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THE 21ST CENTURY CURES ACT: PROVIDING OPPORTUNITIES FOR INNOVATION AND NEW REIMBURSEMENT AVENUES IN MENTAL HEALTH DELIVERY SYSTEMS

This is the fifth article in a series on the 21st Century Cures Act (the "Cures Act"), which was signed into law on December 13, 2016. We will continue publishing a series of articles summarizing various components under the Cures Act. The articles in our series are located here.

This article highlights the opportunities created by Title XII of the Cures Act (Sections 12001-12005) for new reimbursement avenues for mental health and substance use disorder services, as well as efforts by Congress to study and develop future delivery models for inpatient psychiatric services. Additionally, Title XII creates a new technology requirement for personal care and home health services (Section 12006).

I. OPPORTUNITIES FOR INNOVATION IN INSTITUTIONS FOR MENTAL DISEASE

Title XII of the Cures Act removes barriers to the delivery of mental health services in certain settings and instructs the Centers for Medicare & Medicaid Services ("CMS") to provide guidance to state Medicaid programs on opportunities for new delivery models for mental health and substance use disorder services.

Medicaid is the single largest payor for mental health services in the United States; however, federal law has long restricted the availability of Medicaid reimbursement for services provided to adults under the age of 65 in facilities of 17 beds or more that are "primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases" or Institutions for Mental Disease ("IMD").[1] This exclusion of federal financial participation ("FFP") for inpatient psychiatric services provided to adults between the ages of 21 and 64 is referred to as the "IMD exclusion."

The IMD exclusion is often cited as a significant barrier to patient access to critical services and as a contributing factor to psychiatric boarding in hospital emergency departments across the country. In recent years, Congress and HHS have opened a few narrow avenues for state Medicaid programs to access Medicaid matching funds for inpatient psychiatric care through opportunities for Medicaid managed care plans and various demonstration projects. The Cures Act requires CMS to study and report to Congress on the effectiveness of these existing opportunities by which states can expand services despite the IMD exclusion.

Guidance on Opportunities for Innovation

Within one year of the enactment of the Cures Act, CMS must issue a State Medicaid Director Letter on the various opportunities available to state Medicaid agencies to design innovative service delivery systems for beneficiaries who are adults with serious mental illness or children with a serious emotional disturbance. The letter must include guidance on opportunities for Medicaid demonstration projects under Section 1115 waivers to improve care for this population, which may include additional opportunities to waive the IMD exclusion.[2]

Study on IMD Coverage Under the Medicaid Managed Care Regulation

The Cures Act (Section 12002) requires CMS to conduct a study on the extent to which managed care plans are providing coverage for IMD services pursuant to the May 2016 Medicaid managed care rule, which loosens the IMD exclusion by permitting IMD stays of 15 days or less for individuals aged 21 to 64 who are enrolled in Medicaid managed care plans to be covered as "in lieu of" services.[3]

Within three years of enactment of the Cures Act, the HHS Secretary must submit to Congress a report of CMS's findings with regard to this new provision, including:

- The extent to which coverage of mental health services in IMDs has affected the capitated payments for Medicaid managed care plans and the extent to which states are providing capitated payments for the purpose of such coverage for Medicaid managed care enrollees aged 21 to 64;
- The number of Medicaid managed care enrollees who receive IMD services through managed care plans and the range and average

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lengths of stay; and

- How Medicaid managed care plans determine when to provide mental health services through IMDs "in lieu of" other benefits, such as community-based services, to address psychiatric or substance use disorder treatment.

Study on the Medicaid Emergency Psychiatric Demonstration

Title XII (Section 12004) also requires HHS to submit a report to Congress within the next two years that provides an analysis of data obtained from the states that participated in the Medicaid Emergency Psychiatric Demonstration ("MEPD").

The MEPD is a three-year pilot project that was operated by CMS from 2012 through 2015 and provided up to $75 million to fund Medicaid reimbursement for emergency inpatient psychiatric care in certain IMDs that otherwise would have been excluded from FFP under the IMD exclusion. In August 2016, CMS terminated the program due to the inability to certify the MEPD's statutory requirement for budget neutrality.

The Cures Act requires CMS to analyze a number of data points collected from the 11 participating states,[4] including the average length of stay for individuals who received services during the demonstration, the extent to which the utilization of states' hospital emergency departments differed by the individuals who received treatment in an IMD and any effects the demonstration project had on IMDs' costs and total disproportionate share hospital payments.

Providing EPSDT Services to Children in IMDs

The Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") mandate requires states to provide all medically necessary Medicaid services to most enrollees under the age of 21, regardless of whether the services are explicitly included in the state plan. The EPSDT benefit provides comprehensive and preventive health care services for children who are enrolled in Medicaid and plays a key role in ensuring that children and adolescents receive appropriate preventive mental health services. Under prior law, child and adolescent Medicaid beneficiaries were restricted from receiving EPSDT while residents of IMDs. However, the Cures Act (Section 12005) removed this restriction effective January 1, 2019 by permitting the provision of the full range of EPSDT services to children in Medicaid-covered inpatient psychiatric hospitals.

II. SAME-DAY COVERAGE OF MENTAL HEALTH SERVICES AND PRIMARY CARE SERVICES IN MEDICAID

Title XIX of the Social Security Act (42 USC 1396 *et seq.*), as written, presented a barrier to the provision of timely mental health services in primary care settings given the restriction on "same-day billing." Although the federal government did not impose such a restriction, some state Medicaid agencies established payor rules prohibiting a Medicaid patient from seeing a primary care physician and a mental health care professional on the same day. The same-day billing restriction created difficulties for patients who clustered their medical visits and for providers who sought reimbursement for providing these services.

This barrier was removed by the Cures Act (Section 12001) by establishing a rule of construction clarifying that nothing in the Medicaid statute should be construed as prohibiting a state Medicaid plan or waiver program from making a separate payment for the provision of mental health and primary care services to an individual on the same day thereby allowing Medicaid patients to see multiple professionals on the same day for different services.

III. ELECTRONIC VISIT VERIFICATION SYSTEM REQUIREMENTS IN MEDICAID

In an effort to curb fraud and abuse, the Cures Act (Section 12006) includes a provision requiring electronic visit verification ("EVV") for personal care and home health services provided under state Medicaid programs. The EVV legislation provides basic standards for state Medicaid program compliance but leaves much of the actual implementation standards to the states to develop. States that do not comply with this provision by 2019 (for personal care services visits) and by 2023 (for home health visits) will face a penalty of a one percentage point reduction from the Federal Medical Assistance Percentages, which are used in determining the amount of federal matching funds for state medical and medical insurance expenditures.

If you have any questions, or if you would like additional information on this topic, please contact:

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[1] 42 U.S.C. 1396d(a)(29).

[2] In 2015, CMS announced its willingness to consider Section 1115 demonstration project proposals from states for the provision of substance use disorder treatment, which could include FFP for inpatient psychiatric services provided to Medicaid beneficiaries ages 21-64 in IMDs. *See* SMD #15-003, issued July 27, 2015, at *https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf.*

[3] 42 C.F.R. 438.6(e).

[4] MEPD's state participants include: Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, West Virginia and Washington. The state of Washington did not complete the three-year pilot.

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