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June 8, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2333-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via www.regulations.gov

RE: CMS-2333-P Mental Health Parity and Addiction Equity Act of 2008; the Application to Medicaid Managed Care, CHIP, and Alternative Benefit Plans

To Whom It May Concern,

Bi-State Primary Care Association appreciates the opportunity to comment on the proposed rule on Mental Health Parity for Medicaid Managed Care, CHIP and Alternative Benefit Plans (CMS-2333-P).

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization that promotes access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in Vermont and New Hampshire. Bi-State works with federal, state and regional health policy organizations, foundations and payers to develop strategies, policies and programs that provide and support community-based primary health care services in medically-underserved areas. Our members include Community Health Centers, which include Federally Qualified Health Centers (hereafter interchangeably referred to as health centers or FQHCs); Rural Health Clinics; private and hospital-supported primary care practices; Community Action Programs; Health Care for the Homeless programs; Area Health Education Centers; Clinics for the Uninsured, and social service agencies.

Bi-State is focusing its comments primarily on issues that are of particular importance to Health Centers and the patients that they serve. Please see the summary and more in depth comments below. In addition to our comments, we fully endorse the National Association of Community Health Center's (NACHC) letter that will be submitted before the deadline. With NACHC's permission, our letter uses their template and parallels their comments and concerns.

SUMMARY OF COMMENTS

1. CMS should clarify that quantitative visits limits do not apply to required services, such as behavioral health services provided by clinical psychologists and Licensed Clinical Social Workers (LCSWs) at FQHCs.

2. To ensure adequate access to behavioral health services for individuals served under managed care or alternative benefit plans, CMS should encourage states to:

- Cover the services of a broad range of behavioral health providers (e.g., licensed professional counselors);
- Allow FQHCs to bill for two visits when a patient receives both a medical and a behavioral health service on the same day; and
- Implement a robust system for updating FQHCs' PPS rates to reflect changes in how they provide care, such as efforts to integrate physical and behavioral health services.

DETAILED COMMENTS ON THE PROPOSED RULE

1. CMS should clarify that quantitative visit limits do not apply to required services, including behavioral health services provided by clinical psychologists and LCSWs at FQHCs.

The proposed rule proposes that the parity requirements in the Mental Health Parity and Addictions Equity Act apply to both quantitative and non-quantitative treatment limitations. Bi-State requests that CMS clarify that these regulations do not give states any additional authority to impose limits on behavioral health services delivered in health centers. Bi-State is concerned that states may interpret this proposed rule as CMS permitting limitations on behavioral health services at health centers, as long as they are no more restrictive than the comparable limitations on medical and surgical benefits provided in health centers.

Our concern is particularly highlighted because of the growing role of health centers in providing behavioral health services, which will only be extended with the finalization of this new rule, according to the National Academy for State Health Policy, which specifically notes that states will be reliant on health centers to help meet the increased demand for these services.

Under current law, mental health and substance use disorder services are among the "additional health services" that health centers are authorized to provide, and increasingly encouraged to provide, under their scopes of project under the Public Health Service Act. 42 U.S.C. § 254b(b)(2). Additionally, the Medicaid FQHC benefit likewise includes a broad array of behavioral health services. Health centers are well-situated to serve as health homes that address behavioral health needs. Behind diabetes and hypertension, depression was the third most common reason for a visit to a health center in 2008.

In proposed 42 C.F.R. §§ 438.900 and 457.956(a), CMS proposes to give states broad leeway in defining "mental health benefits" and "substance use disorder benefits." This task is by no means straightforward for states, since the terms "mental health" and "substance use disorder" do not appear in the Medicaid provisions of the Social Security Act and do not coincide with the types of "medical assistance" defined in Section 1905 of the Act.

The services comprising the Medicaid FQHC benefit, as described in the statutory list of "medical assistance" categories, include "federally-qualified health center services" ("FQHC services") and "any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan." SSA §§ 1902(bb)(1), 1905(a)(2)(C), which are mandatory for categorically needy individuals. SSA § 1902(a)(10)(A). By definition, "FQHC services" include physicians' services and services incident to physicians' services; and services furnished by a physician assistant, nurse practitioner, clinical psychologist, or clinical social worker, as would otherwise be covered if furnished by a physician, or services incident to those services. SSA §§ 1905(a)(2)(C), 1905(*l*)(2)(A). Thus, "FQHC services" includes the behavioral health services provided by those "core" clinicians.

Per prior CMS guidance, limitations such as visit limits may not be applied to the behavioral health services furnished by core clinicians in FQHCs to categorically needy individuals, even though such limitations might be applied to similar services furnished in other settings. September 22, 2003 Memorandum from Dennis Smith, Director, Center for Medicaid & State Operations, to Administrator, Health Resources and Services Administration. Indeed, States must reimburse health centers for these services to the full extent of the practitioners' work within the scope of their practice under state law. *Id.* In addition, "other ambulatory services" covered under the State plan (for example, where applicable, services furnished by licensed family therapists or licensed professional counselors), when provided in FQHCs, must be reimbursed to the full extent authorized under the State plan. It would be helpful for CMS to reiterate and reinforce this guidance in conjunction with its promulgation of the parity regulations.

2. CMS should provide states adequate guidance to ensure access to behavioral health services.

To ensure adequate access to behavioral health services for individuals served under managed care or alternative benefit plans, CMS should encourage states to:

- Cover the services of a broad range of behavioral health providers (e.g., licensed professional counselors);
- Allow FQHCs to bill for two visits when a patient receives both a medical and a behavioral health service on the same day; and
- Implement a robust system for updating FQHCs' PPS rates to reflect changes in how they provide care, such as efforts to integrate physical and behavioral health services.

Our hope is this proposed rule will lead to increased access to behavioral health services, which is desperately needed for many individuals around the country. The National Academy of State Health Policy indicates that in many instances states will be looking to health centers to provide these services in areas where they are already providing care and health centers are ready for this challenge. In order to ensure that health centers are able to provide these services, we have several recommendations for CMS.

Health centers have been very forward thinking in their work to integrate both primary and behavioral health care in their centers. Bi-State recommends that CMS issue guidance to enhance the opportunity for integrated primary care and behavioral health services, with attention to the delivery of such integrated care in FQHCs.

In order to provide access in underserved areas, health centers often rely on a variety of provider types. At every New Hampshire and Vermont FQHC, there is a level of primary care and behavioral health integration that is critical to access. States often refuse to recognize as "visits" behavioral health services provided by licensed professionals who are not "core providers" – for example, licensed professional counselors and marriage and family therapists. We would encourage CMS to clarify that visits by these behavioral health providers are eligible for the FQHC payment in accordance with state requirements. CMS codifying this would support FQHCs and their services.

Additionally, some states' FQHC Medicaid reimbursement rules deter health centers from implementing primary care and behavioral health services integration. Federal law provides for a payment methodology for FQHCs "on a per visit basis." SSA § 1902(bb)(2). The term "visit" is not defined in federal law, and hence, it falls to states to define a "visit" for purposes of the Medicaid FQHC PPS methodology. Bi-State would encourage the broadest and most comprehensive definition of visit to allow for the greatest access options.

One common problem with respect to care integration is that many states refuse to recognize as valid "visits" primary care and behavioral health encounters provided on the same day. At the same time, many states also fail to maintain working mechanisms for adjusting FQHCs' per-visit rates to reflect changes in the scope of services, as described in Social Security Act § 1902(bb)(3). The integration of primary care and behavioral health often yields fewer, more intensive (and more costly) visits for an FQHC. Too often, due to restrictive "visit" definitions and in adequate policies concerning changes in the scope of services, the health center is penalized rather than rewarded under the Medicaid reimbursement methodology for its advances in care integration. This, in turn, impedes access to behavioral health services. Individuals with disabilities and individuals with co-occurring medical and behavioral health conditions are less likely to seek care if their complaints cannot be addressed efficiently in one health center visit.

CMS should recognize that in today's health care environment, promoting integrated care is a key part of the policy goal of treating behavioral health services on an equal footing with medical and surgical benefits. Accordingly, CMS should publish guidance encouraging sounder reimbursement policies for integrated services in FQHCs.

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Thank you for the opportunity to comment on this proposed rule. Please do not hesitate to contact me at (603) 228-2830 extension 112 or via e-mail at tkuenning@bistatepca.org if you require clarification on the comments presented above.

Sincerely,

Tess Stack Kuenning, CNS, MS, RN
President and Chief Executive Officer
Bi-State Primary Care Association