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

Dear Administrator Slavitt:

The National Council for Behavioral Health (National Council) welcomes the opportunity to provide comments on CMS' notice of proposed rulemaking applying the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid managed care, alternative benefit plans, and CHIP plans. The National Council is a non-profit association representing 2,350 community-based mental health and addiction treatment providers. Along with our member organizations, we are dedicated to fostering clinical and operational innovation and promoting policies that ensure that all Americans have access to high quality health care services.

Together, the passage of MHPAEA and the Affordable Care Act (ACA) offer unprecedented opportunities for the expansion of quality mental health and addiction treatment coverage to millions of Americans. Over the years since these laws' passage, the National Council has supported strong regulations that will ensure parity protections for all in need of care. While compliance and enforcement needs are ongoing, the current proposed regulation represents an essential next step in the regulatory process to fully implement the parity law, and we strongly urge CMS to make finalization of this rule a high priority.

We thank CMS for crafting a proposed rule that ensures parity protections for millions of Americans enrolled in managed care and alternative benefit plans, and offer our recommendations for preserving these positive elements and strengthening the final rule below.

The National Council commends CMS for proposing to apply parity to all beneficiaries enrolled in a Medicaid managed care plan. We appreciate the clarification that parity applies to all Medicaid managed care enrollees, regardless of how mental health and addiction services are delivered. States have a great degree of flexibility in delivering mental health and addiction services through an MCO or other delivery arrangements, and reducing parity protections to only one type of arrangement would have severely limited parity's impact. We thank CMS for recognizing that failure to apply parity to carve-

out arrangements would eliminate parity protections for beneficiaries in several states, significantly reducing parity's overall impact for the Medicaid program.

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 it passed the parity law in 2008, while appropriately accommodating the diversity of state approaches to delivering care.

Recommendation:

- 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 mental health and addiction services are delivered in their state.

We agree with CMS that an increased cost exemption for parity is not needed, and we 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 established a limited exemption for health plans that incur an increased cost of at least two percent in the first year, or 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 mental health and addiction 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.

Recommendation:

- We urge CMS to retain the proposed rule's language specifying that there will not be an exemption for increased costs due to parity and that any increased costs can be built into the state's rate setting structure.

The National Council thanks CMS for using the proposed rule to encourage states to improve coverage of mental health and addiction treatment throughout their Medicaid programs, and for 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' language encouraging 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 mental health and addiction needs of Medicaid beneficiaries, and we very much appreciate the ongoing work at CMS to encourage states to improve their Medicaid coverage for mental health and addiction.

Recommendation:

- We strongly urge CMS to retain language in the final rule that encourages states to apply parity benefits equally for all Medicaid enrollees, regardless of whether they are enrolled in managed care, alternative benefit plans, or traditional fee-for-service.

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 mental health and addiction benefits in any classification unless any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and addiction 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 mental health and addiction coverage are needed. 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.

Recommendation:

- 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 mental health and substance use disorder benefits.

We ask CMS to provide additional information justifying the exclusion of long term care services from parity requirements. 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 mental health and addiction 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 mental health and addiction 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 mental health and addiction services being excluded from parity protections in violation of what congress intended.

Recommendation:

- We request that CMS include in the final rule a detailed discussion justifying the exclusion of long term care from parity requirements, a firm and concrete definition of what constitutes long term care, and an assurance that excluding those services will in no way limit the application of parity to the full range of mental health and addiction services across the prevention, treatment, recovery, and rehabilitative continuum.

Similarly, we ask CMS to provide more detail on how parity applies to intermediate mental health and addiction 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 don't 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 mental health and addiction services. We believe that strong clarification is needed in the finalized version of this rule, stating that intermediate services must meet parity requirements. 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 mental health and addiction services may be incorrectly excluded from parity protections if they are considered long term care services by MCOs or states. The number of classifications does not necessarily need to be expanded to include intermediate services, but more clarity and/or scope protections for intermediate services are needed to ensure that they are appropriately covered by states and MCOs.

Recommendation:

- We strongly urge CMS to include additional details in the final rule pertaining to how intermediate services should be addressed to meet parity requirements. CMS should clearly define covered intermediate services as separate and distinct from non-covered long-term care services, clarify that intermediate services must meet parity requirements, and offer further

details on or examples of how these intermediate services should be classified into the existing four-classification structure in order to perform a parity analysis.

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 mental health and addiction services are subjected to a more restrictive standard than covered medical/surgical services.

Recommendations:

- We 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 drug requirements, and make clear that the full range of mental health and addiction medications must be covered under parity. Medicaid programs often impose discriminatory limits on medications for mental health and particularly substance use disorders. Such restrictions often include lifetime limits on methadone and/or buprenorphine, prescription refill limits that do not reflect the chronicity of the condition, and more stringent prior authorization requirements than those imposed on medications for medical/surgical needs.[1]

We appreciate the attention that CMS has paid recently to improving access to medication assisted treatment for addictions, including last year's informational bulletin from CMS, CDC, SAMHSA, NIDA, and NIAAA that provided guidance to states to improve coverage for substance use disorder medications under Medicaid.[2] 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 mental health and substance use disorders. 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 FDA-approved medications for mental health and addiction be covered, especially considering how few medications are available to treat SUD.

[1] "Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment," American Society for Addiction Medicine, 2013.
[2] http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf

Recommendations:

- We ask for requirements in the final rule that ensure adequate access to all available medications for mental health and addiction, 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.

Recommendations:

- In arrangements for dually-eligible individuals 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 dually-eligible individuals 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 plans subject to the parity requirements to "make their medical necessity criteria for mental health and substance use benefits available to any enrollee, potential enrollee, or contracting provider upon request." 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. The proposed rule also states that other regulations governing disclosure will apply.

We appreciate these protections, but point out that only making information about mental health and addiction services, criteria, and denials available without also providing the corresponding medical/surgical information is insufficient to determine parity compliance. 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.

Recommendation:

- We urge CMS in the final rule to explain in more detail what this proposed 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.

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.

Recommendations:

- 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 mental health and addiction services in Medicaid and CHIP and look forward to working with CMS to implement this critically important regulation. 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,

Linda Rosenberg, MSW
President and CEO
National Council for Behavioral Health