Federation of American Hospitals®

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June 9, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–9964–P
P.O. Box 8010
Baltimore, MD 21244–8010

Re: Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA); 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; Proposed Rule (CMS 2333-P)

Dear Mr. Slavitt:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals.

We appreciate the opportunity to comment on the Proposed Rule applying mental health parity requirements to coverage offered by Medicaid Managed Care Organizations (MCOs), the Children's Health Insurance Program (CHIP), and Medicaid Alternative Benefit Plans. The FAH is a strong supporter of federal parity legislation and of its application to managed care and alternative benefit plan enrollees in Medicaid and to children in the CHIP program. Medicaid and CHIP programs play a critical role in ensuring that vulnerable populations have meaningful access to care. The Proposed Rule recognizes the importance of mental health services for those populations and begin to bridge the gap between coverage of, and access to, those services when compared to physical health services.

In addition to this rule, the FAH further appreciates the Centers for Medicare & Medicaid Services (CMS) recognition of the critical access concerns for people needing inpatient psychiatric hospital services in the recently released proposed rule regarding Medicaid managed care published in the Federal Register on June 1. In that rule, CMS proposes allowing Medicaid managed care plans to cover the cost of health care services for individuals with short stays in Institutions for Mental Diseases. The FAH will be providing separate comments on that as well as other issues raised in the Medicaid managed care rule.

I. Permitting Behavioral Health Carve-outs

Under Medicaid, some managed care plans offer both physical and mental health and substance use disorder (MH/SUD) benefits. Other plans offer only physical health benefits or offer physical health benefits and a limited set of MH/SUD services. The remainder of the MH/SUD services are then offered through separate MCOs or in alternate delivery systems altogether. Those services are, in effect, "carved out" from the delivery of physical health services. In the preamble to the proposed mental health parity rule, comments are sought regarding whether CMS should continue to allow MH/SUD services to be "carved out" from plans offering physical health care services.

The FAH recognizes that under existing regulations, states use a wide variety of approaches to providing managed MH/SUD services and we encourage CMS to continue to allow states the flexibility in the types of managed care arrangements. When carve-outs do exist, clinical and financial incentives should be aligned to help ensure that patient data can be shared among caregivers, care can be coordinated, and all those involved in the patient's care have appropriate financial incentives in place.

II. Recommendation regarding the Timeline for Implementing Parity

FAH is concerned about the overly long timeline proposed for plans to implement parity requirements. State Medicaid programs and Medicaid managed care plans have had ample warning about the need for parity since 2008 with the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which initially established the requirements for Medicaid MCOs to meet parity requirements. CMS further provided preliminary guidance to state Medicaid directors in 2009 regarding the implementation of parity provisions.[1] Plans that have commercial products are already conducting the analyses required to compare physical with mental health benefits and using that information to comply with the federal requirements. We believe that the parity protections should be extended to Medicaid beneficiaries as soon as possible. We recommend that the timeline for implementing the parity requirement should begin for plan years that start on or after the date that is six months after publication of the final rule.

[1] Letter from Cindy Mann to State Health Officials dated November 4, 2009, http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO110409.pdf .

III. Comparing Benefits across Managed Care Plans or Delivery Systems.

When MH/SUD services are carved out from a beneficiary's primary plan and offered through separate plans or separate delivery systems, states are responsible for conducting a comparison between the physical health and MH/SUD benefits and ensuring that the MH/SUD benefits meet the requirements for parity. We anticipate states will request assistance from plans and providers to conduct those analyses. In the interest of increasing the efficiency with which those comparisons can be conducted, as well as reducing confusion and redundancy, we request that CMS provide additional assistance to states to help navigate those waters. CMS could use further guidance to provide templates or other types of assistance to achieve consistency across states and plans in conducting the parity analysis. Such consistency could also improve the ability of plans to meet a shorter timeline for implementing parity as we are recommending above.

IV. Clarification Needed for Non-quantitative Treatment Limitations

The Proposed Rule includes an illustrative list of the kinds of non-quantitative treatment limitations that are required to be applied to MH/SUD benefits in a way that is no more restrictive than the same (or same type of) treatment limitation as is applied to physical health services. Some of the non-quantitative standards included in that list are medical management standards, formulary designs, multiple network tiers and tier designs, standards for provider participation, methods for determining usual customary or reasonable charges, fail first policies and other exclusions or restrictions based on geography, completing a course of treatment, facility type, provider specialty, etc. In the preamble CMS points out that the list is not meant to be exhaustive. FAH urges CMS to be as comprehensive as possible in final rules in identifying those types of policies that are to be considered non-quantitative limitations, and increasing specificity about those policies and how their application can violate parity, as this has been an area of confusion in the application of parity rules in commercial health insurance. Our hope is that such specificity will reduce the likelihood that non-quantitative limits will impede beneficiaries' access to health care.

V. Clarification Needed on Excluded Long-term Care Services

The proposed rule would exclude "long-term care services" from the parity requirements. CMS states in the proposed rule that the reason long-term care services are being excluded is because "long term services included in benefit packages for Medicaid and CHIP beneficiaries are not commonly provide in the commercial market as part of health benefits coverage."

The FAH urges CMS to provide more clarity about those long-term services that are excluded from the parity requirements. The definition should be narrow – identifying only those types of long-term care services, such as custodial or domiciliary care that are not commonly provided in private health insurance markets, while ensuring that the unique kinds of services that Medicaid provides, such as home care and home and community based services that are essential for Medicaid beneficiaries suffering from chronic and long term physical as well as mental health conditions are included. Importantly, this becomes more relevant as Medicaid

managed care plans extend their reach by enrolling more individuals not traditionally included in Medicaid managed care and providing more long term services and supports.

Therefore, we want to make sure that the unique characteristics of the Medicaid program and its beneficiaries are taken into account when putting in place the parity protections as required under MHPAEA. We would urge CMS to clearly define what they mean by long term services and how that definition applies or does not apply to benefits and services that are provided in the commercial health insurance market.

VI. Clarifying Intermediate services

In the preamble to the final MHPAEA rule applying the law to commercial coverage, the Departments of Health and Human Services, Labor and Treasury clarify that the intent is to apply the parity rule to intermediate services (such as residential treatment, partial hospitalization, and intensive outpatient treatment).[2] That final rule, however, did not provide a comprehensive definition of such services, nor direction about how such services should be classified for the comparison with physical health services. The Departments further pointed out that many commenters requested that the Departments clarify how MHPAEA affects the scope of coverage for intermediate services and how these services fit within the six classifications set forth by the interim final regulations.

This proposed rule takes a similar approach in applying parity to Medicaid and CHIP, but unlike the final MHPAEA rule it does not state clearly, either in the regulatory text or in the preamble, that intermediate services offered in Medicaid and CHIP are subject to the parity requirements. Also, as in the commercial market rules, it does not provide a definition as to what those services are or how they should be classified for the purpose of comparing with physical health services.

We urge CMS to clarify that intermediate services must be covered if similar types of services are covered on the medical/surgical part of the health insurance benefit. This level of care is an essential part of the continuum of care for mental health services and therefore, it is critical that CMS make sure the final rule states as clearly as possible that intermediate services are part of the parity structure.

VII. Need for Disclosure and Transparency

The FAH supports efforts to promote transparency as we recognize that effective transparency is critical for consumers, hospitals, physicians and all stakeholders to make smart health care choices and to obtain the health care they need. We encourage CMS to consider the work that has already been done in this area, and to apply those recommendations to the final Medicaid parity rule. In particular, CMS should take into account the ongoing efforts that are underway between the industry and the Departments of Labor and Health and Human Services to enhance and strengthen the disclosure and transparency requirements in application of the parity law as it applies to commercial health insurance. We appreciate CMS' efforts in creating the

[2] Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, November 13, 2013 (78 FR 68240).

specificity that states and health plans would have to follow in disclosing how they are complying with the parity protections as outlined in the final rule.

The FAH appreciates the opportunity to provide our views on these important issues affecting the parity of mental health services for Medicaid and CHIP beneficiaries. We look forward to continuing our work on the crucial matters. If you have any questions, please contact me or Steve Speil of my staff at (202) 624-1529.

Sincerely,

