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:

The Consortium for Citizens with Disabilities (CCD) Health Task Force appreciates the opportunity to provide comments on the proposed rule applying the requirement of mental health parity to Medicaid managed care organizations, alternative benefit plans and Children's Health Insurance plans. CCD supports the proposed rule's application of parity to all beneficiaries enrolled in Medicaid managed care plans and appreciates the clarification that parity applies regardless of how mental health and substance use disorders (MH/SUD) services are delivered.

CCD agrees with CMS that an increased cost exemption for parity is not needed and support the proposal to build any increased costs associated with parity into the state's rate setting structure. CCD also agrees that the cost of bringing Medicaid and CHIP coverage into compliance with parity will be minimal. We also 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.

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

CMS should provide more information on nonquantitative treatment limitations (NQTLs), including more examples, in the final rule and/or follow-up materials. The proposed rule provides 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;
- 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.

CCD has concerns about the use of multiple network tier design, as it is very confusing to consumers and could undermine the goals of parity. We urge CMS to clarify in the final regulation that Medicaid and CHIP plans may not use tiered network designs for any purpose.

CCD urges CMS to 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. Most significantly, 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 urge CMS not to exclude long-term care from the definition of "mental health benefits" and "substance use disorder benefits." We are concerned that this exclusion may lead covered entities to characterize important services as long-term care, particularly since there is little guidance about which, if any, mental health and substance use disorder services might be considered long-term care. If the exclusion is retained, we urge CMS to identify which mental health and substance use disorder services count as long-term care services. We also 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.

CMS proposes having states define what constitutes a "mental health condition" and a "substance use disorder." CCD asks CMS to provide a non-exhaustive list of such conditions that must be covered. We also ask CMS to provide a non-exhaustive list of services that must be covered as "mental health benefits" and "substance use disorder benefits."

Similarly CCD seeks clarification on 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.

CCD supports the requirement to make medical necessity criteria available to current and potential enrollees and providers. It is crucial that enrollees and providers have access to the standards by which a plan will determine whether services will be covered. We believe, however, that these standards should be publicly available to any interested party. Medicaid and CHIP services are funded by taxpayer dollars, accordingly, it is appropriate that plans providing Medicaid and CHIP services should be as transparent as possible in all respects, but particularly in how they decide to cover services. Moreover, all plans and state Medicaid agencies maintain websites. It provides greater transparency, and requires less labor and expense, simply to post this information on the website. In addition, plans should be required provide the information in formats that are accessible to people with Limited English Proficiency and disabilities. Such a requirement would be more consistent with the new proposed rule governing Medicaid managed care, which mandates that all required information about Medicaid managed care be provided in a readily accessible manner and format and be posted to a state website.

In addition, CMS should provide medical necessity criteria to *all* current and potential enrollees, rather than only to those who request it. 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.

Proposed § 457.496(b) provides that state CHIP plans are deemed to satisfy parity requirements if they provide coverage of EPSDT benefits. CMS should clarify, however, 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. 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. CCD urges CMS to clarify that in the context of Medicaid MCOs, ABPs, and CHIP plans, parity requirements may not be used to circumvent compliance with the ADA and *Olmstead*. For example, parity requirements cannot be used **as a pretext** to avoid **engaging in the case by case analysis required for compliance** imposing medical necessity criteria or other restrictions on institutional admissions necessary to avoid needless institutionalization and comply with the integration mandate and *Olmstead*

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 and look forward to working with CMS to implement this critically important regulation. Please contact Julie Ward (ward@thearc.org) if you have any questions or if we can be helpful in any way as CMS moves forward with implementation.

Sincerely,

CCD Health Task Force Co-chairs:

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