid programs of 37 states and the District of Columbia, *but not reimbursable at all under Medicare*, is peer support services. CMS defined "peer support providers" in an August 15, 2007 State Medicaid Director Letter (SMDL #07-11) as "self-identified consumers who are in recovery from mental illness and/or substance use disorders."

One worldwide organization representing peer support service providers, Peers for Progress, defines peer support to involve four key functions:

1. Assistance in daily management
2. Social and emotional support
3. Linkage to clinical care and community resources, and
4. Ongoing support.

In its 2007 determination that peer support services could be Medicaid billable, CMS recognized those services as an evidence-based model of care, and established initial requirements for supervision, training, care coordination, and certification. As with many Medicaid funded services, CMS said peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. CMS said states should use a person-centered planning process to help promote participant ownership of the plan of care, actively engaging and empowering the participant, and individuals selected by the participant, in leading and directing the design of the service plan. A May 1, 2013 clarifying guidance noted that an individual providing peer support can perform a range of tasks not only for beneficiaries but also for their supportive family members, including developing formal and

informal supports, instilling confidence, assisting in the development of goals, and serving as an advocate, mentor, or facilitator for resolution of issues, as well as those skills necessary to enhance and improve the health of an individual (in this guidance a child specifically) with emotional, behavioral, or co-occurring disorders.

There is an emerging evidence base for peer support services. A recent comprehensive evidence-based review of these services[1] noted that peer support services have demonstrated many notable positive outcomes. Despite some methodological challenges for existing studies of peer-delivered services, the study's authors observed that

> *Across the service types, improvements have been shown in the following outcomes: reduced inpatient service use; improved relationship with providers; better engagement with care; higher levels of empowerment; higher levels of patient activation; and higher levels of hopefulness for recovery.*[2]

Despite the acknowledgement, acceptance, and support for coverage of peer support services by the Medicaid program, the State Behavioral Health Agencies have discovered that the Medicare program is reluctant to cover such services, even as a wrap around Medicaid services provided to dual eligible enrollees. In part, this resistance may be because Medicare outpatient (Part B) benefits are statutorily defined in 42 U.S.C. § 1395k. However, § 1395k(a)(2)(J) includes coverage for "partial hospitalization services provided by a community mental health center (as described in 42 U.S.C. § 1395x(ff)(2))," and those services in turn include "such other items and services as the Secretary may provide ... that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, *reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization*, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

Even a casual read of that provision leads to the conclusion that peer support services could be easily covered in community mental health centers under Medicare and Medicare Advantage should CMS be convinced of the wisdom of such coverage. NASMHPD hopes the Working Group will consider recommending peer support services in its final consideration of what supplemental benefits should be covered under Medicare Advantage, and even expand that recommendation to Medicare fee-for-service.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries: **GAO Study of the Exclusion of Behavioral Health Services by Accountable Care Organizations in Coordinating Care for Beneficiaries**

NASMHPD was pleased that the Workgroup acknowledged that "[s]takeholders and researchers indicate that [accountable care organizations (ACOs)] and other models face challenges integrating primary care and behavioral health services, despite the benefits of doing so." The

[1] Chinman M, George P, Dougherty RH, Daniels AS, Ghose SS, Swift A, Delphin-Rittmon ME; "Peer Support Services for Individuals with Serious Mental Illnesses: Assessing the Evidence;" *Psychiatric Services* 65(4): 429-441(2014).
[2] Ibid.

Workgroup proposes that the Government Accountability Office study conduct a study on the current status of the integration of behavioral health and primary care among private sector Accountable Care Organizations (ACOs), public sector ACOs, and ACOs participating in the Medicare Shared Savings Program (MSSP), as well as private and public sector medical homes.

The SBHAs are very supportive of the inclusion of behavioral health providers in Medicaid Health Home teams. There has been significant progress in that venue, primarily because the statutory authorization for the Affordable Care Act's Medicaid Health Homes for Multiple Chronic Conditions program, at 42 U.S.C. § 1396w-4—in requiring that two chronic conditions be present in any eligible individual treated by a health home—specifically identifies mental illness and substance use disorders as two of the chronic conditions intended to be treated, and states that the existence of a mental health condition requires coverage of only one other chronic condition. In addition, the health home statute specifically identifies community mental health centers as one of a non-exclusive range of types of providers qualified to serve as the coordinator/leader of a team of service providers that may include, again specifically, social workers and other behavioral health professionals.

In contrast, as our allies at No Health Without Mental Health (NHMH) so elegantly state in their own comment letter to the Finance Committee, including behavioral health providers in ACOs "is a bit like turning the Titanic because there are always vested interests that will fight these changes." As NHMH also notes:

> *as health systems develop ACOs, little thought is being given to the inclusion of behavioral health services as a part of core provider participation and service delivery. For many health systems who even think of this possibility, the separate, siloed behavioral health payment and service delivery procedures lead them to exclude active behavioral health participation for logistical reasons. Policy proposals must be developed to overcome this systemic barrier preventing integrated care delivery.*

To some degree, unlike the statutory and regulatory authority for health homes, the structure of ACOs as established through CMS regulations does not authorize a behavioral health entity or provider to form and lead an ACO team. The regulatory provision defining which types of practitioners other than hospitals might form an ACO, 42 CFR 425.102, designates ACO professionals in group practice arrangements and networks of ACO professionals as those who might form ACOs, but "ACO professional" is defined in 42 CFR 425.20 exclusively as (1) a physician legally authorized to practice medicine and surgery by the State in which he performs such function or action; or (2) a practitioner who is one of the following: (i) a physician assistant, (ii) a nurse practitioner; or (iii) a clinical nurse specialist. Behavioral health practitioners and providers, other than perhaps psychiatrists by inference as physicians legally authorized to practice medicine, are not eligible to form ACOs.

This regulatory exclusion exists despite an explicit statutory coverage of clinical psychologists and social workers as ACO professionals through a cross-reference to the definition of "practitioners" under 42 U.S.C § 1395u(b)(18)(C) in the statutory language defining "ACO professional". Other groups of providers as determined by the Secretary are eligible to *participate* in an ACO under the *statutory* authority for the Medicare Shared Savings Program, 42 U.S.C § 1395jjj(b)(1)(E), but the ACO must be formed under the *regulatory* authority by one

or more of the ACO participants specifically identified in statute, i.e. ACO professionals in group practice arrangements, networks of individual practices of ACO professionals, partnerships or joint venture arrangements between hospitals and ACO professionals, or hospitals employing ACO professionals.

Unlike the Medicaid Health Home statute, there is no incentive within the structure of the Medicare Shared Savings Program regulations governing ACOs—despite the explicit statutory inclusion—to include behavioral health providers. We urge the Workgroup to recommend adding behavioral health providers to the statutory list of those providers able to form and lead an ACO. Only Congressional action that significant and clear will motivate ACOs to treat behavioral health providers as equals, included in their network mix. And only once such inclusion is achieved, will integration and coordination of behavioral health services within the ACO be assured.

***Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations:* Permanent Authorization for C-SNPs and D-SNPs**

In 2013, the Medicare Payment Advisory Commission (MedPAC) recommended to Congress folding the Chronic Care Special Needs Plan (C-SNP) program into the general Medicare Advantage program. That 2013 recommendation built on a 2008 recommendation that C-SNPs be limited in the types of chronic conditions that could be served by those plans. In its 2013 recommendations, MedPAC suggested exempting from the proposed merger those plans that focus on a small number of chronic conditions, including chronic and disabling mental health conditions. That recommendation was founded on a recognition that the broader Medicare Advantage plans continued to fall short in providing coordinated and integrated behavioral health care services. The recommended exemptions also reflected the Commission's stated understanding that there could be a rationale for maintaining a separate plan option for those conditions to permit innovations in the care delivery for those populations.

With these MedPAC's considerations in mind, but with reservations regarding whether such siloed plan specialization can achieve truly integrated services across the spectrum of care, NASMHPD suggests the more appropriate approach would be for the Workgroup to recommend a short-term reauthorization of no more than five years for C-SNPs focused on services for individuals with chronic and disabling mental health conditions.

D-SNPs

The 2016 Data Book on dual eligible beneficiaries published jointly last week by MedPAC and the Medicaid and CHIP Payment and Access Commission (MACPAC)[3] found that 21 percent of duals under age 65 and 12 percent of duals over age 65 suffer anxiety disorders, 14 percent of duals under 65 suffer bipolar disorders, 31 percent of duals under 65 and 21 percent of duals over 65 suffer depression, and 13 percent of duals under 65 and 7 percent of duals over 65 suffer schizophrenia and other psychotic disorders. It is clear the population of dual eligibles has a significant need for behavioral health services.

[3] *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission (January 2016), p. 35.

That same 2013 MedPAC report recommended permanent statutory authorization of D-SNPs, despite the Commission's acknowledgement that "[m]ost D–SNP contracts do not cover some or all of Medicaid's [long-term services and supports] or behavioral health services." MedPAC noted that some states had been reluctant to contract with D–SNPs to cover some or all of Medicaid's behavioral health services and long-term services and supports (LTSS) for several reasons. In some states, legislation prohibits moving behavioral health services or LTSS into managed care programs. Other states lacked the staff resources or technical capabilities to develop, for D–SNPs, contracts that covered behavioral health services or LTSS. Still other states without legislative prohibitions were nevertheless, at the time, averse to providing Medicaid benefits through managed care (a sentiment that has since largely disappeared).

Nevertheless, MedPAC said that D–SNPs have the potential to integrate Medicare and Medicaid benefits for dual-eligible beneficiaries—that is, assume clinical and financial responsibility for Medicare benefits and some or all of Medicaid's behavioral health services, LTSS, or both. They based this recognition on their findings that one model of D-SNP used by 25 plans or about 8 percent of all D-SNPs covering approximately 65,000 dual-eligible beneficiaries (about 5 percent of all D-SNP enrollees) at the time covered some or all of Medicaid's behavioral health or LTSS services through a single contract with the state. A second model—used by approximately 35 D–SNPs, or 11 percent of D–SNPs, covering an estimated 235,000 dual-eligible beneficiaries, or about 19 percent of all D-SNP enrollees—took the approach of having a Medicaid Managed Care plan provide general medical/surgical services and a D-SNP managed by the same plan issuer manage behavioral health services and/or LTSS. By integrating Medicaid benefits with Medicare benefits, MedPAC felt D–SNPs could offer a more cohesive delivery system than fee-for-service Medicare, eliminating the incentives that exist in both Medicare and Medicaid to shift costs to the other program, improving quality of care, and potentially reducing costs.

While we recognize that the capabilities of the various D-SNPs currently on the market to effectively provide and manage behavioral health services vary widely, NASMHPD believes the recommendation made by MedPAC in 2013 to permanently authorize D-SNPs is still valid, and we hope the Workgroup sees fit to forward that recommendation to Congress for enactment.

Thank you for your consideration of these comments. If you have questions regarding the various issues raised in this correspondence, please feel free to contact NASMHPD's Director of Policy and Health Care Reform, Stuart Gordon, at stuart.gordon@nasmhpd.org or 703-682-7552.

Sincerely,

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Executive Director
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