Disability Rights Education & Defense Fund DREDF

June 9, 2015 **Via submission to www.regulations.gov**

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Proposed Rule concerning Medicaid, Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, RIN 0938-AS24

Dear Mr. Slavitt:

Thank you for the opportunity to comment on the above proposed rule concerning Medicaid, CHIP and the MHPAEA. The Disability Rights Education and Defense Fund (DREDF) is a leading national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. Access to mental health and substance use disorders services at parity is vital to people with various disabilities across a wide spectrum of ages, and is particularly important at the lower income levels served by the Medicaid and CHIP programs. We strongly support the proposed rule's foundational premise that mental parity for Medicaid MCO enrollees applies across mental health service delivery systems, without regard for limitations in state Medicaid plans.

Contract Requirements (§ 438.6):

We support CMS's proposal to ensure that Medicaid beneficiaries enrolled in MCOs receive MH/SUD coverage at parity with medical and surgical coverage, including services delivered through MCOs, fee-for-service (FFS) arrangements, prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs). Congress's clear intent in applying the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid MCOs was to ensure that enrollees of MCOs receive covered mental health services at parity with medical/surgical services. If states and MCOs could circumnavigate parity requirements by entering contractual and sub-contractual relations and parsing out MH/SUD delivery methods, the goals of the MHPAEA would be far too readily thwarted. We also agree that where states choose to provide MH/SUD services through non-MCO service delivery systems, the state must document how the parity rule requirements are met for MCO enrollees. We recommend CMS' provision of some additional guidance specifying the kinds of analyses, coverage provisions or plan documents that must be provided to establish compliance with parity requirements, both at the time of the effective date of the rule and over time as entities

enters or leaves MCO Medicaid delivery in the state, or there are significant changes to the benefits structure.

On the matter of whether CMS should require that all state plan MH/SUD services be included in MCO contracts, DREDF has concluded that such a directive could have too many unintended consequences. In California, when mandatory Medi-Cal was introduced in 2011-12 to the population of Seniors and People with Disabilities in some of our most populous states, the state and numerous stakeholders decided that it would be best to maintain the network of county-based MH/SUD providers that were already in place for Medi-Cal beneficiaries. We think that states should not be required to dismantle experienced provider networks, particularly those that have strong community-based organizational ties and have demonstrated a commitment to, and understanding of, community-based MH/SUD service delivery. Throughout the country, some Medicaid MCOs have faced challenges both reaching chronic consumers of MH/SUD services, and designing and delivering the types of intensive mental health services that are not generally covered under private insurance. FFS carveouts and other arrangements for delivering mental health services have often proved critical to ensure that Medicaid beneficiaries receive appropriate mental health services, at least until MCOs can implement better and best service delivery practices. We therefore agree that states should be provided sufficient flexibility to maintain FFS, PIHPs, and PAHPs contracts to deliver MH/SUD, as long as they bear the responsibility for ensuring parity across all the delivery systems involved.

We support the addition of § 438.6(e) to clarify that where Medicaid MCOs, PIHPs, or PAHPs cover services beyond those covered under the state plan when necessary to comply with parity, states must include those services in determining actuarially sound capitation rates. We urge CMS, however, to change proposed § 438.6(e)(3) to say that the costs associated with these services "must" (rather than "may") be included when determining payment rates so that states are obligated to provide actuarially sound payment rates. Thus, in circumstances where a state has chosen *not* to amends its state plan to cover MH/SUD at parity, it should appropriately be mandated to take into account the costs of any additional services that MCOs, PIHPs or PAHPs must provide to comply with parity.

Exclusion of Long Term Care Services from Meaning of Terms (§ 438.900, § 440.395, § 457.496)

DREDF finds the proposed exclusion of long-term care services from the definitions of both medical/surgical benefits and mental health benefits to be highly problematic. The disability community has long fought an uphill battle to establish the legitimacy and importance of long-term care services as distinct from acute care services directed at "cure." Clearly, people with disabilities and chronic conditions need and benefit from acute and preventive care just as their non-disabled peers, but it is long-term care services that enable them to maintain function and stability so they can live as fully and independently as possible. Mental health services, such as peer support, assertive community treatment, community support teams, and supported employment, are often a critical component of long-term care services. Individuals with traumatic brain injury

or intellectual disabilities may need medication management and independent living skill supports on a long-term basis, and people with developmental disabilities are at a uniquely increased risk for inadequate emotional support and may benefit from ongoing depression screenings. As well, individuals who have been unnecessarily institutionalized for years or decades before achieving a release under *Olmstead*[1] litigation or policy may require significant long-term mental health services and coping adjustments to support a productive and sustainable return to their communities. There is no principled reason for these long-term services to be excluded from the kinds of mental health services that will counted as mental health benefits for the purposes of coverage parity.

Moreover, DREDF advocates strongly that long-term care services other than mental health benefits should be included in the definition of medical/surgical benefits. The sweeping trend in federal and state public health programs over the past several years has been toward the integration of medical and long-term care services. Sought-after benefits include not only the potential for increased care coordination and better care ("the right care, at the right time, in the right place), but the cost savings anticipated when emergency visits, hospitalizations and other institutional care are reduced because beneficiaries receive *appropriate preventive care and long-term care services*. Over time, this anticipated trend should result in more relatively low-cost long-term care interventions, and fewer high-cost acute care interventions. If all long-term care services are baldly excluded from the calculation of benefits that are subject to mental health parity, MCOs can financially benefit from the anticipated cost savings of shifting away from acute care and from rebalancing, while simultaneously bearing no obligation to ensure that there is mental health parity *within* long-term care benefits. The core concept of mental health parity, that mental health services which are as critical to a consumer's health and well-being as medical services should be offered under equal conditions of coverage, surely applies to the long-term maintenance of health and well-being, even if the details of how parity is established may require some additional working out due to how long term care is delivered and paid for.

We acknowledge that states and MCOs, most of which have fairly recently entered the field of Long-term Services and Supports (LTSS), may not be accustomed to categorizing LTSS as either a "mental health" or "medical/surgical" benefit. The lack of familiarization is something that can be overcome with guidance and direction from CMS and stakeholder input. As an analogy, we would like to point to the Essential Health Benefit (EHB) category of "habilitation devices and services." This is an insurance category that is critical to many people with disabilities from seniors with chronic conditions who are battling deterioration in functional abilities to young children with developmental disabilities who are working acquiring skills for the first time. The vocabulary of "habilitation" was not familiar to commercial insurers or to Medicaid but CMS nonetheless recognized the need for inclusive coverage, and proposed mechanisms that would enable states to define and regulate the coverage of habilitation services and devices. DREDF believes that with sufficient CMS guidance and robust stakeholder input, state Medicaid agencies can determine the long-term care components that need to be included as mental health benefits.

[1] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

DREDF recommends that CMS provide a "floor" of guidance to states on the kind of "mental health conditions" that are to be included within each state's definition of the term. A non-exhaustive list would provide greater clarity and uniformity among states, which is important to the development of any data and outcome data across states, than the direction to look for generally recognized independent standards of medical practice.

Finally, we urge CMS to add a provision to the definition of "treatment limitations" which clarifies that states are already subject to existing prohibitions on diagnosis or condition-specific exclusions of treatment, such as EPSDT and Medicaid's prohibition on diagnosis-specific coverage. That is, the proposed rules restriction on the permanent exclusion of all benefits for a particular condition or disorder as a "treatment limitation" is not meant as a modification or limitation of those earlier existing prohibitions.

Parity Requirements for Aggregate Lifetime and Dollar Limits and for Financial Requirements and Treatment Limitations (§§ 438.905, 438.910, 440.395, 457.496):

We support the clarification, in § 438.910(c)(4), that MCOs, PIHPs, and PAHPs must meet the cost sharing requirements applicable to Medicaid managed care plans generally. This clarification will help avoid a possible misreading of the law that the cost-related requirements in this proposed rule supersede pre-existing requirements.

While the proposed rule does not incorporate the provisions of the MHPAEA rule requiring parity within in-network and out-of-network services, it does provide that MCOs, PIHPs, and PAHPs providing access to out-of-network providers for medical/surgical benefits must use the "the same processes, strategies, evidentiary standards, or other factors" for providing access to out-of-network MH/SUD providers (§ 438.910(d)(3)). DREDF supports the breadth of this language but urges CMS to specify what the language means. The proposed rule states that a plan complying with the network adequacy requirements of § 438.206(b)(4) will be deemed in compliance with § 438.910(d)(3), but if § 438.910(d)(3) requires nothing more than compliance with existing law we are unsure why it is necessary. In the commercial insurance world, regulations can address the times when a carrier meets network adequacy standards in general, but must, in certain circumstances, provide access to out-of-network providers. For example, this can occur when a specific provider leaves a particular network or possibly when a member's plan participation expires prematurely, or even when there is financial insolvency within a plan. In a variety of such circumstances, there are processes to protect the member's continuity of care when active treatment should not be interrupted. We advocate for the proposed § 438.910(d)(3) to indicate that processes, protections and other factors that would typically allow a beneficiary to gain access to an "out-of-network" provider for medical/surgical care also be applied to MH/SUD care.

Tiered Network Design and Nonquantitative Treatment Limitations (§§ 438.910(d), 440.395(b)(4), 457.496(d)(4)):

In concert with our colleagues at Bazelon, we adopt the recommendations of the National Health Law Program (NHeLP) concerning CMS's proposal to allow plans to use tiered network designs with respect to Nonquantitative Treatment Limitations (NQTLs). As NHeLP points out, based on experience with tiered network designs in commercial plans, multiple tiers are likely to confuse beneficiaries and undermine parity by leading them to choose plans that have treatment limitations or financial restrictions of which they are unaware, or leading them to incur unexpected financial liability for mental health services. Because the distinction between different tiers is often unclear to many consumers, tiered designs create risks such as beneficiaries choosing a plan based on the fact that their current providers are covered but then discovering that they are responsible for payment for services because their chosen plan requires prior authorization for providers in a particular tier and their visits were not properly authorized. In addition, as NHeLP notes, consumers and regulators may have more difficulty monitoring tiered network plans' compliance with existing protections.

These concerns are particularly significant for public benefits recipients, who lack the resources to pay for the consequences of the confusion caused by tiered network designs. Because tiered designs are so complex and have significant potential to undermine the goals of mental health parity, we strongly urge CMS to forbid Medicaid and CHIP plans from using tiered network designs with respect to NQTLs. Even in the commercial world, there have been vigorous ongoing discussions in such forums as the National Association of Insurance Commissioners (NAIC)'s subgroup on a Model Network Adequacy Act, on how to control tiered network design so as to balance consumer vulnerability with a private plan's ability and desire to compete in a free market. DREDF observes that Medicaid coverage is, or should not be, a "free market" where MCO should be entirely free to strategize for the greatest profit, and certainly managed care Medicaid is not a free market from the beneficiary's standpoint. The justification for allowing tiered network design, with its potential to favor providers that "cherry pick" consumers with the least costly needs, is generally absent in Medicaid and tiered design should therefore not be needed. Efficiency in network design and benefit delivery does not necessarily require or justify the creation of multiple network tiers.

We adopt NHeLP's recommended change as follows:

- remove the example at § 438.910 (d)(2)(iii) that allows plans to use multiple network tiers with respect to NQTLs as follows:

2) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include--

~~(iii) For MCOs, PIHPs, or PAHPs with multiple network tiers (such as preferred providers and participating providers, network design;~~

Availability of Information (§§ 438.915, 440.395(c), 457.496(e)):

DREDF supports the proposed requirement that medical necessity criteria must be made available to current and potential enrollees and providers. However, CMS should

require plans to make medical necessity criteria publicly available online, in sufficient detail to enable potential enrollees or anyone assisting them to choose between MCOs wherever there is a choice. Medical necessity criteria should provide examples of how it would apply to categories such as surgery, DME, individual therapy sessions, and intense in-patient or partial hospitalization for MH/SUD services. Medical necessity criteria for services furnished with public dollars be transparent should be readily and publicly available. In addition, it is unfair and unrealistic to expect Medicaid and CHIP beneficiaries to navigate the process of requesting medical necessity criteria from their plans; this information should be furnished to all current and potential enrollees. If it would be unwieldy to provide this information to all such individuals, at a minimum current enrollees should be furnished with the medical necessity criteria for any service for which they apply.

Plans also need to be clearly and explicitly informed of their obligation to ensure effective communication and provide medical necessity criteria in alternative formats such as Braille, electronic CD and large font to people with disabilities, and in other languages to ensure access for individuals with limited English proficiency.

Compliance Dates (§§ 438.915(b), 438.930, 440.935(d)(4)(i), 457.496(g)(i)):

In concert with Bazelon, we urge CMS to shorten the timeframe for states to comply with applicable n requirements in this rule. The proposed rule provides 18 months for states to come into compliance with these requirements. Given how long ago the statutory requirements that this rule implements were enacted, an additional 18 months from the effective date of the final rule seems an inordinately long period of time for states to comply. We hope that CMS will shorten this timeframe—at least for states with budget cycles that do not require such a lengthy period to achieve compliance—and expedite its consideration of any state plan amendments that states may seek in order to comply with this rule.

CHIP Plans Covering EPSDT Benefits Deemed Compliant with Parity (§ 457.496):

As recommended by Bazelon, we recommend that CMS clarify that coverage of EPSDT means that the CHIP plan furnishes beneficiaries with *all* medically necessary services required by EPSDT, including intensive in-home services, intensive care coordination, and the other services referenced in the May 7, 2013 joint CMS-SAMHSA Informational Bulletin on Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions, http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf. A state's *belief* that its CHIP plan "provides coverage of EPSDT benefits" is not sufficient to constitute compliance with EPSDT, CHIP, or parity requirements.

Interaction with the ADA's Integration Mandate and *Olmstead*:

Parity requirements applicable to plans that are part of state service systems—such as Medicaid MCOs, ABPs, and CHIP plans—must be interpreted together with the requirements of the ADA's integration mandate and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) that public entities administer services to people

with disabilities in the most integrated setting appropriate. We urge CMS to clarify that in the context of Medicaid MCOs, ABPs, and CHIP plans, parity in conjunction with *Olmstead* requires *both* medical/surgical and MH/SUD standards for institutional treatment to be interpreted in ways that maximize the ADA's integration mandate and minimize unnecessary institutional placements.

No Exemption for Increased Costs:

We support CMS's omission of a part of the MHPAEA final regulation that exempted MCOs, PIHPs, and PAHPs, ABPs, and CHIP plans that incur cost increases of at least two percent during the first year (or one percent in subsequent years) from compliance with parity requirements. 80 Fed. Reg. 19422, 19432. We agree with the reasoning that the obligation for states to provide actuarially sound payment rates that account for the increased costs of covering any additional services beyond the state plan will hold MCOs, PIHPs, and PAHPs whole for any increased costs of compliance with parity. We are also find it compelling that few if any plans in the commercial market have applied for a cost exemption, and that ABPs must comply with MHPAEA rules.

The Application of Parity Requirements to Individuals who are Medically Frail and Exempt from ABPs

States are required to screen out individuals who are medically frail, including individuals with serious mental illness, dual diagnoses, and chronic substance use disorders, from ABPs, but this should not mean that they will lose parity protections. CMS has indicated that medically frail individuals should not just receive state plan services instead of an ABP, but should be in their own separate ABPs. 2 C.F.R. § 440.315. As such, they should continue to receive the parity protections that apply to ABP recipients.

Thank you for the opportunity to comment on this important proposed rule. As an organization, we hope one day to also see mental health parity for those lowest income traditional Medicaid beneficiaries who receive state plan services, but acknowledge that as a discussion for another day and another rule.

Sincerely,

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