



April 29, 2016

The Honorable Orrin Hatch
Chairman
Committee on Finance

The Honorable Ron Wyden
Ranking Member
Committee on Finance

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor
and Pensions

The Honorable Patty Murray
Ranking Member
Committee on Health, Education,
Labor and Pensions

The Honorable Roy Blunt
Member
U.S. Senate

The Honorable Debbie Stabenow
Member
Committee on Finance

Dear Senators Hatch, Wyden, Alexander, Murray, Blunt and Stabenow,

The National Association of Medicaid Directors (NAMD) applauds your ongoing leadership to strengthen the nation's behavioral health system. In particular, NAMD – a bipartisan, non-profit association representing Medicaid Directors in all 50 states, the District of Columbia, and the territories – appreciates the bipartisan fashion by which the Finance and Health, Education, Labor and Pensions (HELP) committees have approached this critical issue.

The Medicaid program is the largest payer of mental health services in the nation and has evolved into one of the most important sources of coverage for vulnerable populations with mental health illnesses. Medicaid also is assuming greater responsibility for the health coverage for beneficiaries affected by substance use disorders (SUDs). In 2011, one in five Medicaid beneficiaries had behavioral health diagnoses but accounted for almost half of total Medicaid expenditures, with more than \$131 billion spent on their care (including physical, behavioral, and other Medicaid-covered services).

State Medicaid agencies are advancing transformations in the behavioral health delivery system to produce better outcomes for patients and address historical bifurcation in care delivery. NAMD members are focused on integrating primary care and behavioral health services, expanding capacity for the continuum of services that will lead to improved health outcomes, linking beneficiaries to vital social services and supports, and empowering individuals to make decisions that will improve their well-being. State Medicaid agencies are doing so through managed care entities, accountable care organizations, health homes, patient



centered medical homes and a variety of other delivery system and payment models that are designed to incentivize appropriate access to high quality services.

In light of this work we applaud the Senate Finance Committee for convening a hearing to examine the tools available to state Medicaid agencies to address mental health issues as well as gaps and systemic barriers that need attention. We are encouraged by the discussion at this hearing and during the Senate HELP Committee's mark-up of mental health legislation. In particular, we agree with the calls and legislative proposals offered by several Senators to lift the federal Medicaid payment exclusion for Institutions for Mental Disease (IMD).

We believe the IMD payment exclusion has little to no relevance in the current context of state Medicaid programs and mental health delivery systems. The exclusion undermines access to appropriate services for individuals in crisis and vulnerable populations with mental illness diagnoses. It also is a barrier to mental health parity in the Medicaid program as individuals may receive physical health services in specialized inpatient facilities, but Medicaid funds cannot be used for individuals to access specialized inpatient behavioral health services. Further, the IMD payment exclusion can drive up federal and state health care costs because individuals will utilize more expensive settings such as emergency rooms to treat acute needs. We hope Congress will prioritize changes to this policy this year.

We also are interested in the legislation authored by Senators Blunt and Stabenow, "The Expand Excellence in Mental Health Act," which would ensure that all 24 states awarded Certified Community Behavioral Health Clinics (CCBHCs) planning grants can be funded.

NAMD recognizes and commends community behavioral health centers for the critical role and essential services they provide for many Medicaid enrollees. Consistent with supports available to certain other provider types, behavioral health clinics could benefit from additional tools and resources if they are to undertake practice transformations to take behavioral health care to the next level. We believe with your collective leadership, Congress has rightly placed a high priority on building the infrastructure to fundamentally transform the delivery of behavioral health services for high-needs populations.

However, NAMD wishes to raise for you today two aspects of the demonstration which require Congressional attention. We believe these modifications to the demonstration will better position some state Medicaid agencies to develop and test a range of sustainable approaches for building capacity in the behavioral health clinics that can be scaled beyond the demonstration period. First, we believe the federal agencies and interested state Medicaid agencies and providers would benefit from a longer planning period for the CCBHC demonstration. Of those who decide to apply for the demonstration, additional time may allow for necessary discussions around the structure of this program, ongoing collaboration



with the potential CCBHCs and other community based providers, and meaningful engagement between the state Medicaid agencies and federal partners around the opportunities for alignment with other major Medicaid-led initiatives, including health homes focused on the behavioral health, State Innovation Model (SIM) programs, and Delivery System Reform Incentive Programs (DSRIP), among others.

NAMD also has heard from some planning grant states regarding the incongruence of the statutory language pertaining to reimbursement under the CCBHC demonstration and other Medicaid-led payment and care delivery improvement initiatives. Without question, states believe that transformation in their respective behavioral health systems must start with an upfront investment in the mental health and substance use disorder practices themselves. However, many of the Medicaid Directors in planning grantee states believe successful, sustainable demonstration programs must have the opportunity at the onset to align with emerging and effective state-initiated models to link reimbursement with integration.

To do so, any expansion or extension of the CCBHC program should provide Medicaid agencies the authority to evolve and appropriately utilize the full range of reimbursement and care coordination strategies for improving the quality of services provided, coordinating the continuum of services an individual may need, and delivering services in the most efficient manner. Doing so would expand the options for many planning grant states that wish to position the CCBHC demonstration to be consistent with the nascent movement towards total cost of care and shared savings models with upside and modest downside risk. This would be consistent with the full range of options states may utilize with other safety net providers (e.g. sub-capitation, global payments and episodes of care) which do not mandate them to utilize a prospective payment system.

More specifically, state Medicaid agencies – like most public and private insurers including Medicare –increasingly are exploring and testing payment and delivery system models to hold providers or a contracted managed care organization (MCO) more accountable for the costs and quality of the care they provide or pay for. One of the most critical elements of the new strategies for paying for value is their emphasis on shared accountability for outcomes across the delivery system. Only by holding groups of providers, who share responsibility for a population, accountable for quality, cost and health outcomes can we truly hope to fundamentally re-design the delivery system. New payment methodologies require integration in order to achieve the outcomes that are better for individuals suffering from mental illness: a reduced reliance on hospitalization and emergency rooms; an improvement in functioning, employment, housing stabilization and well-being, and better control of chronic medical conditions.



As NAMD has noted in other communications to Congress and the Administration, a fundamental challenge with a statutory floor for reimbursement, such as the one proposed in the CCBHC demonstration, is that it limits the tools states may utilize to link integration with a guaranteed level of payment. Medicaid programs want to bring hospitals, mental health providers, primary care providers, and community organizations together to develop payment strategies in which they are all accountable for the outcomes of the populations they serve, rather than for just the delivery of discrete services.

As states develop the demonstration and CCBHCs build their own capacity, we believe Congress should allow states to hold CCBHCs accountable for their performance and assuring that the persons they serve receive necessary general medical services. To this end, we believe Congress can support this by permitting but not requiring a prospective payment system (PPS) reimbursement methodology that is shown to be adequate to support certification and functional requirements of a CCBHC.

State-driven Medicaid initiatives are also intended to advance greater alignment across multiple payers on contracting and payment strategies that promote value over volume, greater consistency in quality, cost and patient experience, and expanded primary care access. This work is absolutely critical to facilitate Medicaid's alignment with the delivery and payment modernization Congress approved in the "Medicare and CHIP Reauthorization Act" and related value-based purchasing initiatives spearheaded by U.S. Health and Human Services Secretary Burwell.

We look forward to continuing to work with your offices to ensure that state Medicaid agencies have the tools they need to improve the focus and performance of our behavioral health system.

Sincerely,

A handwritten signature in black ink, appearing to read "Tom Betlach", written over a light blue horizontal line.

Thomas J. Betlach
Arizona Health Care Cost
Containment System Director
State of Arizona
President, NAMD

A handwritten signature in red ink, appearing to read "John B. McCarthy", written over a light blue horizontal line.

John B. McCarthy
Director
Ohio Department of Medicaid
State of Ohio
Vice-President, NAMD