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VIA EMAIL: www.regulations.gov

April 1, 2016

Office of the Deputy Chief Management Officer
Directorate of Oversight and Compliance, Regulatory and Audit Matters Office
9010 Defense Pentagon
Washington, DC 20301–9010

RE: DOD-2015–HA–0109; RIN 0720–AB65, "TRICARE: Mental Health and Substance Use Disorder Treatment"

Dear Deputy Chief Management Officer,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on the Department of Defense (DoD) proposed rule titled "TRICARE: Mental Health and Substance Use Disorder Treatment" (DOD-2015-HA-0109) as published in the February 1, 2016, *Federal Register*.

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, residential, partial hospitalization, and outpatient services.

COMMENTS

We are writing to support the proposed rule, which "seeks to comprehensively update TRICARE mental health and substance use disorder benefits, consistent with earlier Department of Defense and Institute of Medicine recommendations, current standards of practice in mental health and addiction medicine, and our governing laws." We support your acknowledgment that several organizations that accredit various forms of healthcare delivery have developed strong standards to protect patient care in mental health facilities. We recognize the work you have done to simplify the basic program benefits and eliminate the requirement for preauthorization for hospital level care.

We will organize our comments using the four main objectives outlined in the proposed rule. We will also provide additional comments on the proposed rule overall.

Eliminate Quantitative and Qualitative Treatment Limitations on Substance Use Disorder (SUD) and Mental Health Benefits and Align Beneficiary Cost-Sharing

We understand that the requirements of parity do not apply to the TRICARE program, but we salute the Department of Defense for using the law's provisions as models of the proposed changes to the TRICARE benefit structure. Addressing barriers presented by quantitative treatment limitations and the

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elimination of both annual and lifetime limits on inpatient treatment and the presumptive limitations on outpatient treatment clearly address beneficiaries' access issues by removing unnecessary barriers to care. These changes also provide the opportunity for patients to receive care in the most appropriate setting based upon their clinical needs. We support this move as a significant one in addressing the goal of structuring a modernized benefit.

The proposed rule further "seeks to eliminate other regulatory quantitative and qualitative treatment regulations, consistent with principles of mental health parity and our governing laws." We note the use of the term "qualitative treatment limitations." The *Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) and its supporting regulations use the term *non-quantitative* treatment limits. For the purpose of our comments, we are assuming TRICARE is understanding these terms to mean the same thing. The proposed rule notes that, "All claims submitted for services under TRICARE remain subject to review for quality and appropriate utilization in accordance with the Quality Utilization Review Peer Review Organization Program." As the provider and payer industries have worked diligently to implement parity regulations, the greatest challenge has been around implementation of the non-quantitative requirements.

The regulations require that medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness must be "*comparable and no more stringent*" than those for medical and surgical benefits. Plans are required to disclose the "processes, strategies, evidentiary standards, and other factors used by the plan to determine whether and to what extent a benefit is subject to a non-quantitative treatment limitation and be comparable and applied no more stringently for mental health and substance use disorders than for medical/surgical benefits." We strongly recommend that the amount and type of medical management (including such things as preauthorization and concurrent review) be carefully monitored by the TRICARE leadership to assure that they are consistent with the requirements for non-psychiatric care and with the evolving regulatory and legal requirements for parity. Detailed discussion of these issues can be found at the website of the Parity Implementation Coalition (www.parityispersonal.org).

We support the efforts made to align beneficiary cost-sharing between mental health and medical. This supports both access and parity.

Expand Covered Mental Health and SUD Treatment Under TRICARE to Include Coverage of Treatment of Intensive Outpatient Programs (IOPs) and Treatment of Opioid Use Disorder

We strongly support the expansion of benefits to include intensive outpatient programs (IOPs) and treatment of opioid use disorders. The expansion of coverage for addiction treatment will help our nation in its battle with the current opiate epidemic as well as other substance use disorders. The proposed expansion increases community-based services, allows beneficiaries to receive services closer to family, and encourages the use of a full continuum of care.

The inclusion of Opiate Treatment Programs (OTPs) and office-based care (to include medication-assisted treatment, or MAT) acknowledges the advances that have been made in the field relative to these treatment methodologies and is an example of TRICARE's commitment to modernize the mental health and substance abuse treatment benefit.

We support the payment methodology and rate structure outlined in the proposed rule for treatment provided in OTPs.

However, we do want to outline a few areas that we believe could improve the regulation governing OTPs. First, the proposed rule states that to qualify as a TRICARE authorized provider, the OTP is required to be licensed and fully operational for a period of six months (with a minimum patient census of at least 30 percent capacity) and operate in substantial compliance with state and federal regulations. Unlike, inpatient and residential facilities, OTPs may not have a stated capacity as part of their licensure. As a result, it may not be clear as to whether or not the OTP has met this requirement. Therefore, we recommend that the Department of Defense revise this section of the rule, and allow either the 30% percent capacity requirement or a specific average daily census of patients. In addition, several TRICARE programs, OTP and RTC as examples, require that the program be licensed and fully

operational for 6 months before being eligible to qualify as a TRICARE authorized provider. We ask TRICARE to consider whether this requirement is necessary and whether it furthers the access goals of the benefit redesign.

Second, the proposed rule states that a provider must submit claims for services provided to TRICARE beneficiaries at least every 30 days (except to the extent a delay is necessitated by efforts to first collect from other health insurance). Generally, it is the intent of most providers to submit claims every 30 days, however, unforeseen delays do occur. Therefore, we recommend that the requirement should be 45 days.

Third, the proposed rule states that providers must furnish TRICARE, or a designee, with cost data, as requested by TRICARE, certified by an independent accounting firm or other agency as authorized by the Director. There are provider organizations that have multiple treatment sites and a variety of services and programs and the cost of engaging an independent accounting firm with respect to each center is very expensive and could limit access to care. Therefore, we recommend that an entity with multiple sites and service lines be able to submit a consolidated audit of the organization's financial statements, and financial controls to meet this requirement.

Fourth, the proposed rule assumes that patients being treated with Buprenorphine in an OTP setting once stabilized will have two visits per week. During induction, before the patient is stable, the patient may visit the OTP daily. Therefore, we encourage the Department of Defense to consider an induction rate for patients being treated with Buprenorphine in an OTP setting.

We encourage TRICARE to continue to evaluate this benefit as advances are made within the substance use field, especially relative to new medications.

Streamline the Requirements for Mental Health and SUD Institutional Providers to Become TRICARE Authorized Providers

We strongly support TRICARE's recognition of evolving standards from the industry and from accrediting standards bodies. We further acknowledge the Department of Defense's commitment to eliminate the administratively burdensome provider certification process, and to streamline the approval process for institutional mental health and substance abuse providers to become TRICARE-authorized providers.

We are anxious to review the newly rewritten application provisions eliminating the requirements and formal process of certification for residential treatment centers (RTCs), substance use disorder programs (SUDs), partial hospital programs (PHPs), and substance use disorder residential facilities (SUDRFs). We welcome the provision that approval of a hospital for TRICARE is sufficient for it to be a provider of other TRICARE-approved benefits.

Any effort to be more prescriptive than accepted industry standards, as promulgated by national accreditation organizations, has the potential to undermine TRICARE's overall goals of reducing burden and improving access. We urge TRICARE to continue to focus on its stated goals, which we believe are central to a true modernization of the overall program. As TRICARE specifically states in the proposed rule:

> *Requirements for TRICARE certification beyond industry accepted accreditation, while once considered necessary to ensure quality and safety, are now proving to be unnecessarily restrictive and inconsistent with current institutional provider standards and organization.*
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> *Specifically, the proposed rule streamlines procedures and requirements for SUDRFs, RTCs, PHPs, IOPs, and OTPs to qualify as TRICARE authorized providers relying primarily on accreditation by a national body approved by the Director, as opposed to detailed, lengthy, stand-alone TRICARE requirements.*
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> *Mental health and SUD institutional providers may become TRICARE-authorized institutional providers if the facility is accredited by an accrediting organization, approved by the Director, and*

agrees to execute a Participation Agreement with TRICARE as outlined in the proposed regulations.

Develop TRICARE Reimbursement Methodologies for Newly Recognized Mental Health and SUD IOPs and Opioid Treatment Programs

We continue to evaluate the proposed reimbursement proposal and its general consistency with Medicare. We recognize that TRICARE will develop its own reimbursement methods in situations where Medicare does not have a reimbursement benefit.

While the stated rationale for reimbursement seems reasonable, TRICARE must continue to reevaluate reimbursement over time in order to achieve the goal of increasing access to care.

In general, the all-inclusive per-diem payment rates appear to provide a predictable payment methodology, which makes it more possible for organizations to commit to providing services to TRICARE beneficiaries.

Other Comments

We note in the rule references to on-site surveys by TRICARE. While we acknowledge TRICARE's right to do this, we hope that on-site surveys would be done only in extraordinary circumstances and that the commitment to reliance on national accreditation would be sufficient in virtually every case.

We also encourage TRICARE to expedite participation agreements with providers, to the extent possible, so that services can be provided to beneficiaries in a most-timely fashion.

We ask for clarification that the expanded benefits apply to all age groups.

SUMMARY

We applaud the Department of Defense for proposing to change current policies to better align with the scientific evidence of what works to treat serious mental and addictive disorders. We support the Department's commitment to streamlining the procedures and requirements for qualification as TRICARE authorized providers, relying on accreditation by an approved national body, and the execution of a provider agreement. We agree that, "streamlining procedures to qualify as a TRICARE authorized institutional provider will not only increase access to approved care, but also decrease the overall cost of certifying duplicative and now unnecessary quality standards." We look forward to the opportunity to continue to provide and expand essential services to TRICARE beneficiaries and to working with you as the regulations are implemented.

Sincerely,

/s/

Mark Covall
President/CEO