Association for Behavioral
Health and Wellness

*Advancing benefits and services
in mental health, substance use
and behavior change.*

June 9, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2333-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Mental Health Parity and Addiction Equity Act of 2008; the Application to Medicaid Managed Care, CHIP, and Alternative Benefit Plans (CMS-2333-P)

Dear Administrator Slavitt:

The Association for Behavioral Health and Wellness (ABHW) appreciates this opportunity to provide comment on the Notice of Proposed Rulemaking (NPRM) on Mental Health Parity and Addiction Equity Act of 2008; the Application to Medicaid Managed Care, CHIP, and Alternative Benefit Plans.

ABHW is an association of the nation's leading behavioral health and wellness companies. These companies provide an array of services related to mental health, substance use, employee assistance, disease management, and other health and wellness programs to approximately 150 million people in both the public and private sectors. ABHW played a leadership role in the passage of the historic Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and has remained active in its implementation in commercial health plans.

ABHW Comments on Areas Where CMS Requested Feedback in the NPRM:

1. *Should all state plan MH and substance use disorder (MH/SUD) services be included under managed care organization (MCO) contracts?*

ABHW believes that states should have the option to contract with a variety of insurance options for Medicaid behavioral health benefits. We do not support the federal government requiring states to include mental health and addiction services under a managed care organization (MCO). ABHW believes that the state should retain the flexibility and the decision making authority in regard to the contractual relationships for the provision of behavioral health services. In states states to help document parity compliance.

2. *Is there a risk for inappropriately broad readings of the regulation text and consequent use of the proposed §438.910 to include non-State plan services in rate setting for the MCO, PIHP, or PAHP benefit package that are not strictly necessary for compliance with these proposed parity requirements?*

We believe the states can control any inappropriately broad readings of the regulation text and consequent use of the proposed §438.910 to include non-State plan services in rate setting. To the extent that any non-State plan services are included in the benefit package these benefits should not be subject to the parity requirement. Furthermore, ABHW and its member companies appreciate CMS's recognition that the payment rate to health plans must be actuarial sound and that this rate should take into account the cost of compliance with mental health and substance use disorder parity requirements. The inclusion of the full scope of mental health and substance use disorder benefits health plans are obligated to provide in the actuarial sound rate is vital to the proper implementation of this rule and we encourage CMS to work with the states to ensure that these rates are achieved and calculated correctly.

3. *The delay of required compliance for up to 18 months after the date of publication of the final rule.*

We appreciate the 18 month time frame included in the proposed rule and feel that should be enough time for implementation as long as states move quickly after the final rule is issued. States will have a lot of work to do to come into compliance, budgets may need to be adjusted, contracts with plans will need to be amended, and parity analyses will need be conducted. We recommend that the federal regulators provide guidance to the states suggesting swift action once the final rules are released. If a state does not proceed rapidly 18 months for implementation may not be long enough; it depends on how promptly states act after the final rules are issued. ABHW members stand ready to work with their state partners to advance parity and we believe our experience on the commercial side will be an asset to the states as we move forward.

4. *The proposed exclusion of the increased cost-based exemption that currently is available for group health plans and health insurance issuers.*

No comment.

5. *The proposal to exclude long-term care services from the definition of medical/surgical services.*

We believe the proposed decision to exclude long-term care services from the definition of medical/surgical services was the correct choice to make. This proposal seems to be supported by the Administration on Aging definition of long-term care as a "range of services and supports someone may need to meet personal care needs. Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, sometimes called Activities of Daily Living … Other common long-term care services and supports are assistance with everyday tasks, sometimes called Instrumental Activities of Daily Living (IADLs)".

6. *The proposed approach to not specify an intermediate classification to be used in the parity analysis for Medicaid or CHIP programs.*

We support the consistency with the MHPAEA final rule in the proposed rule which gives some flexibility to states and health plans to assign intermediate level services to any of the four classifications

in the proposed rule. We also understand that assignment must be done in a manner that is consistent with what is done for medical/surgical services. The establishment of a fifth classification would be challenging because this is not a direct apples to apples comparison between behavioral health and medical/surgical. Since other aspects of the benefit like copayment/coinsurance levels and level of management are influenced by the classification a service is put into this flexibility allows states and plans to analyze the most appropriate classification for intermediate services based on the entire benefit package that is offered. It is important to preserve state flexibility in plan design and classification of services.

7. *The approach for determining the two-thirds threshold for financial requirements or treatment limitations that are applied to "substantially all" medical/surgical benefits in the same classification when there are multiple managed care delivery systems (e.g., MCOs, PIHPs and PAHPs). (The MCOs, PIHPs and PAHPs would collectively (with the assistance of the state) determine the total amount projected to be expended (including FFS) to determine the two-thirds threshold.)*

This approach, while not impossible, is more complicated to implement for the public sector than it is in the commercial sector. States may have more pieces to aggregate than exist for commercial plans. It will likely be hard to project the total amount to be expended from available data. States will play a key role in making these calculations and additional guidance from the federal government on how to implement these requirements would be helpful.

8. *Comment on any additional provisions concerning the availability of plan information or notice of adverse determinations that may be necessary to facilitate compliance with MHPAEA for MCOs, PIHPs, PAHPs, ABPs and CHIP.*

The Medicaid program already has disclosure requirements concerning the availability of plan information and notice of adverse determinations and those should be followed instead of increasing the administrative burden for states and plans by creating new requirements specifically to parity.

9. *Invite comments related to any additional evidence on the impact of aligning NQTLs for Medicaid services.*

For the past twenty five years, MBHOs have been engaged under state Medicaid programs to assure the provision of appropriate, cost-effective mental health and substance use disorder benefits. These management activities have not only improved the quality of care for this population, but also have enabled states to exercise crucial controls on the costs involved in providing this care.[1] These advances have occurred while at the same time there has been little or no management of ambulatory medical/surgical benefits under Medicaid.

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[1] E.g., "Mental Health Costs and Access Under Alternative Capitation Systems in Colorado," Health Services Research (April 2002), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1430372/ (surveying literature and analyzing cost savings in Colorado program); "Medicaid and Mental Health: Be Careful What You Ask For," 22 Health Affairs 101, 109 (January/February 2003) (use of managed behavioral health care in Medicaid programs results in significantly lower costs, and in many cases, greater access to higher quality treatment).

The inclusion of NQTLs in Medicaid will provide a means for undoing all of this progress. The absence of medical/surgical ambulatory care management under Medicaid means that employment of managed care techniques for mental health or substance use disorder Medicaid benefits will be difficult at best. This highlights the differences between medical/surgical care and mental health and substance use disorder treatment in the starkest way possible. The lower income population covered by Medicaid is frequently the population most in need of the types of services provided by behavioral health organizations, especially in terms of treatment design and follow-up. Such services are all implicated by the vague and expansive nature of NQTLs, leading to the likelihood that use of such techniques will be greatly diminished.

The disincentive to use managed care techniques also poses significant cost issues to state Medicaid programs. It is common knowledge that states are currently searching for ways to control Medicaid costs. As noted above, mental health managed care under Medicaid has resulted in significant cost savings for the states. NQTLs, however, include virtually all mental health care management techniques currently in use. The inclusion of the NQTL provision will essentially rob states of the ability to control the costs of mental health and substance use benefits in any meaningful way. In light of this, ABHW urges that CMS reconsider the inclusion of NQTL parity in the regulation. At a minimum, CMS should consider allowing clinical guidelines to be considered in the application of parity in the NQTL area and allow states to factor these differences into their parity analysis.

Furthermore, the requirement to align NQTLs in Medicaid does not take into account the variety of payment methodologies that exist on the medical/surgical side that do not exist on the behavioral health side. Medical/surgical uses payment methodologies which functionally act as mechanisms of utilization management without need for application of NQTLs. For example, medical/surgical benefits can be subject to, and managed by, bundled payments that inherently allow for less management because the provider has a built in incentive to closely monitor/manage the benefit herself. Behavioral health does not yet incorporate these alternative payment methods, relying rather on fee for service reimbursement methodologies, and therefore needs to incorporate more UM NQTLs than are used on the medical/surgical side. In an NQTL analysis behavioral health will likely have to manage the same way that medical/surgical does in a scenario where they pay the provider with a bundled payment, thus they will have to manage less without the provider having the incentive to do their own management. This is particularly true in Medicaid plans which have historically relied on quantitative benefit limits (e.g. 20 outpatient visit limit per year, 60 days of inpatient treatment per year etc.) in lieu of administering utilization review processes such as prior authorization, concurrent review and retrospective review.

The proposed regulation also do not consider compliance with regulatory, HEDIS, or other accreditation measures as a factor to be considered in the NQTL analysis. This fact, combined with the requirement that the parity analysis be conducted solely by comparing behavioral health NQTLs to medical NQTLs in one direction, without some degree of recognition of the differences between mental health/substance use disorders and other medical conditions, places the behavioral health organization in the position where it is difficult to meet regulatory, HEDIS and other accreditation measures. Medical health plan requirements are measured and captured in different ways, and utilization review often does not assist the medical plan with meeting those requirements and therefore plans don't apply UM to these benefits that might be indispensable for behavioral benefit management.

This "one way" parity analysis places a significant burden on the behavioral health organization, because, in regard to regulation and accreditation measures, utilization review can function as a patient coordination of care and quality of care mechanism. For example, acute inpatient treatment requires a

certain level of severity in order for it to be medically appropriate, utilization review often identifies (and approves) less restrictive treatment settings, consistent with the standard of care, for the consumer, which are medically appropriate. The behavioral health plan can then use that information to help improve the patient's health outcome and meet its regulatory and accreditation requirements. Utilization review can help alert a plan, whether managing the care directly or through use of managed behavioral health organization (MBHO), that a patient has been admitted to an inpatient facility and it can use that information to ensure that the person receives an outpatient follow up appointment within 7 days, or even 30 days after that patient is discharged. Recognizing the importance of these measures to an individual's overall care, the regulators should allow them to be considered as a factor in the NQTL parity analysis.

As an example of a vital UM NQTL, outlier management, defined in a general sense, is a utilization review strategy that avoids applying review to services that fall within an expected range of services based on diagnosis, the standard of care and evidence-based guidelines but instead focuses on identifying cases that fall outside expected norms for number of visits, length and intensity of treatment, etc. Cases that are identified as outliers may then be subjected to various utilization review processes such as retrospective review or concurrent review to determine whether the patient's diagnosis and prescribed treatment is accurate and appropriate.

One of the ironic challenges in achieving parity is that similarly situated outpatient benefits for medical/surgical services (e.g. home health, physical therapy, etc.) still have the ability to utilize quantitative numeric limits to limit benefits which means in some cases that they do not exercise any form of non-quantitative limits that apply utilization management (e.g. prior authorization, concurrent review of medical necessity of services, etc.) including outlier management as such NQTLs are not necessary due to the quantitative benefit limits.

Outlier management is applied to medical/surgical and mental health/substance use disorder services which involve treatment that meets the following criteria: (a) treatment in excess of a certain number of sessions (e.g. 20 sessions); (b) over a defined period of time (e.g. six months); (c) where sessions may involve multiple services with an increasing likelihood of medically unnecessary services with the higher number of services per session; (d) relatively low/modest cost for service but service can be billed at multiple levels of coding; (e) with highly variable rates of progress for individual patients; (f) with variable treatment approaches between providers; and (g) a portion of patients never achieving complete resolution of their condition resulting in on-going management of chronic condition which has no expectation of improvement or resolution nor reasonable expectation of decompensation of their condition.

Based on these criteria there are few services for medical outpatient that would be subjected to outlier management. Services that typically meet all of these criteria include chiropractic care, physical therapy and occupational therapy. However on the behavioral side the use of outlier management applies to a broad array of outpatient services which meet these criteria at a higher rate of frequency than for medical services. This, compounded with the fact that these services for medical are often subject to numeric limits which serve to limit outliers suggests that there is a difference here that should be allowed within the comparability standard of the parity regulations.

10. *Request public comment on rationale for having regulations that are specific to Medicaid and CHIP. (States raised issues with lack of specificity in sub-regulatory guidance, in particular in areas such as: actuarial soundness requirements, NQTLs and concerns regarding existing*

federal and state policies that require UM strategies that were inconsistent with the intent of MHPAEA, application to PIHPs, PAHPs, and FFS. Regulators do not believe additional subregulatory guidance would provide the necessary authority for MCOs and states to implement or enforce MHPAEA parity requirements for Medicaid beneficiaries enrolled in an MCO.)

While similarities exist between the private and public sector we believe a separate rule is necessary to address the nuances of the Medicaid benefit and the population it covers.

11. Under the Paperwork Reduction Act of 1995, soliciting comments on each of the section 3506(c)(2)(A)-required issues for the information collection requirements, including:

- *The need for the information collection and its usefulness in carrying out the proper functions of the agency;*
- *The accuracy of CMS' estimate of the information collection burden;*
- *The quality, utility, and clarity of the information to be collected;*
- *Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.*

No comment.

Additional Comments:

The proposed rule permits, in the preamble, quantitative treatment limitations to accumulate separately for medical/surgical and mental health/substance use disorders as long as they comply with the general parity requirements. We support this provision and appreciate the recognition that implementing a cumulative limit across all benefits would be very challenging and burdensome. We did however note that a similar provision is not included in the actual regulation. We assume that this is an oversight and that the language from the preamble was intended to translate into the proposed regulatory language. This inconsistency needs to be reconciled, we request that additional language is added to the regulatory section of the proposed rule to codify the provision as described in the preamble.
We also request clarification from the regulators regarding the application of the Institution for Mental Disease (IMD) exclusion alongside the proposed regulation's guidance that restrictions based on facility type are a NQTL. We are concerned that the exclusion of IMDs as a treatment option may be considered a NQTL yet Medicaid reimbursement for IMDs is currently prohibited.

Thank you for your consideration of these comments. If you have any questions or would like to discuss any of these issues with ABHW, please contact Pamela Greenberg at (202) 449-7660 or greenberg@abhw.org.

Sincerely,

Pamela Greenberg
President and CEO, ABHW