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Andrew M. 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: Proposed Regulations: Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations (MCOs), the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans (CMS-2333-P)

Dear Administrator Slavitt:

We are writing to you on behalf of the 36,000 members of the American Psychiatric Association (APA) to provide comments to the Proposed Regulations: Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations (MCOs), the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans (ABPs) (Proposed Regulations). The APA is a medical specialty society representing physician psychiatrists in the United States. Our members provide services to Medicaid beneficiaries in all settings; inpatient, partial hospital, outpatient, and in mental health clinics. In an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders (MH/SUDs), the APA has advocated for many years in support of the enforcement of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its Final Rules.

The passage of MHPAEA and the Affordable Care Act (ACA), the promulgation of the Final Rules, and the extension of the parity requirements to MCOs, ABPs, and CHIP are highly significant. Combined, these programs represent the single largest source of insurance coverage for individuals with MH/SUDs. Individuals who suffer from MH/SUDs and are eligible for Medicaid are highly consequential in terms of overall population health and total program costs. The application of the Proposed Regulations holds great promise for increasing access to medically necessary healthcare and for creating cost efficiencies that would otherwise be unachievable.

We appreciate the opportunity to comment on the Proposed Regulations and trust you will give our comments and recommendations due consideration. Overall, the Proposed Regulations are constructive and reinforce certain essential requirements of the Final Rules. However, it is of the utmost importance that Medicaid enrollees are afforded the same rights as others covered by health insurance to access to MH/SUD services and that the Proposed Regulations serve to ensure that all enrollees, beneficiaries, and participants have the same protections under MHPAEA and its Final Rules. Therefore, the Proposed Regulations must strive for compliance with and accountability to MHPAEA and its Final Rules. Accountability can only be achieved through transparency, since this is the only basis for verifying true compliance. Full and public disclosure of all pertinent plan information that documents compliance with MHPAEA and the Final Rules is essential. This is a concern for all patients, but especially for Medicaid enrollees, whose ability to understand their benefits may be compromised. In this regard, there are a number of clarifications and changes to the Proposed Regulations that are necessary.

Set forth below is an overview of the Proposed Regulations, along with our requests for clarifications and recommended changes.

**Disclosure of documentation of Parity compliance is essential and clarifications are necessary.**

The Preamble to the Proposed Regulations recognizes the different delivery systems that states use to provide medical/surgical and MH/SUD services under Medicaid and the need for regulations concerning the performance of a compliance analysis, the party responsible for performing the analysis, and the disclosure of the analysis to the public.<sup>1</sup> We find the disclosure requirements under the Proposed Regulations to be incomplete and require clarification as explained below.

The Proposed Regulations address these issues in three separate sections as follows:

1. 42 CFR Part 438;
2. 42 CFR Part 440; and
3. 42 CFR Part 457.

**1. 42 CFR Part 438.**

There are three issue categories to be discussed under 42 CFR Part 438.

- Responsibility for parity analysis and its disclosure.
- Contract assurances and state methodology.
- Definitional issues respecting operative terms.

**Responsibility for parity analysis and its disclosure.**

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<sup>1</sup> 80 FR 19421.

The Proposed Regulations amend 42 CFR Part 438 to address the responsibilities of all Medicaid MCOs with respect to MHPAEA, including those Medicaid MCOs used by a state for ABPs, regardless of the delivery system used by the state to provide medical/surgical or MH/SUD services.<sup>2</sup> With respect to arrangements with Medicaid MCOs, the party responsible for performing the compliance analysis depends on how the state structures its contractual arrangement.<sup>3</sup> The two types of contractual arrangements are: (1) where the state contracts with the Medicaid MCO for the MCO to provide all medical/surgical and MH/SUD services or single source contracts (SSCs), and (2) where the state has multiple service contracts (MSCs) or fee-for-service (FFS) arrangements to effect the complete benefit package of medical/surgical and MH/SUD services to enrollees (i.e., the MCO providing medical/surgical services is responsible only in part or not at all for MH/SUD services, and the state provides those through a combination of prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), or FFS arrangements).

Where there is an SSC, the MCO is responsible for performing the parity analysis.<sup>4</sup> Based on this analysis, the MCO is required to inform the state what changes will be needed to the MCO contract in order to make it parity compliant.<sup>5</sup> The state is then responsible for facilitating these necessary changes, after it has satisfied itself as to the validity of the MCO analysis.<sup>6</sup>

It is not clear what, if any, documentation or information included in the forgoing analysis and reviews is subject to disclosure. For example, does the state have to publicly disclose the methodology it provides, or does not provide, to the MCOs; the actual MCO parity analysis; is it required to or should it audit the actual MCO analysis; or the MCO's report to the state? It is also not clear what the state must do with the MCO analysis. The Proposed Regulations only stipulate that the state has responsibility for "disclosure" where the full scope of medical/surgical and MH/SUD services ***are not*** provided through the MCO.<sup>7</sup> Presumably, then, the state's responsibilities do not extend to the SSC category. Specifically, 438.920(b)(1) and (2) state:

(b) *State responsibilities.* (1) In any instance where the full scope of medical/surgical and MH/SUD services ***are not*** provided through the MCO, the State must review the MH/SUD benefits provided in the MCO, PIHP, PAHP, or FFS state plan service to ensure the full scope of services available to all enrollees of the MCO complies with the requirements in this subpart. The state must provide documentation of compliance with requirements in this subpart to the general public within 18 months of the effective date of the final rule.

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<sup>2</sup> Id.

<sup>3</sup> Id.

<sup>4</sup> Id.

<sup>5</sup> Id.

<sup>6</sup> Id.

<sup>7</sup> 42 CFR 438.920 (b).

(2) In any instance where the full scope of medical/surgical and MH/SUD services **are not** provided through the MCO, the State must ensure that the enrollees of the MCO receive services in compliance with this subpart.<sup>8</sup>

This is inconsistent with the expectation the Preamble creates. The Preamble states:

...where the MCO has sole responsibility for offering MH/SUD services, the MCO would be responsible for undertaking the parity analysis and informing the state what changes will be needed to the MCO contract to comply with the provisions of this proposed rule. As proposed in §438.920, states would be required to make available to the public their methods of complying with these Proposed Regulations within 18 months after the rule is finalized.<sup>9</sup>

This Preamble language suggests that, at a minimum, the state make available their “methods” of compliance with the rules for this SSC category. However, the inclusion of the “are not” qualifier suggests otherwise.<sup>10</sup> **This requires clarification and we recommend that CMS require states to make these analyses public.**

In MSC arrangements, the state would have responsibility for undertaking the parity analysis across these delivery systems. The state, as with SSCs, has responsibility for taking whatever remedial steps are necessary to effect parity compliance across these delivery systems. The Preamble states:

In addition, we are proposing at §438.920(b) that the state make available documentation of compliance with these proposed regulations to the general public within 18 months of the effective date of this rule and post it on the state Medicaid Web site.<sup>11</sup>

With respect to MSCs, there are material matters of consequence respecting disclosure. Namely, the actual parity analysis conducted by the state and the methodology used for the review; what constitutes the “documentation of compliance” that is to be disclosed; and what does “make available to the public” mean? These definitions are more fully discussed below.

In addition, with respect to MSCs, the Proposed Regulations do not mirror the Preamble language.<sup>12</sup> The Preamble to the Proposed Regulations stipulates as follows:

...[W]e are proposing at Section 438.920(b) that the state make available documentation of compliance with these proposed regulations to the general public within 18 months of the effective date of this rule and post it on the state Medicaid Web site.<sup>13</sup>

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<sup>8</sup> Id.

<sup>9</sup> 80 FR 19421.

<sup>10</sup> 42 CFR 438.920 (b).

<sup>11</sup> 80 FR 19421.

<sup>12</sup> 42 CFR 438.920(b).

<sup>13</sup> 80 FR 19421.

The Proposed Regulations, on the other hand, simply state that the state is to “make available” the documentation. **The Proposed Regulations language is too vague and should be modified to read as stated in the Preamble.**

*Contract assurances and state methodology.*

With respect to both SSCs and MSCs, there are a couple of issues to note. According to the Proposed Regulations, in all MCO contracts states are required to include provisions to ensure that enrollees receive services that are in compliance with the requirements of the new Subpart K (Parity in Mental Health and Substance Use Disorder Benefits).<sup>14</sup> The Preamble sets forth CMS’s expectation that states will include a methodology in these contracts that will establish and demonstrate compliance.<sup>15</sup> The Proposed Regulations, however, do not include the expectation that states include a methodology in its contracts with Medicaid MCOs as a requirement.<sup>16</sup> Further, the term “methodology” is not defined in the Proposed Regulations, thereby leaving it up to the state and the MCO to negotiate the definition and determine what methodology they use to determine compliance. **To ensure compliance with the parity requirements, the Proposed Regulations should include as a requirement that the expectation set forth in the Preamble (i.e., states must make a methodology available to MCOs respecting parity compliance) and should define the term “methodology.”**

*Definitional issues respecting operative terms.*

The Preamble states that “methods of compliance be made available,” and in different places references “documentation of compliance” and “methodology”. These terms need definition, if for no other reason than that they can easily be construed to mean different things. The Preamble and the language of the Proposed Regulations reference these operative terms, but provide no definition. At a minimum, “methodology” and “documentation” on their face mean very different things. If left undefined, this may well lead to differing interpretations on what, in fact, must be disclosed.

“Methodology” suggests a description of a protocol as to how the pertinent information will be assembled, reviewed (what questions will be asked), and analyzed (in this case, per the regulatory tests). “Documentation” is the product of the methodology (i.e., the written analyses and conclusions against the tests) or, in other words, substantiation of the claim of parity compliance.

“Methods of compliance” could mean that the state included the contract provision and that the state reviewed the MCO analysis and made the necessary changes.<sup>17</sup> “Documentation of compliance” can mean the same thing as “methods of compliance” or it could mean the actual

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<sup>14</sup> 42 CFR 438.6(n).

<sup>15</sup> 80 FR 19432.

<sup>16</sup> 42 CFR 438.6(n).

<sup>17</sup> Id.

analysis and reports developed to document that the plan is in compliance. **In any case, clarification of these terms is necessary.**

Regarding the term *documentation of compliance*, it is imperative that CMS make clear what is meant and provide some definitional boundaries. **We recommend that CMS stipulate at a minimum that *documentation of compliance* specifically include the following elements:**

- a. **A description of the methodology used by the state to perform the required regulatory tests for each applicable financial requirement, quantitative treatment limitation and nonquantitative treatment limitation.**
- b. **The methodology used by the state to review and assess compliance with all other parity requirements in subpart K; e.g., benefits classification, subclassifications, etc.**
- c. **The methodology used by the state to assure that there are no separate treatment limitations that apply only to MH/SUD benefits.**
- d. **Clear statements of the conclusions reached respecting each of the items under numbers 1, 2, and 3 above.**
- e. **A summary analysis for each of the conclusions in number 4 that specifically sets forth the rationales for the conclusions reached.**

Another term that has the potential to create confusion is “scope of services.” We presume the Proposed Regulations at 438.920(b) are intended to mean that the state’s review of the benefits encompasses the full scope of services and is inclusive of all the regulatory requirements in subpart K for each MH/SUD service.<sup>18</sup> Some of the language of the Proposed Regulations—i.e., “scope of services”—has assumed near term of art status in some parity circles, and we have a concern that it could be misconstrued.<sup>19</sup> The phrase is also used in different ways in the Preamble and regulatory language. For example, *scope of services* is often used when referring to the rules concerning benefits classification and symmetry issues between medical/surgical and MH/SUD services within each benefit classification category, but not all of the other regulatory tests. We would not want to see confusion in the interpretation of exactly what *documentation of compliance* refers back to. Our experience with the parity rule in the commercial sector suggests this concern is valid.

**We recommend that the proposed regulatory language be modified to ensure that the review encompasses all applicable rules for each service covered by the MCO arrangement. APA has been intimately involved in the application and interpretation of the MHPAEA Final Rules in the commercial sector and is concerned that any ambiguity when it comes to certain terms could lead to loss of benefits for patients.**

## **2. 42 CFR Part 440.**

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<sup>18</sup> 42 CFR 438.920(b).

<sup>19</sup> 42 CFR 438(b)(1).

Where ABPs are not delivered through a managed care arrangement and are provided on a fee for service (FFS) basis, the state is responsible for the parity analysis.<sup>20</sup> The Proposed Regulations require states using ABPs to provide sufficient information in the ABP state plan amendment request to assure compliance with MHPAEA.<sup>21</sup> CMS will review the plan amendment to assure compliance with MHPAEA and EHB anti-discrimination provisions. Beyond requiring “sufficient information,” there is no stipulation in the Preamble or Proposed Regulations that defines a required methodology and/or documentation of compliance analysis consistent with our recommendation above. In addition, the state has no responsibility to the public to disclose its documentation of compliance other than providing sufficient information to CMS.<sup>22</sup>

Further, parts of the proposed language at §440.395(d)(1) are confusing. The section stipulates:

(d) *Applicability*—(1) *Alternative Benefit Plans (ABPs)*. The requirements of this section apply to states providing benefits through ABPs. For those states providing ABPs through an MCO or PIHP the rules of 42 CFR part 438, subpart K also apply, and approved contracts will be viewed as evidence of compliance with the requirements of this section.

We are unclear as to how the language respecting “approved contracts” is intended to operate. Cross-referencing this language back to the requirement at §438.436(n), it appears that the review and oversight of compliance rest solely with the state (inasmuch as CMS accepts the contract as evidence of compliance without regard to the credibility of the actual parity analysis). It is also unclear what the CMS oversight/audit role will be in this regard. MCO contracts must require assurance of compliance. We view this as particularly problematic in the SSC category of MCO contracts. MCOs are required to perform the parity analysis and while the states are *expected* to provide a methodology, they are not *required* to do so.

As CMS knows, the parity regulations and requirements are quite complex. We believe there are available methods of reporting and assessing compliance that are tested and should be recognized such as those in California.<sup>23</sup> Our experience in the commercial sector suggests that there is much too much variability in how plans actually conduct parity analyses against the one defined set of stated regulatory tests. **We recommend that there be uniform reporting.**

**APA urges CMS to further clarify the language in conjunction with due consideration of specifying methodologies that would support actual documentation of compliance rather**

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<sup>20</sup> 42 CFR §440.395.

<sup>21</sup> 42 CFR §440.395(d)(3)

<sup>22</sup> See 42 CFR §440.395(c) or (d) and §438.920(b)

<sup>23</sup> See

[https://www.dmhc.ca.gov/LawsRegulations/MentalHealthParityandAddictionEquityActof2008\(MHPAEA\).aspx#.VXcFIGx0yUk](https://www.dmhc.ca.gov/LawsRegulations/MentalHealthParityandAddictionEquityActof2008(MHPAEA).aspx#.VXcFIGx0yUk).

than potentially allowing for accepting unilateral declarations of compliance that may have no substance.

### **3. 42 CFR 457.496.**

42 CFR 457.496 applies to CHIP state plans, including when benefits are furnished under contracts with MCEs. Responsibility for parity analysis rests with the state. The Preamble makes it clear that if states offer benefits through a CHIP state plan with various delivery systems (managed care and non-managed care; i.e., FFS), the state would need to apply the provisions of the Proposed Regulations.

We interpret this to mean that the state has responsibility for the parity analysis for each of the following situations:

- When the MCE has complete responsibility for the full scope of medical/surgical and MH/SUD services;
- When the state has arranged for medical/surgical and MH/SUD services through a combination of delivery system arrangements; and
- When the state CHIP program is provided solely on a FFS basis.

It is unclear from the Preamble and the Proposed Regulations language at §457.496(f) what the state's responsibility is for documentation of compliance and its disclosure. Moreover, it is not clear what assurances the state must provide to CMS when submitting its CHIP plan. **We recommend that all pertinent documentation of compliance respecting the CHIP program be required to be disclosed as well.**

### **APA supports use of §1902(a)(4) authority to extend the rule's application to PIHPs and PAHPs and/or Medicaid FFS.**

We strongly concur with CMS's decision to utilize its authority under §1902(a)(4) of the Social Security Act (the Act) to extend MHPAEA requirements to these non-MCO defined entities. This is essential to eliminating loopholes and/or potential workarounds to the requirements and intent of §1932 (b)(8).

### **CMS should not require that all State Plan MH/SUD services be Included under MCO contracts.**

The APA does not think that it is necessary to require all state plan MH/SUD services to be included under MCO contracts and it would likely make no material difference. First, we are in a rapidly evolving healthcare service delivery environment and flexibility at this stage is likely to be useful. Second, requiring that all services be provided through an MCO would not necessarily reduce the number of delivery arrangements or the challenges to effecting compliance. It is likely that MCOs would turn around and carve-out directly to PIHP or PAHP-like entities.



Generally, carve-outs tend to foster continuation of discrimination against the MH/SUD population. They reinforce the stigmatization of psychiatric illness by segregating its treatment from the treatment of other illnesses. Carve-outs also make coordination of care more difficult since care is administered by two separate entities, each with its own system. Because of this disconnect, patients often receive care that fails to get to the cause of illnesses—both psychiatric and physical.

We also have concerns about how these multi-faceted delivery arrangements square with the HHS integrated care initiatives in the public sector. Our primary concern is that having multiple delivery mechanisms makes it difficult to effect true, patient-centered integrated care.

Moreover, integrated care initiatives have the potential to qualify as non-quantitative treatment limitations. Robust service delivery mechanisms that ensure integrated care for those with primary medical conditions must be equally available to those with primary MH/SUD conditions. We are aware of many state arrangements where, on the surface, this does not appear to be the case. Unequal provision of services and access to care may otherwise limit the scope or duration of the benefit and/or constitute a de facto separate treatment limitation.

**We agree with the requirement for states to perform the parity analyses for complex service delivery systems.**

We concur with CMS's decision to use its authority under §1902(a)(4) to require states to perform the parity analyses for complex service delivery arrangements. Without a single source of accountability for compliance, auditing and enforcement would be difficult at best. However, the proposed scheme for primary parity analyses provides that where MCOs are responsible for the full scope of benefits, they must perform the analyses and provide reports to the states. We have concerns about this duality of responsibility and this was discussed in more detail above.

**We agree with concerns related to actuarially sound rates and recommend changes to parity analyses requirements be made. The risk of underfunding should also be a concern.**

The proposed revisions to §438.6(e) are essential, since the achievement of parity, given the benefits classification rule, will invariably require the addition of non-state plan services and/or the removal of certain treatment limitations in MCO contracts. This is a welcome departure from prior CMS guidance and the previous exclusion of payment for non-state plan services in MCO contract arrangements.

We note the concern raised in the Preamble to the Proposed Regulations regarding the potential for inappropriately broad readings and inclusion of non-state plan services for parity compliance in the formulation of a state's actuarial rates.

Achieving parity compliance through the Proposed Regulations involves detailed analyses of the benefits classification requirements and the rules that apply to financial requirements, quantitative treatment limitations (QTLs), and non-quantitative treatment limitations (NQTLs). The parity analyses responsibilities laid out in the Proposed Regulations, whether for a single or multiple service delivery arrangements, clearly stipulate that changes that are needed to effect parity compliance are to be clearly identified, presumably with supporting rationales. It cannot be overemphasized that states, and the MCOs, PIHPs, and PAHPs they contract with, must conduct appropriate analyses per the rules and the tests they provide.

These analyses, therefore, should yield a template with the exact elements that may require or justify additional rate-setting considerations. If it is not specified as necessary per the documented conclusion of the required parity analyses, it cannot be considered valid. CMS should consider developing a template that identifies and translates service changes into rate-setting formulations, which would provide a basis for necessary audit activities and may have beneficial sentinel effects.

An additional issue we have regarding rate setting concerns the potential for underestimating the costs that additional services and/or less stringent treatment limitations may entail. It would defeat the intent of the Proposed Regulations to require the addition of new services that will not be funded at a level that will permit them to actually be accessed.

**Clarification is necessary with respect to how parity requirements apply to combined programs covering the dually eligible.**

While it is unequivocally clear that MHPAEA does not apply to Medicare, we are, however, requesting clarification of how the parity requirements apply to the Medicaid portions of these initiatives and responsibility for parity analyses in these situations.

**We agree with CMS's decision not to provide an increased cost exemption.**

We concur with CMS's rationale and decision not to provide for an increased cost exemption under the Proposed Regulations.

**The compliance timeframe should be shortened.**

We urge CMS to finalize and implement these Proposed Regulations as swiftly as possible. There have been significant delays in implementing the Proposed Regulations under MHPAEA since its passage in 2008. Final regulations governing parity in the commercial health insurance market were not released until 2013 and there has been a similar delay in proposing these regulations for Medicaid and CHIP. If states are given 18 months after the finalization of these Proposed Regulations to bring their Medicaid and CHIP programs into compliance with parity, it could well be close to ten years after the passage of MHPAEA before parity regulations are fully enforceable. This is far too long a time.

CMS has explained that states require 18 months from the finalization of the rule to bring their programs into compliance because managed care contracts may need to be revised and state legislative action may be required before a state can come into compliance with the regulations. While we understand that states often need time to implement significant changes to their Medicaid and CHIP programs, states have known for many years that parity is applied to these programs and that these programs needed to generally be in compliance, even absent regulations.

In a November 4, 2009, State Health Official Letter, CMS told states that “MCOs or PIHPs must meet the parity requirements of MHPAEA, as incorporated by reference in title XIX of the Act, for contract years beginning after October 3, 2009.” Regarding the application of parity to CHIP, the letter told states that “This requirement was effective as of April 1, 2009.” The letter went on to tell states that they:

Will need to begin to assess their own compliance with the MHPAEA parity requirements prior to the issuance of MHPAEA regulations. For States that use MCOs or PIHPs to provide Medicaid benefits, a review of current contract language with the plans should occur before the next contract year begins to ensure that MHPAEA parity requirements are in place. Similarly, each State will need to review its CHIP plan to determine if the CHIP State plan imposes more restrictive requirements on mental health or substance use disorder benefits than on medical/surgical benefits.<sup>24</sup>

States were clearly made aware that their Medicaid and CHIP plans needed to meet parity requirements before the issuance of these Proposed Regulations, both in guidance from CMS and in the law. Section 3(d)(2) of the CHIP Reauthorization Act made it clear that states were required to make a good faith effort in both their Medicaid and CHIP programs to comply with the requirements prior to the issuance of any regulations or risk losing federal financial participation and Medicaid ABPs that have been implemented since the passage of the ACA, including all ABPs implementing the ACA’s Medicaid expansion, have had to comply with parity, and CMS has repeatedly told states of the parity compliance requirement for these plans.

Because parity has already been in effect for Medicaid and CHIP plans absent the regulations, states should only need to implement the provisions of the Proposed Regulations that differ in approach or detail from the guidance that has already been given them by CMS. Therefore, we believe that full compliance should take no longer than 12 months from finalization of the Regulations for all or almost all states, and most states should be able to comply much sooner. We encourage CMS to shorten the timeline for compliance from 18 months from finalization to no more than 12 months, unless a state can demonstrate to CMS that meeting the requirements of the final rule in 12 months is not possible. If a state can demonstrate the

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<sup>24</sup> See <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.

genuine need for the full 18 months, CMS could extend the implementation deadline for that state, but only if that state can show that it continues to make strong progress implementing parity in the interim.

In addition to our request that compliance be required no more than 12 months after the finalization of this rule for states that cannot meet exemption criteria, we ask CMS to include in the final regulations “benchmarks” that all states must meet to show progress in implementing the regulation between release of the final rule and the day it goes into effect. Such benchmarks should include demonstrating to CMS that the state has a plan in place to bring its coverage into compliance, that all MCO contracts that are implemented or renewed before the deadline fully comply with the parity regulations, that all FFS CHIP and ABP coverage meets parity requirements, and that the state has taken all steps for compliance absent some of the more time consuming steps, like renegotiating MCO contracts or passing authorizing state legislation. States and CMS should also make compliance reports public. Similarly, we urge CMS to quickly release the final rule so all parity protections can be implemented and enforced as soon as possible.

**We strongly disagree with exclusion of long-term care services from medical/surgical benefits.**

The Proposed Rules would exclude all long-term care services from the definition of medical-surgical and MH/SUD services in the Medicaid and CHIP context. The Preamble states:

We believe this clarification is consistent with the intent of the MHPAEA final regulations, as the kinds of long-term care services included in the benefit packages for Medicaid and CHIP beneficiaries are not commonly provided in the commercial market as part of health benefits coverage.

Additional long-term care services and supports, such as personal care, home and community based services, or long-term psycho-social 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.<sup>25</sup>

We strongly disagree with the Proposed Regulations’ definitional exclusion and the legitimacy of the underlying rationale and recommend that CMS provide a definition of long-term care services that delineates those types of long term care services that are subject to the parity rule. This definition should also clearly state those services that are excluded and a statutory/regulatory basis for this exclusion.

The Proposed Regulations do not define the term, and this is highly problematic since it permits complete freedom in benefit design to label a service or level of care (e.g., residential) as long-term care and exclude it from the requirements of the parity rule. The categorical

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<sup>25</sup> 80 FR 19423.

exclusion without a specific definition does not provide a bright line distinction or principled basis to decide between what services should be considered long-term and the rationale. There are many services covered in the commercial sphere that are comparable, such as home-based care, where the services would be covered under medical-surgical conditions but not for MH/SUD because they are defined as “long-term care.” This opens the door for arbitrary decisions that can be wholly justified on any basis or plausible rationale that characterizes the services as long-term, and it precludes any systematic basis to audit compliance with applicable MHPAEA requirements.

The Medicaid program allows for the coverage of long-term care services through several vehicles and over a continuum of settings. This includes institutional care and home and community-based long-term care. In fact, commercial insurers *do* cover many of these benefits. Recently CARF International, which accredits many medical and behavioral residential community-based services, surveyed its accredited facilities to determine which of these accept both Medicaid and commercial insurance. As you can see from the attached letter from CARF (see attachment), the vast majority of their programs, which are both short-term and long-term in nature, accept commercial insurance. This contradicts the statement that commercial insurers do not typically reimburse for long-term care.

More important, under §1932(b)(8) of the Act, Medicaid MCOs are required to comply with the requirements of MHPAEA “to the same extent that those **requirements** apply to a health insurance issuer that offers group health insurance.” To assert that services or benefits not offered in the commercial sector is a basis for exclusion under the Medicaid rule totally misconstrues and misapplies the meaning of the term requirements cited above.

MHPAEA does not require that any service or benefits be offered or not offered. The statute provides that if the services are offered they must meet MHPAEA’s requirements. Specifically, if a group health plan offers both medical/surgical benefits and MH/SUD benefits, the financial requirements or treatment limitations applicable to such MH/SUD benefits:

- Can be no more restrictive than the predominant financial requirements of treatment limitations applied to all medical and surgical benefits covered by the plan
- And there can be no separate financial requirements or treatment limitations that are applicable only with respect to mental health or substance used disorder benefits.

The Proposed Regulations’ approach misconstrues the intent and substance of the parity requirements in that it de facto means that parity only applies to Medicaid and CHIP services that are also covered by commercial insurance. We find no basis in the statute for this interpretation and application. The proper interpretation of MHPAEA and 1932(b)(8) is that the parity requirements apply to all covered services/benefits in Medicaid and CHIP, and the parity requirements apply to all services/benefits covered by a commercial health plan.

We do recognize that there may be statutory requirements, such as the Institutions for Mental Disease (IMD) payment prohibition, which necessitate that certain services be exempted from parity requirements, and this would be a legitimate basis for exclusion. However, there is no discussion of any relevant interplay between the Proposed Regulations and the IMD exclusion. We believe this is essential, especially given the new Proposed Regulation provisions for Medicaid MCOs, which propose inclusion of payment for the services in IMDs for short stays.

We have serious concerns regarding the statutory legitimacy of excluding a category of undefined services/benefits on the basis that parity does not apply where there is no symmetry of services between those covered by Medicaid and a commercial arrangement. While there may not be a direct analog between the commercial and Medicaid markets in long term care, there are similar types of services provided. Even if this were a legitimate criterion for defining services not subject to parity requirements under Medicaid, it is factually incorrect. If CMS finalizes this rule as proposed and allows the exclusion of long-term care services, it creates a slippery slope that would allow plans to argue to exclude other services beyond the long-term care category since they are similarly covered by Medicaid, but not by commercial insurers.

The categorical exclusion of long-term care services from the benefits definition is inappropriate and the criteria upon which this exclusion is based is invalid.

**Exclusion of all benefits for a specific condition or disorder must be clarified.**

The Proposed Regulations provide that a permanent exclusion of all benefits for a specific condition or disorder is not a treatment limitation. We are requesting clarification of the basis for this under the Medicaid program.

We understand this mirrors the Final Rule for private sector and non-federal governmental plans. However, we are unclear how this proposed provision squares with existing nondiscrimination provisions the Medicaid program operates under, including the nondiscrimination provisions under sections 1302 and 1557 of the ACA. Is a condition or disorder not a "disability" under these statutory provisions? Medicaid MCO regulations provide at 42 CFR §438.210(a)(3)(ii) that an MCO, PIHP, or PAHP: "May not arbitrarily deny or reduce the amount, durations, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary."

If permitted, this provides any state with considerable latitude in shaping benefits in ways that potentially enable selection against portions of its beneficiary populations. Are states allowed to structure multiple MCO arrangements, with some limiting the conditions covered and others providing fewer exclusions? Can states simultaneously establish enrollment criteria for these arrangements based on prior claims history? Clarification of this provision is essential and must follow the existing statutory provisions.

**Intermediate services must be clearly defined.**

Medicaid has different definitions of intermediate care and other terms that are used to describe MH/SUD services than the same terms that are employed in the commercial sector. When finalized, these rules must list and clarify key terms that are used differently in the Medicaid and commercial markets, what they mean in each setting, and how this affects the parity protections offered to plan participants.

APA supports the inclusion of Section 428.900 entitled “Meaning of Terms” in the Proposed Regulations. However, this list is insufficient to clarify the distinct definitions of certain terms that may have very different meanings when used with regard to the Medicaid plans versus the MHPAEA Final Rule, all with implications for the parity requirements embedded in the rule.

For example, in Medicaid intermediate care can often refer to residential services/facilities often provided to individuals with intellectual disabilities (i.e., ICF/IDs). The lengths of stay can be as long as several years. Intermediate services in the MHPAEA Final Rule published in 2013 refer to a range of services that are in between acute hospital and professional office based services such as intensive outpatient, partial hospitalization, and residential services. These services are for variable lengths of stay ranging from short term to intermediate and, on occasion, longer terms, and do not always include room and board. Further, some definitions in Medicaid include habilitation as opposed to active treatment and rehabilitation. To avoid confusion, CMS should include a list of terms that have different meanings in Medicaid and commercial plans and clarify how these meanings apply in the context of parity protections provided in Medicaid and the commercial market.

Further, there is a need for definitional clarity of the term *intermediate care services* for the Medicaid program. The APA believes this should correlate with the treatment of intermediate care in the commercial parity Final Rule (i.e. intermediate services provided by the plan must be included in comparable classifications in both the MH/SUD and medical/surgical classifications).

The MHPAEA Final Rule states:

The Departments did not intend that plans and issuers could exclude intermediate levels of care covered under the plan from MHPAEA’s parity requirements. At the same time, the Departments did not intend to impose a benefit mandate through the parity requirement that could require greater benefits for mental health conditions and substance use disorders than for medical/surgical conditions. In addition, the Departments’ approach defers to States to define the package of insurance benefits that must be provided in a State through EHB.

Although the interim final regulations did not define the scope of the six classifications of benefits, they directed that plans and issuers assign mental health and substance use disorder benefits and medical/surgical benefits to these classifications in a consistent manner. This general rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must

assign covered intermediate mental health and substance use disorder benefits to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.

These final regulations also include additional examples illustrating the application of the NQTL rules to plan exclusions affecting the scope of services provided under the plan. The new examples clarify that plan or coverage restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services must comply with the NQTL parity standard under these final regulations.

The MHPAEA Final Rule clarifies that intermediate care services do not always fit neatly into the inpatient or outpatient classifications. As a result, while not providing a definition of intermediate care services, the MHPAEA Final Rule did provide plans with the flexibility to put these services in one of the existing six classifications in the same way that they assign comparable medical/surgical services.

Because there is such great flexibility in the way that plans can assign and cover intermediate care services, we believe the Medicaid Parity Final Rule must clearly articulate that parity applies to intermediate care services. The APA is concerned that plans or states could misread the long-term care provisions in the Proposed Regulations to deny coverage of routinely covered MH/SUD services and benefits such as intensive outpatient, partial hospitalization and residential treatment. Given our experience with exclusions and/or lack of reimbursement for partial hospitalization and residential treatment in the commercial markets, we urge CMS to align the treatment of intermediate care with the commercial MHPAEA Final Rule.

***The APA supports cumulative financial requirements and quantitative treatment limitations.***

We concur with CMS and support the proposed provisions that prohibit cumulative financial requirements, but permit treatment limitations for the reasons set forth in the Preamble.

***The APA has concerns about the deemed compliance of CHIP and EPSDT services.***

The Proposed Regulations incorporate the statutory requirement that CHIP plans providing EPSDT services are to be deemed in compliance with plan's financial requirements and quantitative treatment limitations. We concur with the CMS clarification that if states apply NQTLs to EPSDT services, those limits must be applied consistently with the intent of MHPAEA. However, we are concerned that state CHIP plans may be deemed compliant with



parity even when EPSDT coverage is poorly implemented and MH/SUD services are subjected to a more restrictive standard than covered medical/surgical services. We are unclear from the regulations proposed at 457.395 as to what assurances states must provide to CMS when submitting their state CHIP plans. We recommend that the language specify that assurances provided to CMS and that the documentation of compliance be consistent with our earlier recommendation.

**The availability of plan information is essential to ensuring access to care.**

The availability of information provisions is critical to ensuring access to medically necessary MH/SUD services and must be parallel with the rights of ERISA beneficiaries and participants of individual plans for MCO, ABP, and CHIP beneficiaries. MHPAEA's Availability of Plan Information requirements, along with the related guidance issued and other laws, regulations, and guidance regarding plan benefits, provide for the transparency, disclosure of information, and protections for plan participants and beneficiaries related to MHPAEA compliance.

In addition to certain disclosure requirements included amongst the "Availability of Plan Information" provisions, the Final Rules also direct readers to other applicable disclosure requirements under ERISA, the claims procedure and internal claims and appeals and external review processes regulations,<sup>26</sup> and the Summary of Benefits and Coverage requirements of the ACA.<sup>27</sup> Furthermore, the Departments have issued specific directives and subregulatory guidance (including Facts and Questions (FAQs)) and opinion letters) in order to guide all affected parties in the appropriate disclosure of information to current and potential plan participants, beneficiaries, authorized representatives, and contracting providers and to clarify the scope of disclosure of plan documents and other information, including who is entitled to receive the information (i.e., the current or potential plan participant, beneficiary, authorized representative, or contracting provider).

In addition to the regulations and guidance provided, the Preamble to the Final Rules provide:

Even with these existing disclosure requirements under existing law, the Departments remain focused on transparency and whether individuals have the necessary information to compare NQTLs of medical/surgical benefits and mental health or substance use disorder benefits under the plan to effectively ensure compliance with MHPAEA.<sup>28</sup>

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<sup>26</sup> See 29 CFR 2520.104b-1.

<sup>27</sup> See 29 CFR 2560.503-1, 26 CFR 54.9815-2719T(b)(2)(i), 29 CFR 2590.715-2719(b)(2)(i), and 45 CFR 147.136(b)(2)(i) (requires non-grandfathered plans and issuers to incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503-1). In September 2014, the United States Department of Labor's Employee Benefits Security Administration published a Reporting and Disclosure Guide for Employee Benefits Plans that sets forth a brief summary of the disclosure requirements under ERISA. For a copy of this document, see [www.dol.gov/ebsa/pdf/rdguide.pdf](http://www.dol.gov/ebsa/pdf/rdguide.pdf).

<sup>28</sup> 78 FR 68248.

The governing departments want to ensure that individuals can effectively obtain the information necessary to perform the appropriate regulatory tests, determine whether plans are in compliance, and seek the compliance of health plans with the law and the Final Rules.<sup>29</sup>

Following the enactment of the ACA, issues regarding disclosure of plan information are important to the sponsoring departments as they are not only issues that affect patients with MH/SUDs, but they involve the appropriate disclosure of information to all insureds. The ACA created a more transparent marketplace with additional consumer protections, some of which are addressed in this paper, and compliance with these consumer protections are essential to fulfilling the purpose of not only MHPAEA, but the ACA. Following the intent of both MHPAEA and the ACA, it is critical that all enrollees, participants, and beneficiaries regardless of the plan they are covered by have the same rights to access information and any barriers to access should be discussed and eliminated. Without the disclosure to all interested parties, there is a lack of transparency and therefore, a corresponding possibility for states to avoid compliance with the law and rules. Access to information is critical and we urge CMS to enact and finalize similar provisions in the Medicaid sector to ensure that beneficiaries have such access.

**Full access to medical necessity criteria pursuant to §'s 438, 440, 457 is essential.**

We agree with the Proposed Regulations, which are consistent with MHPAEA, requiring that MCOs, PIHPs, and PAHPs make their medical necessity criteria for MH/SUD benefits available to any enrollee, potential enrollee, or contracting provider upon request. However, we are concerned with the language that finds an MCO, PIHP, or PHAP in compliance with the Proposed Regulations if it disseminates its practice guidelines.<sup>30</sup> After reviewing the appropriate regulations that govern "Practice Guidelines,"<sup>31</sup> it is unclear whether the practice guidelines set forth the actual medical necessity criteria applied to the MH/SUD benefits. If an enrollee, potential enrollee, or contracting provider cannot access the actual medical necessity criteria, it is difficult for them to determine how the medical necessity criteria will be applied to their benefits and whether the criteria are in compliance with the law and its rules. Therefore, we request clarification that these Practice Guidelines are deemed the medical necessity criteria and that they provide sufficient detail that anyone could determine the specific basis as to why a benefit was denied.

We also seek clarification as to whether these Practice Guidelines set forth the appropriate medical necessity criteria related to medical/surgical benefits. If there is no way for enrollees to access the medical necessity criteria related to medical/surgical benefits, enrollees cannot review issues related to compliance with MHPAEA. ERISA participants and participants and beneficiaries of individual plans have other rights to access this information. Medicaid enrollees also should be provided access to this information.

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<sup>29</sup> Id.

<sup>30</sup> 42 CFR 438.915(a).

<sup>31</sup> 42 CFR 438.236(c).

The Proposed Regulations also do not address the disclosure of processes, strategies, evidentiary standards, and other factors used in applying the medical necessity criteria to MH/SUD benefits. Processes, strategies, evidentiary standards, and other factors are generally embedded in the medical necessity criteria and are essential in understanding how the medical necessity criteria is applied to determine if MH/SUD benefits are covered given the patient's condition. It is important to make this clarification to ensure transparency.

Finally, the Proposed Regulations do not discuss the disclosure of NQTLs other than medical necessity criteria. Without this information it is not possible for enrollees, potential enrollees, and contracting providers to analyze a plan's compliance with MHPAEA. It is important to review the means by which an enrollee can access information related to all NQTLs so that they can understand their benefits and assure compliance with MHPAEA.

***Reasons for denials pursuant to §§ 438, 440, 457 must be specific.***

The Proposed Regulations also address the provision by an MCO, PIHP, or PHAP of a reason for a denial for MH/SUD services to the enrollee. We acknowledge that the claims procedure regulations under 29 CFR 2560.503-1 do not apply to Medicaid and that Medicaid has its own regulations regarding a reason for denial. However, the regulations for non-Medicaid plans are dramatically different than the regulations that govern Medicaid services and provide a more complete and reasoned denial for the beneficiary. While Sections 438.404 and 431.210 and those at §457.110 and 457.1103 provide that a reason for denial must be provided to the enrollee, the regulations do not require much more. Section 2560.503-1 does just the opposite. Section 2560.503-1, in combination with 29 CFR 2590.715-2719, provides that a reason for denial must be specific and provided in a patient-centered manner. This reason must be provided in a notice of adverse benefit determination, which meets requirements that include (without limitation) the following:

- The plan must disclose the provisions relied upon in making the denial and all information necessary to perfect the claim.
- Notices must include information sufficient to identify a claim (including the date of service, provider name, claim amount (if applicable), and availability of the diagnosis and treatment codes).
- The reason for denial must include the denial code and its meaning and a description of the standard used in denying the claim.
- If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement must be made that such internal rule, guideline, protocol or similar criterion must be provided upon request.
- For denials based on medical necessity, the health plan must provide an explanation of the scientific or clinical judgment used to make the decision, applying the terms of the plan to the participant's medical circumstances. Based

on this provision, the denial should be specific to the participant or beneficiary and provide the reasons why the prescribed service is not medically necessary for the particular participant or beneficiary.

- The notice provided by the health plan should be provided in a manner calculated to be understood by the claimant.

Medicaid enrollees, who are on average more vulnerable than non-Medicaid enrollees, should be afforded the same protections and considerations afforded to participants and beneficiaries of ERISA and individual health plans. Without similar protections, there is a danger that Medicaid enrollees will not be able to access medically necessary health benefits. The Department should use its authority under §1902(a)(4) to ensure that Medicaid enrollees are similarly protected.

**Access to plan information is essential.**

The MHPAEA Final Rules state that ERISA participants can access instruments under which the plan is established or operated within 30 days of a request for such information. These instruments include the medical necessity criteria related to both MH/SUD and medical/surgical benefits and the processes, strategies, evidentiary standards, and other factors used to apply an NQTL to benefits under the plan, regardless of whether there is a claim or an adverse benefit determination. In addition, although not specifically stated in the Final Rules, this ERISA disclosure right applies to the disclosure of **all** instruments under which a plan is established and operated, including documents related to the establishment of financial requirements, QTLs, all NQTLs (not just medical necessity criteria), and any documents or instruments that may be deemed proprietary or commercially valuable. This right to information allows ERISA participants the unique ability to understand their health plan benefits and affords them the opportunity to assure that their plan benefits comply with MHPAEA. To our knowledge, there is no parallel provision, which gives enrollees the same broad-based right of access to plan documents. This is problematic in some cases, as the enrollee would be unable to access certain NQTL information (other than the medical necessity criteria related to the MH/SUD benefits). Without complete and parallel access to plan information, compliance cannot be tested and full transparency cannot be achieved.

Medicaid enrollees should also have access to information necessary to appeal a denial of benefits. Pursuant to the claims procedure and internal claims and appeals and external review processes regulations, a claimant has the right to access copies of all documents, records, and other information relevant to a claim for benefits.<sup>32</sup> This includes the medical

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<sup>32</sup>See 29 CFR 2560.503-1(h)(2)(iii), which provides that a plan's claims procedures must:

Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section[.]

necessity criteria related to MH/SUD and medical/surgical benefits following an adverse benefit determination, but is not limited to medical necessity criteria.<sup>33</sup> The information to be provided by a plan administrator or health insurance issuer must be documents of a comparable nature with information on medical necessity for both MH/SUD and medical/surgical benefits (including processes, strategies, evidentiary standards, and other facts used to apply NQTLs).<sup>34</sup> CMS should use its authority to issue regulations and guidance that affords Medicaid enrollees the same right to access information upon a review or appeal of a denied claim.

**Clarification of the coverage unit and the combined rule provisions is needed.**

The Final Rules under MHPAEA provide for a definition of “coverage unit” and a “combined rule.” Under the Final Rules of MHPAEA, a coverage unit is defined as, “the way in which a plan (or health insurance coverage) groups individuals for purposes of determining benefits, or premiums or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.”<sup>35</sup> The combined rule requires plans to look at a participant or beneficiary’s coverage as a whole unit when determining compliance with the law and rules.<sup>36</sup> This requirement was developed so that a health plan or employer could not evade the law by offering medical/surgical and MH/SUD benefits through different entities or plans. In the context of the Final Rules, the term “coverage unit” and the “combined rule” are essential constructs for proper application of the general parity rule and also serve to foreclose evasion of MHPAEA through benefit design.

In the Proposed Regulations, the definitions of “aggregate lifetime dollar limit” and “annual dollar limit” remove reference to “coverage unit,” and there is no combined rule. We assume that CMS removed the reference due to the fact that a coverage unit for purposes of ERISA and individual plans is not the same as a coverage unit for purposes of Medicaid. However, we seek clarification as to whether this is truly the case. While Medicaid does not group individuals for purposes of determining benefits based on their single, married, or family status, they do have coverage units that determine benefits. We think it is important, just as in the Final Rule, for the Medicaid rules, to delineate the criteria that define the appropriate unit(s) of analysis for parity purposes. This is especially so where the state has more than one MCO arrangement (regardless of whether they are SSCs or MSC arrangements) and where individuals can be assigned to the MCO on the basis of criteria established by the state without beneficiary choice.

As an example: A state has two MCO arrangements. This example presumes each is a separate ‘coverage unit’ based on what the language at §438.905 implies, which is that each MCO

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<sup>33</sup> 29 CFR 2590.712(d)(3).

<sup>34</sup> See 78 FR 68247-68248.

<sup>35</sup> 29 CFR 2590.712(c)(1)(iv).

<sup>36</sup> 78 FR 68250.

arrangement stands alone. Both MCOs have full responsibility for all MS and MU/SUD services, albeit they have different levels of coverage for both categories, but all are in compliance with parity. The criteria for assignment to one or the other is determined based on claims/cost experience for the last 12 months. Beneficiaries below a certain dollar amount threshold are assigned to the first and those above the threshold are assigned to the second. (Of course, criteria for assignment could vary.) In this example, while both MCO arrangements meet the parity tests, the range of MH/SUD services available under the two vary considerably.

If this is permissible under the Proposed Rule, then, in our view, what is at issue are the eligibility criteria the state establishes for assignment and the lack of beneficiary choice. Can the eligibility criteria be discriminatory? Are they applicable tests for same?

Our reading of the proposed rule language is that the provisions under §438 and §440 are silent on this matter. However, the language governing the CHIP program at § 457.496(f) suggests that there is a coverage unit/combined rule:

If, under an arrangement or arrangements to provide CHIP state plan benefits any enrollee can simultaneously receive coverage for medical/surgical benefits and coverage for mental health or substance use disorder benefits, then the requirements of this section apply separately for each combination of medical/surgical benefits and of mental health or substance use disorder benefits that any enrollee can simultaneously receive from the state Medicaid agency.

This language mirrors the combined rule language of the FR but is not a regulatory construct under §438 and §440. While we would not project that a state would pursue a course of structuring MCO arrangements that would select against high cost and MU/SUD individuals, our reading suggests it is plausible under the Proposed Regulations.

We recommend that clarification of the coverage unit and combined rule provisions of the Final Rule be provided. Our concerns may not have merit, but we would request clarification as to the oversight of eligibility/assignment criteria that would preclude selection against a group of individuals.

**Prescription drugs must be a priority.**

The Medicaid final rule must reaffirm that the application of more stringent quantitative and non-quantitative treatment limitations to MH/SUD medications than those applied to medical/surgical medications are violations of federal law. Careful review of all documentation of compliance with respect to all applicable FRs, QTLs and NQTLs for this benefits classification is essential.

The APA appreciates that federal agencies, including CMS, have issued bulletins on improving access to addiction medications, but that guidance is insufficient. State Medicaid programs

are still often imposing discriminatory limitations on medications for mental health and particularly substance use disorders. Such restrictions may include, but are not limited to:

- Limits on dosage not based on clinical guidelines;
- Non-coverage of one or two of only three Food and Drug Administration (FDA) approved medications to treat opiate/alcohol dependence;
- Lifetime limits on certain addiction medications not imposed upon other medications covered under the plan;
- Complex initial prior authorization and reauthorization requirements that become more stringent with each reauthorization period; and
- Limited coverage for counseling while requiring counseling as a preauthorization/reauthorization requirement.

Medications are essential to successful treatment of MH/SUD disorders and the application of the Medicaid Parity rule promises to correct many of these limitations, which will not pass muster under the regulatory tests. This should be a priority area, albeit its complexity, for the states to analyze, and transparency as to the documentation of compliance for this benefits classification is essential.

**Access to out-of-network providers should be acknowledged as an NQTL.**

The Proposed Regulations eliminate the in-network and out-of-network distinctions for the inpatient and outpatient benefit classifications. We concur with the rationale for this and the stipulation that access to out-of-network providers is a non-quantitative treatment limitation. However, we have questions about the language at §438.910(d)(3) that provides:

(3) *Application to out-of-network providers.* Any MCO, PIHP or PAHP providing access to out-of-network providers for medical/surgical benefits within a classification, must use the **same** processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for MH/SUD benefits. If as MCO, PIHP or PAHP is found to be in compliance with §438.206(b)(4), it will be **deemed in compliance** with the standards of (d)(3).

We think some clarification is required. First, the use of the word *same* in the proposed codification may cause some confusion inasmuch as the NQTL regulatory test requires comparability of factors and that the factors be applied no more stringently. We would advocate that the word *same* is appropriate here given the significance of the access issue when an MCO, PIHP, or PAHP cannot otherwise provide the services. Second, we urge CMS to promulgate guidance regarding how the NQTL rule would operate, with emphasis on examples that illustrate when the rule is not being complied with. Third, we would emphasize that the status of this out-of-network matter as an NQTL presumes that compliance with the regulatory test will be documented.

Last, the proposed language stipulates that compliance with §438.206(b)(4) creates deemed status for compliance with §438.910(d)(3). However, the language at §438.206(b)(4) does not stipulate the same requirements. So if compliance with §438.206(b)(4), which does not stipulate the two paragraphs on the NQTL requirement that appears in §438.910(d)(3) is seemed to satisfy the NQTL test, then the intent of §438.910(d)(3) is thwarted. We would respectfully request clarification of this apparent conflict of language.

**Network adequacy must be clarified as being an NQTL.**

We think the Final Rules should make clear that network adequacy is an NQTL. We understand that the NQTL illustration list is not all inclusive, but this is a critical matter and deserves emphasis. States and Medicaid MCOs have critical requirements at 42 CFR § 438.206, Availability of services; and at § 438.207, Assurances of adequate capacity and services. These provisions are at the heart of network adequacy.

It has been our experience that there is often confusion about network adequacy as an NQTL. This most often arises in provider network situations we would deem inadequate. As you know, the MHPAEA Final Rule provides the following discussion in its Preamble:

These final regulations make clear that, while an illustrative list is included in these final regulations, all NQTLs imposed on mental health and substance use disorder benefits by plans and issuers subject to MHPAEA are required to be applied in accordance with these requirements....specifically, plan standards, such as in- and out-of-network geographic limitations, limitations on inpatient services for situation where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, **and network adequacy**, while not specifically enumerated in the illustrative list of NQTLs, must be applied in a manner that complies with these final regulations.<sup>37</sup>

We recommend that issuance of the Medicaid Final Regulations echo this clarification.

**We support CMS's utilization management decision.**

We concur with CMS's decision in the Proposed Regulations to eliminate 42 CFR §456.171 and the clarification that utilization management of inpatient services in the mental hospitals, regardless of setting, is permissible so long as the standards and processes are consistent with the regulatory test for NQTLs. MHPAEA clearly requires removal of this provision since there is no comparable regulatory provision for medical/surgical admissions. Even if there were a similar provision for medical/surgical utilization review, it would still require an appropriate NQTL analysis.

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<sup>37</sup> 78 FR 68246.



In conclusion, we appreciate having this opportunity to make these comments and hope you will give our recommendations due consideration.

Sincerely,

A handwritten signature in blue ink that reads "Saul Levin MD, MPA". The signature is fluid and cursive, with the first name "Saul" being the most prominent.

Saul Levin, MD, MPA  
CEO and Medical Director



May 26, 2015

To whom it may concern:

Please find attached descriptions for CARF-accredited program categories that are "long-term care" in nature, outside the boundaries of nursing home care, and have revenue streams from both Medicaid and commercial insurance for payment of services. It is our understanding that this information may help provide clarity to what is defined as "long-term care" as it relates to the application of The Mental Health Parity and Addiction Equity Act (MHPAEA) and a current request for comments on CMS-2333-P, Application of MHPAEA to Medicaid and CHIP.

The following is an illustrative listing of programs currently accredited by CARF, extracted from our database on the funding sources identified by the providers, as long term in nature, for those specific programs and when the payers for such services are both Medicaid and commercial insurance payers.

Behavioral Health Programs:	Companies:
Assertive Community Treatment .....	35
Community Integration .....	58
Day Treatment .....	48
Inpatient Treatment .....	17
Integrated Behavioral Health/Primary Care .....	10
Intensive Outpatient Treatment .....	140
Outpatient Treatment .....	916
Partial Hospitalization .....	15
Residential Treatment .....	82
Supported Living .....	23
<b>Employment and Community Services Programs:</b>	
Community Employment/Employment Supports.....	64
Community Employment/Job Development.....	73
Community Employment/Job Supports.....	7
Community Integration .....	44
<b>Medical Rehabilitation Programs:</b>	
Comprehensive Inpatient Rehab – LTAC Hospital .....	11
Comprehensive Inpatient Rehab – Skilled Nursing.....	16
Home and Community Services .....	20
Interdisciplinary Pain – Inpatient.....	3
Interdisciplinary Pain – Outpatient.....	3
Outpatient Rehab – Interdisciplinary.....	181
<b>Opioid Treatment Programs:</b>	
Outpatient Treatment .....	98

I hope this information is constructive to your efforts.

Regards,

Brian J. Boon, Ph.D.  
President/CEO