



June 9, 2015

VIA ELECTRONIC SUBMISSION

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

Attention: CMS-2333-P

Medicaid, Children's Health Insurance Programs; Parity and Addiction Equity Act (MHPAEA) 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; Proposed Rule 80 Fed. Reg. 19417 (April 10, 2015)

Dear Administrator Slavitt:

Georgetown University Center for Children and Families is a nonpartisan research and policy center with a mission to improve access to affordable, comprehensive health coverage for children and their families. We are pleased to offer comments on the proposed rule to apply mental health parity to Medicaid and CHIP.

Among children served by Medicaid the Government Accountability Office (GAO) finds that 14 percent of children had a potential need for mental health services, yet nearly two-third of them did not receive treatment.¹ And less than 10 percent of adolescents with substance abuse disorders enter treatment.² Countless more children face mental and behavioral challenges that go undetected or do not meet diagnostic criteria; their needs are left unmet in the existing system. Full implementation of the proposed rule has the potential to substantially improve access to mental health (MH) and substance use disorder (SUD) services in Medicaid and CHIP.

We commend CMS for the specificity and comprehensiveness of the proposed mental health parity rule and are generally supportive of the approach. We agree with the decision to require that all Medicaid managed care organizations (MCOs) must provide enrollees a set of benefits that meet the requirements of mental health parity, regardless of whether MH/SUD services are provided by the MCO or through another service delivery system. Without this requirement, many Medicaid enrollees could arbitrarily be denied the protections of this rule solely because of the state's delivery system. This would be contrary to the spirit of the laws regarding mental health parity and addiction equity. We also urge CMS in applying this rule to

closely consider the impacts of its application on integration of mental health, substance use disorders and primary care services; successful coordination and work across systems can make an important difference in timely access to needed care.

Overall, the comments below reflect our belief that mental health and substance use disorders parity should broadly apply to all populations served by Medicaid and CHIP, particularly children, regardless of service delivery arrangements or defined benefits. The rule asserts that children and adolescents receiving MH/SUD treatment services through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit are deemed to have met the parity standard. While EPSDT by definition should meet this standard, its application, as evidenced by the number of class action lawsuits pertaining directly to the lack of adequate behavioral health services for children and adolescents in Medicaid, shows the risk in presuming compliance.³

The rule also specifies that its scope is limited to populations in MCOs or Medicaid alternative benefits packages, clarifying that beneficiaries in many fee-for-service (FFS) arrangements would not be covered by this rule. While many children rely on Medicaid MCOs, a substantial share (22 percent) receive services through FFS arrangements.⁴ In effect, the rule excludes parity protections for especially vulnerable populations in FFS arrangements: children and adolescents receiving Supplemental Security Assistance (SSI) and foster care assistance. According to the 2013 SSI Annual Statistical Report, two-thirds of the 1.3 million children and adolescents receiving SSI have mental health disorders.⁵ An estimated 60 percent of youth in foster care have a mental health condition.⁶

While we understand that the statute may present limitations on CMS's ability to apply parity requirement to all children in Medicaid and CHIP, we believe that the practical effect of the EPSDT presumption and FFS exclusion may run counter to the spirit of the Mental Health Parity and Addiction Equity Act of 2008 and CHIP Reauthorization in 2009. *Therefore, we recommend that CMS require states to document that children and adolescents enrolled in FFS, MCOs, or carve-outs in Medicaid or CHIP—including those with EPSDT benefits under either program—can access appropriate and timely access to the types of mental health services and substance abuse providers they need. CMS should also clarify that a state CHIP program providing EPSDT benefits 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 medically necessary services. A state's assertion that its CHIP plan "provides coverage of EPSDT benefits" is not sufficient to constitute compliance with EPSDT, CHIP, or parity requirements.*

Additional, specific comments on the proposed rule:

We note that the proposed rule provides that a permanent exclusion of all benefits for a particular condition or disorder is not a treatment limitation for Medicaid, CHIP, and alternative benefit plans (ABPs). We understand that this provision is carried over from the regulations governing group health insurance plans. However, this provision is problematic when applied to

Medicaid because it could lead states to violate Medicaid's EPSDT requirements or the Medicaid regulation prohibiting discrimination based on diagnosis. We are concerned that states may believe that this regulation trumps the broader provisions applicable to state plan services. Therefore, we recommended revising to clarify that the provision does not affect a state's obligation to comply with 42 U.S.C § 1396d(r)5 or 42 C.F.R.§ 440.230.

Further, we are concerned with the complete exclusion of long-term care services and supports (LTSS) from the parity requirements. LTSS represents a significant portion of Medicaid services and parity is equally important for these services and program participants, including many children and adolescents. Many Medicaid beneficiaries use LTSS for both mental health/substance use disorder services and medical/physical benefits that may be either community or facility based. As required for other Medicaid services, states should also be required to show that they have parity in their LTSS programs to ensure that individuals have similar access to both medical/surgical LTSS and to MH/SUD LTSS.

We commend CMS for providing detailed examples of non-quantitative treatment limits (NQTLs). We request that CMS offer additional direction to states about NQTLs as they relate specifically to children and adolescents with MH/SUD diagnoses, providing concrete examples.

Finally, we support the decision to explicitly require, at § 438.910(4), that MCOs must continue to comply with cost sharing restrictions applicable to Medicaid managed care plans generally. This eliminates any risk that plans would be under the mistaken impression that the cost-related requirements in this proposed rule would supersede pre-existing requirements.

We appreciate your efforts to develop a comprehensive proposal that ensures beneficiaries get the crucial mental health and substance use care they need. Please feel free to contact me (ewb27@georgetown.edu) with any questions.

Sincerely,



Elisabeth Burak
Senior Program Director

¹ United States Government Accountability Office, "Children's Mental Health Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care," (December 2012), available at <http://www.gao.gov/assets/660/650716.pdf>.

² United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration, "2012 National Survey on Drug Use and Health: Summary of National Findings," (September 2013), available at <http://archive.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.pdf>.

³ EPSDT lawsuits related to the lack of intensive behavioral health services have been filed in Massachusetts (Rosie D), California (Kate A and Emily Q), and Washington (T.R.)

⁴ S. Burwell, "2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP," United States Department of Health and Human Services (November 2014), available at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf>.

⁵*SSI Annual Statistical Report, 2013*. Washington, DC: Social Security Administration, September 2014.

⁶*Health Care of Youth Aging Out of Foster Care*. Elk Grove Village, IL: American Academy of Pediatrics, 2012.