NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
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VIA EMAIL: www.regulations.gov

February 21, 2013

Ms. Marilyn Tavenner, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: CMS–2334–P; RIN 0938–AR04: "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing"

Dear Ms. Tavenner,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to comment on the proposed rule issued by the Department of Health and Human Services (HHS) in the January 22, 2013, *Federal Register* on the "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing" [CMS-2334-P].

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 700 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 care, residential treatment, partial hospitalization, and outpatient services.

COMMENTS ON THE PROPOSED RULE

The *Affordable Care Act* (ACA) provides Americans with better health security by putting in place comprehensive health insurance reforms that will (according to the ACA):

- Expand coverage,
- Hold insurance companies accountable,
- Lower healthcare costs,

- Guarantee more choice, and
- Enhance the quality of care for all Americans.

We believe that all of these principles must be applied to Medicaid and CHIP beneficiaries within the ACA exchanges.

The goal of the ACA is to give coverage in 10 essential benefit categories (one of which is mental health/substance use). The goal was never to give "just some coverage."

In the mental health/substance abuse treatment arena, there are some specific concerns that we want to bring to your attention that we believe must be addressed in a final rule.

CMS should clearly state that the Medicaid "Institutions for Mental Diseases" (IMD) restrictions do not apply to the coverage provided to the Medicaid expansion population under the ACA.

There are strong legal reasons to take this approach. To address the legal rationale for why the IMD exclusion should not apply to the Medicaid expansion population, we asked the firm of Foley Hoag to provide us with their analysis. The Foley Hoag legal memorandum is attached for your reference.

In addition to a legal rationale, we would strongly suggest that there would be a real-life negative impact on millions of newly covered individuals, if access to IMDs (freestanding community psychiatric hospitals) was restricted.

Newly insured individuals under the Medicaid expansion should have the same access, choice, quality, and cost-effective treatment for inpatient psychiatric care as they do for medical/surgical treatment. This is not just about fairness and equity; it is about Americans getting the right care, in the right setting, at the right time.

Inpatient psychiatric care today is delivered in the community in short-term, acute-care settings, including freestanding psychiatric hospitals. Inpatient psychiatric care is an integral component of community-based care for persons with serious mental illnesses, and it makes no sense from a public policy or patient-centered perspective to limit the inpatient psychiatric settings that people in need of this life-saving service can access.

Limiting access to community psychiatric hospitals also would impact the costs of inpatient psychiatric care. More choice results in more competition and lower costs.

Just as for medical problems, people living with serious mental illnesses rely on their doctors and hospitals for ongoing care and treatment. When they need that life-saving care, they want to go to the hospital and doctors that have been treating them over time. Restricting access to psychiatric hospitals would mean that patients may not be able to go to hospitals that their doctor recommends or where their doctor has inpatient practicing privileges.

Since the 1990s there has been a major reduction in inpatient psychiatric facilities. Between 1990-2000, inpatient psychiatric beds per capita have declined by 44% in state and county mental hospitals, 43% in non-governmental psychiatric hospitals, and 32% in general hospital psychiatric units. This major decline in psychiatric beds per capita has resulted in a major increase in emergency department visits for psychiatric disorders. In many communities patients need to stay in emergency departments for hours, days, or (in some cases) more than a week before being able to find an available bed. Others are transported long distances to get inpatient psychiatric care. It is hard to fathom what it would be like for so many Americans who are in crisis because of a major mental illness without the option of being treated in a psychiatric hospital. It is a crisis now in many communities, but it is hard to imagine how much worse it would be for so many more Americans if access were restricted to community psychiatric hospitals.

It should also be pointed out that the previously issued guidances and regulations on implementation of the ACA have focused on building upon the current insurance marketplace. For example, the benchmark

plans that will be the structure for health plans sold in the exchanges as well as for the Medicaid expansion population are based on current health plans offered in the marketplace today – such as the Federal Employees Health Benefit Plan (FEHBP), state employee plans, and small business health plans. The private insurance marketplace today does not establish broad limitations in restricting coverage in community psychiatric hospitals. Therefore, this is another strong reason why it would make no sense to apply the IMD exclusion to the Medicaid expansion population.

The above are some of the reasons why restricting access to freestanding psychiatric hospitals would have a negative impact for real people who need this crisis level of care. But we have not mentioned the federal *Mental Health Parity and Addiction Equity* law yet. That law is very clear. Mental Illnesses and addictive disorders must be treated on par with other medical disorders. This is all about fairness and equity. The ACA further expands on the federal parity law by requiring the Medicaid expansion population (as well as plans sold inside and outside the exchanges to small business and individuals) to be covered for mental health and addictive disorders in accordance with the federal parity requirements.

We greatly appreciate the proposed rule's explicit recognition that alternative benefit plans must provide benefits required by the Essential Health Benefits, including mental health and substance use benefits in a manner consistent with the requirements of the *Mental Health Parity and Addiction Equity Act (*MHPAEA).

It seems not only inconsistent, but would undermine the basic fairness and equity concept of the parity law and regulations, if freestanding community psychiatric hospitals would be the only type of hospital specifically excluded within the category of all hospitals. This would perpetuate the discrimination that people living with mental illness have been experiencing for way too long.

We have also joined with many other organizations as part of the Coalition for Whole Health in submitting additional comments on this proposed rule.

We look forward to working with the Department to make sure that Medicaid expansion population with mental and addictive disorders have the same coverage that is afforded to all other Americans.

Sincerely,

/s/

Mark Covall
President/CEO

Attachment: Foley Hoag legal memorandum