June 29, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
Submitted via regulations.gov

RE: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS–2439–P)

On behalf of the NYS Council for Community Behavioral Healthcare, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on Ensuring Access to Medicaid Services ("the Proposed Rule").

The NYS Council is a statewide, non-profit, membership organization composed of 120 community-based organizations that provide recovery-focused mental health and/or substance abuse/chemical dependence and addiction treatment programs and services for New Yorkers in need. NYS Council members offer a broad array of behavioral health services designed to meet the unique needs of children and adolescents, individuals and families seeking our assistance. Our services are available in a variety of community settings including freestanding agencies, behavioral health divisions of general hospitals, and county mental hygiene programs.

The NYS Council is generally supportive of the provisions in the Proposed Rule (1) implementing controls and procedures to ensure that managed care organizations (MCOs) maintain provider networks that are sufficient to make all covered services available to members, and (2) setting forth standards to determine whether MCOs are paying network providers at levels sufficient to enable them to provide high-quality care. The NYS Council also supports the finance-related provisions of the Proposed Rule that are seeking to require states to hold MCOs to account in a more transparent manner for the expected use of capitation payments in arrangements involving State-Directed Payments (SDPs) made by MCOs to network providers, and in value-based payment (VBP) arrangements with network providers.

The requirement in Section 1902(a)(30)(A) of the Social Security Act that payments be sufficient "to enlist enough providers so that care and services are available under [the Medicaid state plan] at least to the extent that such care and services are available to the general population" applies in the managed care setting, as well as fee-for-service (FFS). As Medicaid managed care grows more prevalent—with 72 percent of all Medicaid beneficiaries enrolled in comprehensive managed care plans as of 2020—it is more crucial than ever that states set forth clear expectations in their contracts with plans, and that CMS exercise oversight of MCOs' effectiveness.

Such oversight is particularly critical in the realm of behavioral health. As CMS correctly observes in the companion rulemaking, Ensuring Access to Medicaid Services (CMS-2442-P), "improving access to behavioral health services is a critical national issue facing all payors," 88 *Federal Register* (FR) 28804 (May 3, 2023). Inadequate Medicaid payments to community mental health and substance use treatment providers (CMHSUTPs) that form the nation's outpatient behavioral health safety net, and for

which Medicaid is typically the most prevalent payor, are one key reason for the shortage of available behavioral health services for Medicaid beneficiaries.

Unfortunately, the expansion of Medicaid managed care has often exacerbated these concerns. Over the last decade, the implementation of behavioral health managed care in some states was accompanied by onerous new MCO prior authorization requirements and unnecessary claim denials, resulting in reduced or delayed access to services for members and financial strains for network providers. Adequate payment under managed care, and rigorous controls to ensure MCOs are not impeding the prompt provision of care, are essential so that CMHSUTPs, as safety net providers, can hire qualified providers, serve their clients well, and participate in innovative care models and community partnerships.[1]

While the NYS Council supports CMS' overall goals in this rulemaking, we suggest various modifications below that we recommend CMS make to its methodological choices in order to take into account the critical role of outpatient behavioral health providers in MCO networks. For example, we are concerned that the portions of the rulemaking focused on access effectively shift the burden of network adequacy from MCOs to network providers, by making appointment wait times the chief marker of adequate networks. We are also concerned that the payment adequacy standards CMS is proposing for MCO provider payments, focused on a comparison with Medicare rates, are not in all instances appropriate for CMHSUTPs, which furnish a variety of services that Medicare does not cover.

We additionally wish to flag various respects in which the new requirements concerning SDPs should be clarified for the protection of CMHSUTPs. Participation in SDPs—particularly those involving value-based payment arrangements—are critical to allow CMHSUTPs to play a role in innovative models of care delivery for Medicaid managed care enrollees.

Below, we have associated our comments with the numbered topic section used in the Proposed Rule, and we have placed our comments in the order in which topics appear in the Proposed Rule.

I.B.1.b. Appointment Wait Time Standards (42 C.F.R. §§ 438.68(e), 457.1218)

CMS is proposing to revise its framework for evaluating managed care network adequacy. Overall, the NYS Council recommends that CMS reinforce the *MCO's role* in ensuring network adequacy. The MCO, after all, is the entity contractually entrusted with using federal and state funds, via the capitation payment, to arrange for the provision of care in a manner that ensures access for all enrollees. We are concerned that a shift toward solely relying on appointment wait times as a measure of network adequacy, effectively shifts to providers (and away from MCOs) the network adequacy function.

The 2016 Medicaid managed care regulations required states to establish time-and-distance requirements to ensure that each MCO maintains an adequate provider network. In a 2020 revision to the regulations, which generally relaxed many of the managed care enrollee protections that had been added in 2016, CMS reworded the regulations to require that the states use *some* quantitative network adequacy standard, at their discretion. (Such standards would include but not be limited to maximum time-and-distance standards, minimum provider-to-enrollee ratios, and maximum wait times for an appointment.) In the present Proposed Rule, it appears CMS is seeking to find a compromise between the standards set forth in 2016, which MCOs found overly onerous; and those included in the current (2020) regulations, which gave such broad discretion to states concerning network adequacy that the purpose of the rules was not well-served.

The NYS Council supports CMS' decision to add more "teeth" to the network requirements, correcting some of the effect of the 2020 revisions. We also support CMS' decision to focus its network adequacy

[1] See Cindy Mann and Adam Striar (Commonwealth Fund), How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost (August 17, 2022).

scrutiny on four types of services, including outpatient mental health and SUD services. (See 88 FR 28098.) However, we recommend that CMS not rely solely on appointment wait times for this purpose. Our concerns are two-fold: first, providers, especially CMHSUTPs, face unique pressures that may make it untenable to meet aggressive appointment wait time requirements; and second, an appointment wait time standard cannot ensure adequate access to care for enrollees if MCOs are not contracting with enough providers. Network adequacy standards focusing on MCOs' provider contracting must also be in place and should hold more weight when determining network adequacy.

CMS proposes to require, in 42 C.F.R. § 438.68(e)(1)(i), that states establish minimum wait times for routine outpatient mental health and SUD appointments, "within state-established time frames but no longer than 10 business days from the date of request." 88 FR 28243. By contrast, a maximum appointment wait time of 15 days would apply to routine primary care services. While these standards are phrased as a plan-wide requirement, it is likely that most MCOs would implement the requirement by requiring each individual network provider, via the provider agreement, to meet this standard. Meeting a 10-day appointment wait time (or an even more strenuous requirement, if the state selected it) could be challenging for CMHSUTPs. First, the standard may be untenable for new clients. Many CMHSUTPs, as safety-net providers of a wide range of behavioral health services, conduct an initial registration or screening process to identify new clients' needs. The Proposed Rule text, requiring providers to provide an appointment within 10 days of the enrollee's "request," without distinguishing between new and established clients, does not take into account the fact that initial requirements for new clients such as a screening may be required.

Additionally, providers today encounter operational challenges in making services available on a short timeframe that are not easily overcome. Behavioral health clinician shortages are acute in most geographical areas of the US—particularly the rural and urban underserved areas where CMHSUTPs tend to be the chief providers of Medicaid behavioral health services.[2] Additionally, MCOs themselves frequently erect barriers to network providers furnishing care quickly. For example, some MCOs impose prior authorization requirements that delay the provider in granting a requested appointment. Some MCOs take many months to process providers' credentialing applications for individual clinicians, making it difficult for newly contracted CMHSUTPs to begin furnishing services immediately. Additionally, in light of the national mental health workforce crisis, many of our members providing services through Certified Community Behavioral Health Clinics (CCBHCs), which have a 10-day access standard upon completion of the initial screening, have reported workforce shortages as the greatest barrier to being able to meet that standard, thus our concern is that the current workforce needed to feasibly meet this standard is not yet in place.

Due to the aforementioned factors, we urge CMS not to appointment wait time standards as proposed. Instead, access goals should be achieved through a focus on payment adequacy. If CMS does adopt maximum appointment wait time standards, mental health/substance use disorder services should align with the proposed 15 days for primary care, not 10 days. The timeframe should be a maximum (i.e., states should be required to use a 15-day timeframe, rather than a timeframe of their choosing, at maximum 15 days). Additionally, if such requirement is established, the term "date of request" should be modified to reflect, instead, the date when the service has been requested and any relevant prior authorization requirement has been met. CMS should also reevaluate its regulation on provider credentialing (42 C.F.R. 438.214(b)). The regulation at present merely requires states to establish a uniform credentialing process and MCOs to document their procedures. The regulations should be amended to include provisions that deter MCOs from placing undue delays on provider credentialing to the detriment of network providers and enrollee access. The regulation could provide, for example, that

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[2] See HRSA, Designated Professional Shortage Area Statistics (Mar. 2023) and Commonwealth Fund, Understanding the U.S. Behavioral Health Workforce Shortage (May 2023).

MCO credentialing effective dates must be established as a date no later than the date when the provider submitted a valid, approvable application.

The present Proposed Rule adds more rigor to the network adequacy rules, but only by imposing new requirements on network providers. CMS' proposed provision at 42 C.F.R. § 438.68(b)(1) would require states to "develop a quantitative network adequacy standard, other than appointment wait times," for providers including mental health/substance use disorder providers, adult and pediatric. 88 FR 28243. The text would leave it to states to determine what the quantitative standard should be.

The NYS Council also recommends CMS reinstitute plan-oriented network adequacy requirements. In finalizing the regulation, we recommend CMS add a more prescriptive quantitative network adequacy provision that ensures MCOs are contracting with enough CMHSUTPs to construct an adequate network for each mental health and substance use service. We also recommend that CMS include specific requirements for "essential community providers" that serve low-income patients. Additionally, we recommend that the text of the regulation be amended to require states to use either time-and-distance requirements, or minimum provider-to-enrollee ratios for each service category, to measure network adequacy for CMHSUTPs. Finally, the NYS Council recommends that CMS adopt requirements requiring MCOs to contract with CMHSUTPs that operate under program requirements requiring them to serve low-income, medically underserved individuals. Under the Affordable Care Act, Qualified Health Plans (QHPs) are required to contract with a "sufficient number and geographic distribution" of essential community providers (ECPs) to ensure timely access to services.[3] The regulations require QHPs to contract with at least one ECP of each type in each county of the QHP's service area, with types of QHPs encompassing mental health facilities and substance use disorder treatment centers.[4] CMS should augment the network adequacy requirements to add specific contracting requirements, mirroring the QHP requirements, for essential community providers. This would be particularly appropriate given that CMS' rationale for the appointment wait times includes a goal of aligning expectations with those applicable to the QHPs. (See 88 FR 28099.)

I.B.1.d. Assurances of Adequate Capacity and Services—Provider Payment Analysis (42 C.F.R. 438.207(b), 457.1230(b))

In this provision, CMS proposes to augment the requirements of 42 C.F.R. § 438.207, which at present only requires states to require MCOs to submit assurances that they have capacity to serve their full enrollment without any concrete requirements for the MCO to demonstrate that capacity. CMS proposes to add a requirement that MCOs test the adequacy of their payments to network providers by submitting a comparison of total amounts paid in four service categories (primary care, OB/GYN, mental health, and substance use disorder services) to comparable payments under Medicare. This proposed requirement is analogous to CMS' proposed requirement in the FFS Access Proposed Rule that states' FFS payment adequacy be tested by comparing payment rates with comparable rates under Medicare fee schedules. Specifically, CMS proposes that each MCO would be required to compare total amounts paid on claims for evaluation and management (E/M) CPT/HCPCS codes for the four service areas, with comparable Medicare fee schedule payments for the same codes. 88 FR 28105.

While the NYS Council is generally supportive of CMS' proposal that acknowledges network provider payment is a key factor in MCOs maintaining adequate provider networks, we do recommend that CMS reexamine its proposed methodology with respect to behavioral health services. A comparison of payments to Medicare fee schedules would fail to capture a large portion of the care furnished by CMHSUTPs under contract with MCOs. Some of the most essential services provided in community behavioral health settings—ranging from peer supports services, to psychosocial rehabilitation services,

[3] PPACA 1311(c)(1)(C); 45 CFR § 156.235.

[4] 45 C.F.R. § 156.235(a)(2)(ii)(B).

to assertive community treatment —do not correspond to any E/M service covered under the Medicare Physician Fee Schedule. In fact, in general, state Medicaid programs have been innovators in the extent of their coverage of outpatient behavioral health services, in comparison with Medicare, which in general, continues to cover only a limited range of psychotherapy and diagnostic services furnished by a limited range of practitioners.

Accordingly, the NYS Council strongly urges CMS to consider the broader scope of Medicaid-covered behavioral health services than Medicare-covered services. We recommend that CMS revise the proposed text of 42 CFR 438.207(b)(3) to include (in addition to the Medicare comparison) a comparison to another payor, for mental health and substance use disorder services. As one alternative, the regulation would require a comparison of payments by the MCO to the amount the state's FFS program would pay for the same services under the state plan methodology. (Such a provision would mirror CMS' proposal at 437.207(b)(3)(ii) for measuring payment adequacy for homemaker services, home health aide services, and personal care services.) CMS could also include, in addition to the Medicare comparison, comparison of payment to commercial payers' rates where feasible to better assess the landscape and implication of rate variation on access with the caveat that this information may be proprietary and difficult to obtain as recognized in the proposed rule. Finally, CMS should not exclude from consideration providers paid under encounter-based methodologies. Including encounter-based methodologies in this comparison will be important as 12 states with Medicaid arrangements for CCBHCs use encounter-based rates and 10 states will be added to the demonstration every other year beginning in 2024.

Another issue impacting MCO enrollees' access to care relates to out-of-network services. As a general matter, MCOs are not required to pay providers for out-of-network services, but there are some statutory exceptions. Among them, the Social Security Act, at Section 1903(m)(2)(A)(vii) requires states' contracts with MCOs to provide for either the MCO or the state to pay providers for medically necessary services that are furnished to MCO enrollees out-of-network, where the services are "immediately required due to an unforeseen injury or illness." However, unlike other managed care out-of-network coverage/payment requirements, this requirement is not memorialized in the Medicaid managed care regulations. Being able to secure out-of-network payment from MCOs for services provided to enrollees on an urgent basis is critical for CMHSUTPs, which frequently furnish mental health and SUD services to clients in crisis situations. We urge CMS to amend the regulation at 42 C.F.R. § 438.206(b) to add this situation the list of situations in that subsection where coverage of and payment for out-of-network services is required.

I.B.2. State-Directed Payments

The NYS Council generally supports CMS' proposed revisions to the regulatory provisions on SDPs in this section of the Proposed Rule. Our comments consist largely of requested clarifications in several areas, as detailed below.

Generally, MCOs have discretion in managing their capitation payments for the provision of the scope of services covered under their contracts with states, and this includes negotiating payments with network providers. Nonetheless, in some circumstances states seek to include specific requirements in their contracts with MCOs for how specific provider types in the network should be paid. CMS recognized in its 2016 regulations that CMS needed to formalize situations that form an exception to that general flexibility, where states may require MCOs to pay network providers under a specific methodology or at a specific level.

Under the 2016 regulations, SDPs are generally expected to relate to value-based purchasing (VBP) models, requirements for payment under a minimum fee schedule or use of a uniform increase, or multi-payor or Medicaid delivery system reform initiatives. SDPs are consuming an ever-larger portion of states' capitation payments to MCOs. CMS is seeking in the Proposed Rule to add specificity to the

definitions and procedures surrounding SDPs and to ensure that states' contracts with MCOs hold the entity responsible for expending funds as required, so that federal and state funds are responsibly used.

SDPs that have been implemented in recent years have been beneficial for CMHSUTPs. First, as CMS notes in the preamble, states have used SDPs "to ensure certain minimum payments are made to safety net providers to enhance access to care" and to "enhance behavioral health care providers as mandated by state legislative directives." 88 FR 28110. Generally, the bargaining leverage exercised by MCOs in network provider contracts can be challenging for CMHSUTPs, given that they have been historically underpaid under Medicaid FFS, as well as by other payors. In a state where Medicaid payments to CMHSUTPs have, for example, historically covered only sixty percent of the CMHSUTPs' costs of providing services to Medicaid beneficiaries, an SDP with a minimum fee schedule requirement may make a critical difference for CMHSUTPs' continued ability to maintain solvency and pursue innovations in care.

SDPs may also provide an opportunity for CMHSUTPs to participate in VBP arrangements. Generally, CMHSUTPs—providers that truly need more robust Medicaid payment and that use Medicaid payments to provide essential behavioral health services in managed care networks—only benefit from increased federal oversight to ensure that the SDPs serve their intended purpose.

CMS proposes to define a State-directed payment, in 42 C.F.R. § 438.6, as "a contract arrangement that directs an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) of this section." 88 FR 28235. Those paragraphs, in turn, designate SDPs that provide for a minimum fee schedule or increase for participation in a VBP or other delivery reform initiative. The NYS Council seeks clarification from CMS as to whether a requirement by the State that MCEs pay CCBHCs their prospective payment system (PPS) rate constitutes a SDP subject to the procedures set forth in 42 C.F.R. 438.6.As background, under the CCBHC Medicaid demonstration originally authorized under the PAMA 2014 legislation, states are required to ensure that CCBHCs receive the PPS rates assigned by the state, including for services provided under contract with an MCO. As to the latter, states may choose whether (1) to make direct supplemental payments to compensate for any amounts by which MCO payments fall short of PPS payment; or (2) to delegate contractually to the MCO the obligation to pay CCBHCs under the PPS methodology.[5]

A contractual requirement that the MCO pay CCBHCs their Medicaid PPS rate would appear to meet the criteria for an SDP, as the PPS rate could be considered a "minimum fee schedule for providers that provide a particular service," per 42 C.F.R. 438.6(c)(1)(iii)(C). Nonetheless, CMS' recent proposed revision to the Medicaid CCBHC PPS guidance states, with respect to the CCBHC demonstration: "States that elect to require their managed care plans to make the full PPS payment as part of the CCBHC demonstration are permitted to do so without obtaining written prior approval under 42 CFR 438.6(c) (often referred to as state directed payments) because the PPS is a statutory requirement of the CCBHC demonstration."[6]

If it is CMS' conclusion that MCO contracts requiring payment of CCBHCs at the PPS rate are not SDPs, we request that CMS issue guidance concerning minimum required components of states' contract provisions with MCOs addressing that issue, similar to the requirements contained in the proposed 42 C.F.R. § 438.6(c)(5) relating to states' contracts with MCOs concerning SDP obligations. A concern of note is whether the required payment is an SDP or a CCBHC PPS rate, when requiring plans to pay providers specific rates, MCOs may treat network providers in a disfavored manner or otherwise fail to make full payment under the required methodology. Just as CMS is introducing additional accountability for states and plans by setting forth required contract elements for SDPs, similar guidance would be

[5] See CMS, Criteria for the Demonstration Program to Establish CCBHCs (Appendix II to SAMHSA 2015 Request for Applications for CCBHC State Planning Grants)

[6] CMS, CCBHC PPS Guidance, Proposed Updates (May 2023).

helpful for CCBHC payment provisions. (Please note that CMS issued guidance on this topic for the FQHCs in 2016, but the guidance now no longer appears on the CMS website. The State Health Official Letter guidance document stated that where states implement the requirement that MCOs pay FQHCs the PPS rate, rather than paying supplemental payments, states need to maintain controls to make sure the full rate is paid for the covered services, and also to ensure that the MCOs are contracting with at least one FQHC per service area. However, that guidance no longer appears on the Medicaid website.)

While generally supportive, the NYS Council recommends use of a streamlined application process and seeks clarification regarding minimum fee schedule amounts. The NYS Council is supportive of CMS' proposal to omit the requirement of advance CMS approval of SDP proposals that require MCEs to pay Medicare payment rates. Under the 2020 regulations, CMS already excused SDPs requiring payment at

Medicaid State plan rates from the federal approval process. This revision is a logical expansion of that policy - particularly needed, given that most Medicaid FFS payment rates are not high enough even to cover providers' costs. At the same time, we hope that the application process and CMS approval requirements for SDP applications seeking to impose a minimum fee schedule or payment increase on a basis *other than* state plan or Medicare rates, will be relatively straightforward where the SDP is being used to augment historically insufficient payments to safety net providers.

We urge CMS either to include a provision in the regulations that would exempt from prior approval SDPs providing for payment at a minimum fee schedule or for a minimum payment increase for CMHSUTPs, or to clarify in preamble language that in general, "minimum payment rate" SDPs that are implemented to provide needed rate increases for historically underpaid safety-net providers will be considered meet the relevant goals and requirements for approval. We encourage CMS, if possible, to use a streamlined application process, and to exempt such proposals from the requirement to submit a written evaluation plan, per 42 CFR § 438.6(c)(1)(iv). We further request that CMS clarify, for purposes of the "minimum Medicare fee schedule" SDP at 42 CFR § 438.6(c)(1)(iii)(B), the required Medicaid payment rate need not be based on the Medicare Physician Fee Schedule. Medicare has in recent years expanded its coverage of behavioral health services to some extent. Effective in 2024 (due to an amendment made by Consolidated Appropriations Act 2023), Medicare will cover a benefit, "intensive outpatient services," comprising a wide array of outpatient behavioral health components (with fewer required hours of service per week than the existing similar Medicare service, "partial hospitalization"). States should be able to look to other Medicare payment methodologies, such as the Medicare OPD PPS used for partial hospitalization and likely to be used for intensive outpatient services, in establishing minimum fees under an SDP.

The NYS Council supports CMS' proposal to add specific requirements in the regulation as to how states design managed care VBP programs and implement them in their managed care contracts. CMS has a valid concern that without clear requirements and expected performance metrics, MCOs may use VBPs simply to increase the numerator (i.e., the portion devoted to claims payments and quality activities) in their medical loss ratio (MLR), without meaningfully structuring provider payment to encourage the provision of high-quality, consumer-centered care. We support the requirements CMS has introduced at 42 CFR §§ 438.3(i)(3) and 438.6(c)(2)(vi). Also, among the newly proposed requirements is that in a state's contract with MCOs, the state is to require the MCO, in its network provider agreements, to "specify a dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract." See 88 FR 28234. The NYS Council supports requirements that network provider agreements clearly define both the performance goals and the associated payment for VBP arrangements.

We also request that CMS make clear, either in the text of the regulation or in preambles, that for purposes of CCBHCs paid under a PPS methodology, specific amounts paid by MCOs as bonuses or payments for performance under a VBP arrangement are not counted within MCO service payments for purposes of the supplemental payment required under the CCBHC demonstration. The demonstration

requires that states either (1) make supplemental payments to network providers to compensate for the gap between MCOs' payment for covered CCBHC services, or (2) require MCOs to pay the full PPS rate for covered CCBHC services. If an MCO chooses, under a VBP arrangement, to make bonus payments to a CCBHC for covered services, such payments should be considered *in addition to* the CCBHC's service payments, under either of the two frameworks set forth above.[7] It is a critical protection for providers paid under a PPS methodology that includes supplemental payments for managed care services, because without it, the financial impact of any incentives provided by the MCO would be neutralized by the calculation of the supplemental payments. Without this protection, CCBHCs would not be able to participate meaningfully in SDPs providing for value-based payments.

I.B.4. In Lieu of Services and Settings

The NYS Council is generally supportive of CMS' proposal to add a new Section 438.16 to the regulations, formalizing the rules of in lieu of services and settings (ILOS). In the behavioral health area, ILOS provisions in states' contracts with MCOs have been productive in allowing MCOs to pay network providers for behavioral health services or modalities with proven effectiveness, that are different from the parameters of the service under the Medicaid state plan. We interpret CMS' proposed requirement at Section 438.16(b) that an ILOS be "approvable as a service or setting through a waiver under section 1915(c) of the Act or a state plan amendment, including section 1905(a), 1915(i), or 1915(k)," to encompass most of the types of ILOS provisions that have offered MCOs needed flexibility—for example, coverage of behavioral health services via telehealth in states where existing state plan rules did not authorize this modality, prior to the COVID-19 public health emergency.

We appreciate CMS' recognition in the rulemaking of the beneficial uses of ILOS for covering health-related social needs. We further appreciate CMS' affirmation that the existing regulatory provision allowing for MCOs to cover, as an ILOS, a short-term inpatient mental health or SUD facility stay of no more than 15 days, in spite of the statutory prohibition on coverage of stays in an institution for mental diseases (IMD), will not be affected by the new ILOS rule. We remain concerned at the negative impact of the IMD exclusion on Medicaid beneficiaries' access to critical behavioral health treatment, but we recognize this is an issue that Congress, rather than CMS, must first address.

The NYS Council appreciates the opportunity to provide these comments. We welcome any questions or further discussion about the recommendations described here. Please contact me at lauri@nyscouncil.org. Thank you for your time and consideration.

Sincerely,

Lauri Cole
Executive Director

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[7] This concept is described in the Medicare regulations concerning supplemental payments to Federally qualified health centers (FQHCs) for services furnished under contract with a Medicare Advantage Organization: "Any financial incentives provided to FQHCs under their MA contracts, such as risk pool payments, bonuses, or withholds, are prohibited from being included in the calculation of supplemental payments due to the FQHC."42 CFR § 405.2469(c).