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June 3, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Proposed Rule: RIN 0938-AS24 Medicaid and Children's Health Insurance Programs; Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program, and Alternative Benefit Plans; (Vol. 80, No. 69, April 10, 2015)

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the proposed rule from the Centers for Medicare & Medicaid Services (CMS) that would apply certain requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to coverage offered by Medicaid managed care organizations (MCOs), Medicaid alternative benefit plans (ABPs) and Children's Health Insurance Program (CHIP) plans.

The proposed rule is an important step in bringing Medicaid MCOs, ABPs and CHIP into compliance with MHPAEA, which requires commercial health plans that offer mental health or substance use disorder (MH/SUD) benefits to provide them at parity with their medical/surgical benefits, thereby removing barriers to care and limitations on coverage affecting many patients. The proposed rule seeks to align the MCO and CHIP markets with the commercial insurance market (including the state and federal Health Insurance Marketplaces). The AHA remains committed to improving access to mental health and substance use disorder benefits for individuals who suffer from these conditions. Ensuring parity standards apply across all types of Medicaid and CHIP health plan benefit designs will help safeguard access to and the affordability of MH/SUD care for our nation's most vulnerable.

The impact of the proposed rule for hospitals that provide MH/SUD services for Medicaid and CHIP enrollees will be highly dependent upon how their state has constructed its Medicaid and CHIP mental health policies. We believe CMS should address the following five issues so that they apply to all state programs:

- oversight of state and MCO compliance with parity assessment standards;
- parity assessments standards and benefit classifications;
- state MCO capitation rates;
- state responsibility and stakeholder consultation; and
- behavioral health "carve outs."

Our detailed comments follow.

COMPLIANCE OVERSIGHT

The AHA strongly recommends that CMS exert greater oversight to ensure that both state governments and the MCOs operating in the states comply with the MHPAEA parity standards. State Medicaid programs vary both in the type of MH/SUD services that are covered, and how those covered services are delivered through either fee-for-services (FFS) or managed care arrangements. States, through their Medicaid plans, can limit the type of MH/SUD services covered and impose treatment limitations, such as day or visit limits. States also can deliver MH/SUD services through an MCO or through other managed care arrangements. These other managed care arrangements, known as limited risk contracts or "carve outs" consist of prepaid health plans such as prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs).

In states where the MCO has sole responsibility for delivering MH/SUD services, the proposed rule would require that MCOs are responsible for the parity analysis and informing the state what changes need to be made to the MCO contract. In states where the MH/SUD services are provided through a combination of MCOs and other managed care arrangements, the state would have responsibility for undertaking the parity analysis to measure compliance across all service delivery arrangements (i.e., MCO, PIHP and PAHP). While the state is required to document that the MCO contract complies with parity requirements, the proposed rule does not require that the state provide CMS assurance that it is complying with parity requirements in all delivery settings. The state is only required to provide assurance that parity requirements have been met when submitting their ABP or CHIP state plan amendments to CMS for approval. CMS should require the state to ensure that all delivery settings for MH/SUD benefits are complying with the parity requirements.

The AHA supports CMS's proposal to require that state managed care contracts comply with parity standards regardless of whether MH/SUD services are provided in a full-risk MCO or other managed care arrangement, such as behavioral health "carve out" plans. States have considerable flexibility in designing the benefits and delivery arrangements for MH/SUD. These unique state mental health delivery arrangements are an important distinction between Medicaid and commercial insurance coverage. The proposed rule addresses these

variations in service delivery by requiring that each MCO enrollee be provided access to a set of benefits that meets the parity standards, regardless of whether the MH/SUD services are provided by the MCO or through managed care "carve out" arrangements (i.e., MCO, PIHP and PAHP).

The AHA supports the application of the parity requirements for MH/SUD benefits provided to Medicaid beneficiaries who only receive MH/SUD services in a FFS setting, even though the proposed rule does not require it. The proposed rule does not apply parity requirements to benefits provided in a FFS setting except for the ABP and CHIP populations because of statutory limitations. The MHPAEA and other related mental health parity laws do not require the application of mental health parity for traditional Medicaid FFS. The rule's preamble does, however, encourage states to apply such parity requirement to FFS. The AHA supports such state efforts to provide parity for MH/SUD benefits for all Medicaid beneficiaries.

PARITY ASSESSMENT STANDARDS

In general, MHPAEA parity assessments examine financial requirements, such as copays and deductibles; treatment limits, such as day or visit limits and aggregate lifetime and annual dollar limits that are applied to benefits. If a health plan provides coverage for MH/SUD benefits in any classification, coverage for MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. The MHPAEA further requires health plans to ensure that financial requirements (copays and deductibles) and treatment limitations (day or visit limits) that are applicable to MH/SUD benefits are no more restrictive than the "predominate" financial requirements and treatment limitations applied to "substantially all" medical and surgical benefits covered by the plans. The proposed rule applies these principles.

Classification of Benefits and Scope of Services. **The AHA encourages CMS to better assess the adequacy of MCO provider networks and state oversight of network issues. We are concerned that the lack of access to mental and behavioral health providers for Medicaid and CHIP beneficiaries could thwart CMS's overall goal to align Medicaid and CHIP markets with the commercial markets regarding parity assessments. Toward that end, CMS should carefully re-evaluate its proposal, which narrows the benefit classifications for inpatient and outpatient and does not include an examination of in- and out-of-network providers.**

As it stands, the rule proposes only four benefit classification categories for MCOs, PIHPs and PAHPs:

1. Inpatient
2. Outpatient
3. Emergency Care
4. Prescription Drugs

CMS's rationale, as noted in the preamble, for not including the in-network and out-of-network distinctions for the inpatient and outpatient classifications is based on the unique features of the

Medicaid and CHIP programs that limit beneficiary cost-sharing and managed care out-of-network requirements. Medicaid and CHIP beneficiary cost-sharing requirements vary by income and not whether the service is provided in or out of network, or through managed care or non-managed care delivery arrangements. Current Medicaid regulations also require that MCOs not able to provide necessary covered services in network must make arrangements for out-of-network services. CMS assumes that the beneficiary cost-sharing requirements and current managed care requirements for out-of-network providers are sufficient protections for Medicaid beneficiaries that they do not experience problems accessing providers. We have heard from our members, particularly in states that allow "carve-outs" of MH/SUD benefits, that accessing out-of-network providers for their Medicaid patients is a very real problem.

The AHA also recommends that CMS clarify how intermediate care benefits, such as residential treatment, partial hospitalization and intensive outpatient treatment, are factored into the benefit classifications for parity assessments. The proposed rule does not treat intermediate care as a separate benefit classification. The rule, however, instructs that the MCO, PIHP or PAHP apply intermediate care MH/SUD benefits to any of the four classification categories as long as they are applied in a consistent manner as intermediate care medical/ surgical benefits. CMS should consider providing states more detailed guidance with examples of how these benefits might fit into the four benefit classifications in the proposed rule and how parity could be assessed.

ACCOUNTING FOR THE INCREASED COST OF COMPLIANCE

The AHA recommends that CMS require that states adhere to greater transparency requirements and provide public information on how the state will accommodate the cost of compliance for MCO capitation rates. The MHPAEA regulations recognize the cost of coming into compliance with parity requirements for commercial health plans through an increased cost exemption. This cost exemption allows commercial plans that meet a certain increased cost threshold to be exempted from the parity requirements for the following plan or policy year. Because Medicaid MCOs are paid by the state through a capitated payment, the proposed rule does not include an increased cost exemption for MCO plans. The rationale is that the state capitated rate for the MCO can adequately account for any compliance costs MCOs experience through the state's actuarially sound capitated payment methodology. The proposed rule, however, does not provide any further guidance to states on how to factor compliance costs into the rate setting methodology, nor does the rule require any CMS oversight to ensure that the capitation payments are adequate. Transparency regarding MCO capitated rates is important for provider-based Medicaid plans, as well as providers contracting with MCOs.

STATE RESPONSIBILITY

The AHA recommends that CMS require states to engage all stakeholders – providers, beneficiary advocates, MCOs and other managed care entities – in an open and public process on the state's plans to comply with the parity requirements. We further recommend that the state process be ongoing and transparent before, during and after the

effective date of the final rule. CMS should require states to conduct ongoing monitoring of parity compliance with public reporting.

States have oversight responsibility to administer their compliance with the federal MHPAEA standards. The proposed rule outlines two options for a state if the MCO benefit package does not meet parity requirements: 1) the state could change its Medicaid state plan to include missing services; or 2) the state could add benefits or remove treatment limitations from the benefit package provided by the MCO, PIHP or PAHP. States also would be required to include contract provisions requiring compliance with the parity requirements in MCO, PIHP and PAHP contracts. States that "carve-out" some or all MH/SUD services through a combination of MCOs, PIHP, PAHPs or FFS would have responsibility for assessing parity across these delivery arrangements. States would be required to provide assurance of compliance with parity requirements when submitting to CMS their ABP or CHIP plans for approval. The state would be required to make available documentation of parity compliance to the general public within 18 months of the effective date of the final rule. Greater transparency and stakeholder engagement will be important measures to ensure that these parity requirements are effectively implemented.

ALIGNMENT WITH MEDICAID MANAGED CARE, CARE COORDINATION AND BEHAVIORAL HEALTH

CMS just published a proposed rule that represents a major rewrite of the current Medicaid managed care regulations. This is an opportunity to align the mental health parity requirements with the updated Medicaid managed care regulations. The AHA recommends that CMS consider the following issues as it finalizes the mental health parity rule and the Medicaid managed care rule.

The AHA recommends that CMS eliminate the state option that allows behavioral health services to be carved out of Medicaid managed care benefits. Most states carve out behavioral health from managed care. Among the Medicaid disabled population, half are diagnosed with a mental illness, and care is not coordinated. Carve-out arrangements create barriers to the integration of behavioral and physical health care and inhibit the sharing of information across care settings.

The AHA urges CMS to continue to examine, through the Medicaid Emergency Psychiatric Demonstration project, whether eliminating or restricting the scope of the Institutions for Mental Disease (IMD) exclusion can improve access to care and help reduce costs. The IMD exclusion prohibits federal Medicaid reimbursement for inpatient care provided to individuals between the ages of 21 and 64 in IMDs, such as private free-standing psychiatric hospitals with more than 16 beds.

Thank you for your consideration of our comments. If you have any questions, please contact Jeff Goldman, vice president for coverage policy, at (202) 626-4639 or jgoldman@aha.org or Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President