COALITION FOR WHOLE HEALTH

June 9, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Proposed Rule Applying the Requirements of MHPAEA to Medicaid MCOs, ABPs, and CHIP Plans (CMS-2333-P)

Dear Administrator Slavitt:

On behalf of the Coalition for Whole Health, thank you for the opportunity to provide comments on the proposed rule applying parity to Medicaid managed care, alternative benefit plans, and CHIP plans. The Coalition for Whole Health is a coalition of national, state, and local organizations advocating for improved coverage for and access to mental health (MH) and substance use disorder (SUD) prevention, treatment, and recovery services. A central goal of the coalition is the strong implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA), and we appreciate your consideration of our comments.

With the passage of MHPAEA and the Affordable Care Act (ACA) we have seen historic expansions of quality coverage for MH/SUD. MHPAEA was passed by congress in 2008, and final regulations governing how MHPAEA applies to commercial health insurance coverage were published in 2013. While compliance and enforcement needs are ongoing, these proposed regulations represent an essential next step in the regulatory process to fully implement the law, and we strongly urge CMS to make finalization of this rule a high priority. Below are our comments on the proposed rule.

- **We appreciate the proposed rule's application of parity to all beneficiaries enrolled in a Medicaid managed care plan.**

We believe that the proposed approach to apply parity to all beneficiaries enrolled in Medicaid managed care organizations (MCOs) is consistent with what congress intended when they passed the parity law in 2008. We appreciate the clarification that parity applies to all Medicaid managed care enrollees, regardless of how MH/SUD services are delivered.

We were quite concerned when CMS signaled in a 2013 letter to states that parity may not be required for MH/SUD carve-out arrangements. The letter said that "CMS urges states with these arrangements to apply the principles of parity across the whole Medicaid

managed care delivery system when mental health and substance use disorders services are offered through a carve-out arrangement." States have considerable flexibility to deliver MH/SUD services through an MCO or through a different system than most other services are provided, and reducing parity protections to only one type of arrangement would have severely limited parity's impact. We also are aware of responses from some states to the letter that indicated that they felt their Medicaid programs did not need to be concerned with MHPAEA because CMS was not applying parity requirements to their type of MH/SUD delivery system. Simply urging states to apply parity when carve-out arrangements exist was clearly insufficient, so we were very happy to see CMS reconsider its approach in the proposed rule.

We thank CMS for recognizing that failure to apply parity to carve-out arrangements would eliminate parity protections for non-ABP beneficiaries in several states, significantly reducing parity's overall impact for the Medicaid program. We also thank CMS for recognizing that congress intended parity to apply to all enrollees in Medicaid MCOs. We support the approach laid out in the proposed rule to apply parity across delivery systems and strongly encourage CMS to implement a final rule that does not weaken parity protections for enrollees in Medicaid MCOs based on how MH/SUD services are delivered in their state.

- **We agree with CMS that an increased cost exemption for parity is not needed and support building any increased costs associated with parity into the state's rate setting structure.**

The regulations governing parity's application to commercial health insurance exempt health plans that incur an increased cost of at least two percent in the first year that parity's requirements apply, or incur an increased cost of at least one percent in any subsequent plan or policy year. To our knowledge, no health plan in the commercial market has been able to demonstrate increased costs that are sufficient to gain an exemption, and no exemptions have been given. We appreciate that CMS agrees that an increased cost exemption is not needed for parity compliance in Medicaid and CHIP.

We also appreciate that CMS proposes to include any costs of parity compliance in the state's rate setting structure. We believe that any costs associated with bringing Medicaid and CHIP coverage into compliance with parity will be minimal. We also believe, as does CMS, that proper implementation of parity may well save money as more beneficiaries will be able to access appropriate care for their MH/SUD conditions, resulting in fewer emergency department visits and hospitalizations as well as improved physical health. Building any costs associated with adding services or removing treatment limitations into the actuarially sound rate methodology is appropriate, and we believe that the proposed language is sufficient to limit rate setting to only include the services necessary to meet state plan and parity obligations.

- **We appreciate that CMS is using the proposed rule as an opportunity to encourage states to improve their coverage of MH/SUD throughout their**

Medicaid programs, and that CMS is encouraging states to implement parity in a way that maximizes parity's impact.

Parity protections apply to beneficiaries in Medicaid MCOs, Medicaid ABPs, and CHIP. While these protections will clearly benefit very large numbers of individuals, there are also millions of additional Medicaid enrollees who are not protected under the parity law. We therefore strongly support CMS in its encouragement of states to provide state plan benefits in a way that comports with the requirements of parity to expand protections beyond what is required under federal law. We believe that all states should design their Medicaid programs in a way that can address the full range of MH/SUD needs of Medicaid beneficiaries, and we very much appreciate the ongoing work at CMS to encourage states to improve their Medicaid coverage for MH/SUD.

In addition to our strong support of the proposed rule applying parity to Medicaid and CHIP coverage, we have a number of recommendations for improvements that we would like to see in the final rule. These recommendations are detailed below.

- **CMS proposes to give states 18 months after the finalization of this rule to comply with parity requirements. We believe that this is much more time than most states require, and we encourage CMS to implement a shorter timeline and require states to demonstrate progress.**

Congress passed MHPAEA in 2008. Final regulations governing parity in the commercial health insurance market were not released until 2013, and these proposed regulations for Medicaid and CHIP were released more than five years after the last congressional action on parity. While we understand that our healthcare system is undergoing historic changes and that there have been significant demands placed on HHS and states to develop and implement regulations governing the future of health policy, slow implementation of the parity law already has delayed the benefits of its protections for many consumers. If, as proposed, states are given 18 months after the finalization of this rule to bring their Medicaid and CHIP programs into compliance with parity, it will be close to 10 years after the passage of the parity act before all of the parity regulations are fully enforceable. This is far too much time, and we strongly encourage CMS to implement this rule as quickly as possible.

CMS has explained that states require 18 months from the finalization of the rule to bring their programs into compliance, because managed care contracts may need to be revised and state legislative action may be required before a states can come into compliance with the regulations. While we understand that states often need time to implement significant changes to their Medicaid and CHIP programs, states have known for many years that parity applied to these programs and that these programs needed to generally be in compliance, even absent regulations.

In a November 4, 2009 State Health Official Letter[1], CMS told states that "MCOs or PIHPs must meet the parity requirements of MHPAEA, as incorporated by reference in title XIX of the Act, for contract years beginning after October 3, 2009." Regarding the application of parity to CHIP, the letter told states that "This requirement was effective as of April 1, 2009." The letter went on to tell states that they

> "Will need to begin to assess their own compliance with the MHPAEA parity requirements prior to the issuance of MHPAEA regulations. For States that use MCOs or PIHPs to provide Medicaid benefits, a review of current contract language with the plans should occur before the next contract year begins to ensure that MHPAEA parity requirements are in place. Similarly, each State will need to review its CHIP plan to determine if the CHIP State plan imposes more restrictive requirements on mental health or substance use disorder benefits than on medical/surgical benefits."

States were clearly made aware that their Medicaid and CHIP plans needed to meet parity requirements before the issuance of these proposed regulations, both in guidance from CMS and in the law. Section 3(d)(2) of the CHIP Reauthorization Act made it clear that states were required to make a good faith effort in both their Medicaid and CHIP programs to comply with the requirements prior to the issuance of any regulations or risk losing federal financial participation. And Medicaid ABPs that have been implemented since the passage of the ACA, including all ABPs implementing the ACA's Medicaid expansion, have had to comply with parity, and CMS has repeatedly told states of the parity compliance requirement for these plans.

Because parity has already been in effect for Medicaid and CHIP plans absent the regulations, states should only need to implement the provisions of the regulations that differ in approach or detail from the guidance that has already been given them by CMS. Therefore, we believe that full compliance should take no longer than 12 months from finalization of the rule for all or almost all states, and most states should be able to comply much sooner. We encourage CMS to shorten the timeline for compliance from 18 months from finalization to no more than 12 months, unless a state can demonstrate to CMS that meeting the requirements of the final rule in 12 months is not possible. If a state can demonstrate the genuine need for the full 18 months, CMS could extend the implementation deadline for that state, but only if that state can show that it continues to make strong progress implementing parity in the interim.

In addition to our request that compliance be required no more than 12 months after the finalization of this rule for states that cannot meet exemption criteria, we ask CMS to include in the final rule "benchmarks" that all states must meet to show progress in implementing the regulation between release of the final rule and the day it goes into effect. Such benchmarks should include demonstrating to CMS that the state has a plan in place to bring its coverage into compliance, that all MCO contracts that are implemented or renewed before the deadline fully comply with the parity regulations, that all fee-for-

[1] http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf

service CHIP and ABP coverage meets parity requirements, and that the state has taken all steps for compliance absent some of the more time consuming steps, like renegotiating MCO contracts or passing authorizing state legislation. States and CMS should also make compliance reports public. Similarly, we urge CMS to quickly release the final rule so all parity protections can be implemented and enforced as soon as possible.

- **CMS should provide more information on nonquantitative treatment limitations, including more examples, in the final rule and/or follow-up materials.**

The proposed rule duplicates the definition on nonquantitative treatment limitations (NQTLs) from the final MHPAEA rule. As with the final parity rule, the proposed Medicaid/CHIP rule requires that a MCO, PIHP, or PAHP may not impose a NQTL for MH/SUD benefits in any classification unless any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than those used in applying the limitation for medical/surgical benefits in the classification.

The proposed rule goes on to provide an illustrative list of NQTLs that includes:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for admission into provider networks and reimbursement rates;
- Network tier design;
- Methods for determining usual, customary, and reasonable charges;
- Fail-first policies such as refusal to pay for higher cost therapies unless it can be shown that lower cost therapies are not effective;
- Exclusions based on failure to complete a course of treatment;
- Restrictions based on geography, facility type, provider specialty, or other limiting criteria; and
- Standards for providing access to out-of-network providers.

We appreciate that CMS includes some discussion and a list of some NQTLs in the proposed rule. However, based on our experience more detailed information about what constitutes a NQTL and numerous examples of typical parity violations where NQTLs are applied more stringently to MH/SUD coverage are needed. This includes examples related to provider networks, prescription drugs, requirements and exclusions based on a patient's response to treatment, and other NQTLs that have typically been more strictly applied to MH/SUD. It is also clear to us based on our experience that identifying and analyzing NQTLs in Medicaid and CHIP plans is often difficult and confusing for states.

As parity has been implemented in commercial health insurance, the Departments of HHS, Labor, and Treasury have provided many different examples of parity violations related to NQTLs. These examples have been included in the interim final rule, the final rule, and in

supplementary materials such as FAQs. The wide range of examples provided have been quite helpful for plans and consumers to identify violations. As CMS develops and implements regulations governing the application of parity to Medicaid and CHIP, we urge CMS to include more information on what constitutes NQTLs and how the application of NQTLs can violate parity. This should include as many examples as possible. The examples should be provided in the final rule, supplementing materials, or both, and CMS should regularly provide ongoing guidance to states and plans that highlights typical violations as they are identified.

- **CMS should provide more information on how parity applies to long term care services, and specifically detail what long term care services and similar services are included and excluded from the parity requirements.**

In the proposed rule, CMS states that:

> "We are also proposing that the definition of 'medical/surgical services' clearly exclude long term care services in the Medicaid and CHIP context. We believe this clarification is consistent with the intent of the MHPAEA final regulations, as the kinds of long term services included in benefit packages for Medicaid and CHIP beneficiaries are not commonly provided in the commercial market as part of health benefits coverage."

The proposed rule goes on to say that "long term care services and supports, such as personal care, home and community based services, or long term psychosocial rehabilitation programs, are also commonly included in benefit packages for all or targeted populations of Medicaid and CHIP beneficiaries, but these benefits are not typically provided in a commercial environment" and therefore long term care services are not to be included in one of the classifications of benefits. Finally, the terms "mental health benefits" and "substance use disorder benefits" as defined in the proposed rule do not include long term care MH and SUD benefits.

We ask CMS to provide additional information justifying the exclusion of long term care services from parity requirements. We first ask for clarification about how CMS defines long term care services. We are concerned that excluding from parity review long term care services will limit the application of parity to the full continuum of effective MH/SUD services. For example, although CMS states that certain long term care services are not typically covered by commercial insurance, commercial plans do typically cover post-acute care services, including skilled nursing, inpatient rehabilitation, and home health services. In addition, while we appreciate the desire for consistency between the regulations applying parity to the commercial market and regulations applying parity to Medicaid and CHIP, we believe that the regulations must reflect the differences between commercial insurance and Medicaid/CHIP, as well as the different needs of the populations that each type of health coverage serves. We do not believe that parity only applies to Medicaid/CHIP services that are typically also covered by commercial insurance. Rather,

we believe that parity applies to all covered benefits in Medicaid and CHIP, and that parity applies to all benefits covered by a commercial health plan.

We also understand that not all long term care medical/surgical services have a corresponding MH/SUD service. If CMS implements its proposed approach to exclude long term care services from parity requirements, we ask for much more detail on which long term care services are excluded and assurances that excluding those services will in no way limit the application of parity to the full range of MH/SUD services across the prevention, treatment, recovery, and rehabilitative continuum for these illnesses. We are very concerned that allowing MCOs and/or states to select which long term care services are excluded from parity requirements will result in certain MH/SUD services being excluded from parity protections in violation of what congress intended.

- **Similarly, we ask CMS to provide more detail on how parity applies to intermediate MH/SUD services.**

The final parity rule that applies to commercial coverage included a detailed discussion of intermediate services; that is those services such as residential treatment, partial hospitalization, and intensive outpatient treatment that do not fit neatly into an inpatient/outpatient classification. The final MHPAEA rule did not include a definition of intermediate services or an intermediate services classification, but was clear that parity applied to these services. This proposed rule applying parity to Medicaid and CHIP likewise does not include an intermediate services definition or classification, but instead would allow the regulated entity or state to assign intermediate level services to any of the classifications as long as those classifications are done in a consistent manner for medical/surgical and MH/SUD services. We believe that strong clarification in the finalized version of this rule stating that intermediate services must meet parity is needed. Clarification of intermediate services is especially critical if CMS moves forward with its intended approach to exclude long term care services from parity, as some intermediate MH/SUD services may be incorrectly excluded from parity protections if they are considered long term care services by MCOs or states. We do not necessarily believe that the number of classifications needs to be expanded to include intermediate services, but we believe that more clarity and/or scope protections for intermediate services are needed to ensure that they are appropriately covered by states and MCOs.

- **CMS should clarify how parity and the IMD exclusion co-exist, and explicitly state that services typically provided in IMDs remain subject to parity.**

The Medicaid institutions for mental disease (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. The exclusion has long been a barrier to Medicaid beneficiaries seeking nonhospital, residential treatment services for MH/SUD.

The proposed rule is silent on how states and MCOs implement parity in a way that also complies with the IMD exclusion. While we understand that the IMD exclusion is a payment exclusion longstanding under federal law, it is also a payment exclusion that disproportionately affects beneficiaries with MH/SUD conditions, in a way that is contrary to the MH/SUD equity goals of the parity law. We also know that states vary considerably in their coverage of MH and particularly SUD services, and believe that many states have been reluctant to implement comprehensive SUD benefits in their Medicaid programs due in part to the fact that the IMD exclusion means that some medically necessary services cannot be covered in the most appropriate treatment facilities.

We urge CMS to make clear in the final rule that parity protections apply to the full range of MH/SUD services, including residential treatment services and other services that are typically provided in facilities that fall under the IMD exclusion. CMS has also recently released proposed regulations for Medicaid managed care that includes some important policy changes related to the IMD exclusion. We look forward to additional information from CMS on how these proposed changes will be implemented. . We also encourage CMS to revisit its policies related to the IMD exclusion to ensure that Medicaid beneficiaries with MH/SUD are able to access the full range of medically necessary health care services needed to treat their conditions, consistent with parity's goal of equity in MH/SUD coverage and treatment.

- **We urge CMS to carefully review CHIP coverage that is deemed to comply with parity because it provides EPSDT benefits.**

The proposed rule reflects the statutory requirement that CHIP plans providing EPSDT services are to be deemed in compliance with parity's financial requirements and quantitative treatment limitations. We appreciate that CMS clarified that if states apply NQTLs to EPSDT services, those limits must be applied consistent with the intent of MHPAEA. However, we are concerned that state CHIP plans may be deemed compliant with parity even when EPSDT coverage is poorly implemented and MH/SUD services are subjected to a more restrictive standard than covered medical/surgical services. We therefore urge CMS to carefully review CHIP EPSDT coverage for financial requirements or treatment limitations that would otherwise violate parity and work with states to eliminate those discrepancies. We also urge CMS to work with states to carefully monitor and enforce parity requirements on any NQTLs that may apply to CHIP EPSDT coverage.

- **CMS should strengthen the prescription drugs requirements, and make clear that the full range of MH/SUD medications must be covered under parity.**

Medicaid programs often impose discriminatory limits on medications for MH and particularly SUD. Such restrictions often include lifetime limits on methadone, injectable naltrexone, and/or buprenorphine, prescription refill limits that do not reflect the chronicity of the condition, and more stringent prior authorization requirements.[2]

[2] "Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment," American Society for Addiction Medicine, 2013.

We appreciate the attention that CMS has paid recently to improving access to SUD medication assisted treatment, including last year's informational bulletin from CMS, CDC, SAMHSA, NIDA, and NIAAA that provided guidance to states to improve coverage for SUD medications under Medicaid.[3] The informational bulletin, like this proposed rule, clarified that prescription drug coverage must comply with the requirements of MHPAEA.

We believe that parity, effectively implemented, will significantly improve patient access to medications for MH/SUD. However, effective implementation of parity for prescription drugs requires that states and MCOs have strict requirements that they must meet, and we urge CMS to strengthen parity requirements related to prescription drugs in the final rule. Specifically, we believe that parity requires that all approved medications for MH/SUD be covered, especially considering how few medications are available to treat SUD. We ask for requirements in the final rule that ensure adequate access to all available medications for MH/SUD, without any more stringent limitations than those imposed on other medications. We also encourage CMS to prioritize prescription drug coverage in its enforcement of parity, and to carefully monitor claims data to quickly identify and remedy any problems.

- **We ask CMS to clarify how Medicaid parity protections apply to dual eligible populations enrolled in Medicaid MCOs that cover Medicare services, particularly where distinctions between Medicaid and Medicare are difficult.**

The proposed rule says that CMS is not applying parity requirements to "Medicare Parts A, B, or D services covered by Medicaid MCOs, such as those covered by integrated plans for people who are dually eligible for Medicare and Medicaid," because "Medicare benefits are controlled by the Medicare statute and regulations, which are not within the scope of this proposed rule." We ask for clarity on how Medicaid parity requirements are to be met in situations where Medicaid MCOs cover Medicare services and payments are blended.

We understand that Medicare is not subject to parity requirements. However, Medicaid coverage provided through MCOs clearly must meet parity. In arrangements for dual eligibles where Medicaid coverage is provided through an MCO and Medicare coverage can clearly be separated, we urge CMS to clarify that the Medicaid coverage must meet parity. In managed care arrangements where Medicaid and Medicare coverage for dual eligibles cannot be easily separated, we urge CMS to use its authority to require that parity protections apply to the full coverage offered under the arrangement.

- **CMS should ensure that disclosure requirements are sufficient to evaluate parity compliance.**

The proposed rule improves transparency by requiring Medicaid and CHIP coverage subject to the parity requirements to "make their medical necessity criteria for MH/SUD benefits available to any enrollee, potential enrollee, or contracting provider upon request."

[3] http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf

The proposed rule also notes that other consumer protections apply in Medicaid that require MCOs, PIHPs, and PAHPs to notify the requesting provider and enrollee of any decision to deny a service authorization or approve a service in an amount, duration, or scope that is less than requested. We appreciate these protections, but point out that only making information about MH/SUD services, criteria, and denials available without also providing the corresponding medical/surgical information is insufficient to determine parity compliance.

The proposed rule also says that other regulations governing disclosure will apply. We urge CMS in the final rule to explain in more detail what this rule and other regulations require related to disclosure, and to ensure that all information needed by providers, enrollees, and potential enrollees to determine parity compliance is fully available in a timely manner. The disclosure requirements in the Medicaid/CHIP parity regulations that are specific to parity compliance should be no less stringent than the disclosure requirements that apply to commercial plans under the final MHPAEA rule.

- **CMS should provide additional information on requirements related to transparency and methodology for compliance.**

Depending on how services are delivered, the proposed rule requires the state, MCO, PIHP, or PAHP to ensure that the full scope of services available to all enrollees of the MCO complies with the requirements of parity. It also requires the state to provide documentation of compliance with parity to the general public within 18 months of the final rule.

We ask CMS to provide more details on what information states have to report and make public. CMS should also include more details on its oversight role, including what CMS requires from states to satisfactorily demonstrate parity compliance. We also urge CMS to require states to report their progress well in advance of the effective date of the final rule to allow for proper oversight and to ensure full compliance with parity beginning the day the regulations take effect. States should be required to make all of their reports public and CMS should make reports from all states available on Medicaid.gov as they are submitted.

Thank you again for the opportunity to provide comments on the proposed rule extending the requirements of parity to Medicaid MCOs, ABPs, and CHIP. We appreciate the strong commitment CMS has made to improve access to MH/SUD services in Medicaid and CHIP. We look forward to working with CMS to implement this critically important regulation and to ensure that enrollees understand their parity rights. Please let us know if you have any questions or if we can be helpful in any way as CMS moves forward with implementation.

Sincerely,