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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 - Application to Medicaid Managed Care, CHIP, and Alternative Benefit Plans

The National Association of Community Health Centers (NACHC) 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).

NACHC is the national membership organization for federally qualified health centers (FQHCs). FQHCs play a critical role in the health care system, serving as the health home to over 23 million people, the majority of whom live below the Federal Poverty Level. In 2013, FQHCs served over 1 in 7 Medicaid beneficiaries nationwide. With over 9,300 sites, FQHCs provide affordable, high quality, comprehensive primary care to medically underserved individuals, regardless of their insurance status or ability to pay for services. For additional information on FQHCs, please see the attachment.

We begin with a summary of our comments, and then explain each one in depth.

SUMMARY OF COMMENTS

1. In the discussion of quantitative service limits, CMS should explicitly state that nothing in this NPRM permits states to apply such limits to required services, such as BH services provided by clinical psychologists and Licensed Clinical Social Workers (LCSWs) at FQHCs.

2. To ensure adequate access to BH services for individuals served under Medicaid managed care or alternative benefit plans (ABPs), CMS should encourage states to:
   - cover the services of a broad range of BH providers (e.g., licensed professional counselors);
   - allow FQHCs to bill for two visits when a patient receives both a medical and a BH 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. **In the discussion of quantitative service limits, CMS should explicitly state that nothing in this NPRM permits state to apply such limits to required services, such as BH services provided by clinical psychologists and Licensed Clinical Social Workers (LCSWs) at FQHCs.**

   The NPRM states that managed care organizations and ABPs may impose quantitative treatment limits on BH services as long as these limitation are no more restrictive than those imposed on medical and surgical services. NACHC strongly supports the way in which CMS is proposing to implement these provisions in situations where BH services are an optional service. However, while BH services are generally optional under Medicaid, the services of specific types of BH providers are a required service if they are provided through an FQHC. Per statute, these provider types must include clinical psychologists and LCSWs; in addition, if a state plan covers ambulatory services provided by other types of BH providers, then these providers' services are also required under Medicaid if provided by an FQHC.

   Without clarification, NACHC is concerned that states could misinterpret this NPRM as authorizing them to place quantitative limits on BH services provided at FQHCs by clinical psychologists, LCSWs, and other provider types included under the state plan, as long as these limits are no more restrictive than those on medical and surgical benefits. To avoid such confusion, NACHC requests that CMS include a statement in the preamble clarifying that quantitative treatment limits may not be applied to required services, including (but not necessarily limited to) services provided by clinical psychologists and LCSWs at FQHCs.

2. **To ensure adequate access to BH services for individuals served under Medicaid managed care or alternative benefit plans (ABPs), CMS should encourage states to:**
   a. **cover the services of a broad range of BH providers (e.g., Licensed Professional Counselors, Licensed Marriage and Family Therapists);**
   b. **allow FQHCs to bill for two visits when a patient receives both a medical and a BH service on the same day; and**
   c. **implement a robust system for updating FQHCs' PPS rates to reflect changes in how they provide care, such as integrating physical and BH services.**

By expanding parity protections to managed care and ABPs, this NPRM will lead to increased coverage for BH services for millions of Medicaid patients nationwide. However, as you are aware, providing coverage is not the same as ensuring that such services are available and accessible to patients. As stated by the National Association of State Health Policy last month:

> "A 2013 report to Congress from the Substance Abuse and Mental Health Services Administration highlighted the significant challenges facing the aging and under-funded MH/SUD work force. Expansion of health care coverage through the Affordable Care Act is expected to increase the demand for these services. Parity is therefore only a piece of the puzzle for state policy makers looking to ensure network adequacy and access to services."

Later in this article, NASHP explicitly highlights the role that FQHCs can play in helping State Medicaid programs to ensure access to BH services, stating: "States are also looking to integrated physical/mental health care initiatives and safety net providers, such as Federally Qualified Health Centers, to help with the expected increase in demand."

To ensure that patient access to BH services keeps pace with the coverage expansions resulting from this regulation, NACHC urges CMS to take steps to increase the range and availability of BH services under Medicaid. Specific strategies to ensure this access include:

A. Encourage states to cover the services of a broad range of BH providers.

CMS should encourage all states to cover services of a broad range of qualified BH providers. Examples of provider types that states could – but are not required to - cover under their State Plans include (but are not limited to) Licensed Professional Counselors and Licensed Marriage and Family Therapists. While some states already cover services provided by these provider types, numerous other states could significantly expand the availability of BH services by allowing LPCs, LMFTs, and other appropriate provider types to bill under Medicaid.

B. Encourage states to permit FQHCs to bill for two visits when a patient receives both a medical and a BH service on the same day.

As emphasized by NASHP, FQHCs are at the forefront of integrating primary and BH care for vulnerable populations, including Medicaid beneficiaries. Such integration has been shown to lead to improved access to BH services, as well better outcomes on both physical and behavioral health and lower *total* costs of care. (See article from the Commonwealth Fund.) These conclusions make intuitive sense, given that individuals with disabilities and/or co-occurring medical and BH conditions are less likely to seek care early if their complaints cannot be addressed efficiently in one visit.

Unfortunately, some states' Medicaid reimbursement rules discourage this integration by prohibiting FQHCs from billing separately for primary care and BH encounters provided on the same day. By encouraging states to permit "same-day billing" for primary care and BH services provided a single day, CMS can encourage the continued expansion of care integration at FQHCs, which (as discussed above) will lead to expanded access, lower total costs of care, and improved health outcomes. This would be consistent with Medicare law too, which allows an FQHC to bill for both a medical and mental health visit in the same day.

C. Encourage states to implement a robust system for updating FQHCs' PPS rates to reflect changes in how they provide care, such as efforts to integrate physical and BH services.

Social Security Act § 1902(bb)(3), along with the FAQs that CMS published when the FQHC PPS was initially implemented, require states to adjust FQHCs' per-visit rates on a regular basis to reflect changes in "the type, intensity, duration and/or amount of services provided".

Unfortunately, many states fail to make these adjustments on a timely or regular basis. Given that integrating primary and BH services often yields fewer, more intensive (and more costly) visits for an FQHC, states' failure to update FQHC PPS rates to reflect these higher-intensity visits penalizes FQHCs for their integration efforts. This in turns serves as a financial disincentive for FQHCs to integrate care, which (as discussed above) leads to reduced access to BH services, poorer health outcomes, and higher total costs of care. To mitigate these impacts, NACHC

recommends that CMS remind states of the requirement to regularly update FQHC PPS rates to reflect changes in the scope of services provided. In addition, CMS should encourage states, as part of this process, to revise their policies to permit same-day billing (if not currently permitted).

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Thank you for the opportunity to comment on this Notice of Proposed Rulemaking. NACHC staff, and our member health centers, would be happy to provide CMS with any further information that would be beneficial. To initiate a discussion, please contact me at 202-296-0158 or cmeiman@nachc.org.

Sincerely,

Colleen P. Meiman, MPPA
Director, Regulatory Affairs
National Association of Community Health Centers

Overview of Federally Qualified Health Centers

For 50 years, Health Centers have provided access to quality and affordable primary and preventive healthcare services to millions of uninsured and medically underserved people nationwide, regardless of their ability to pay. At present there are almost 1,300 health centers with more than 9,300 sites. Together, they serve ***over 22 million patients***, including nearly seven million children and more than 1 in 7 Medicaid beneficiaries.

Health centers provide care to all individuals, regardless of their ability to pay. All health centers provide a full range of primary and preventive services, as well as services that enable patients to access health care appropriately (e.g., translation, health education, transportation.) A growing number of Health Centers also provide dental, behavioral health, pharmacy, and other important supplemental services.

To be approved by the Federal government as a Health Center, an organization must meet requirements outlined in Section 330 of the Public Health Service Act. These requirements include, but are not limited to:

- Serve a federally-designated medically underserved area or a medically underserved population. Some Health Centers serve an entire community, while other target specific populations, such as persons experiencing homelessness or migrant farmworkers.
- Offer services to all persons, regardless of the person's ability to pay.
- Charge no more than a nominal fee to patients whose incomes are at or below the Federal Poverty Level (FPL)
- Charge persons whose incomes are between 101% and 200% FPL based on a sliding fee scale
- ***Be governed by a board of directors, of whom a majority of members must be patients of the health center.***

Most Section 330 Health Centers receive Federal grants from the Bureau of Primary Health Care (BPHC) within HRSA. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing care to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients who are not indigent or who have insurance, whether public or private, are expected to pay for the services rendered. In 2013, on average, the insurance status of Health Center patients is as follows:

- 41% are Medicaid recipients
- 35% are uninsured
- 14% are privately insured
- 8% are Medicare recipients

No two health centers are alike, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed care to uninsured and medically underserved people.