AMERICA'S ESSENTIAL HOSPITALS

June 9, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

**Ref: CMS–2333–P: Medicaid and Children's Health Insurance Program; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans**

Dear Mr. Slavitt:

America's Essential Hospitals appreciates the opportunity to submit these comments on the above-captioned proposed rule. We support the Centers for Medicare & Medicaid Services (CMS) as it ensures the protections of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) are extended to coverage offered by Medicaid managed care organizations (MCOs), CHIP, and Medicaid Alternative Benefit Plans (ABPs). This is an important step in bringing the existing subregulatory guidance into regulation and to protect access to mental health and substance use disorder (MH/SUD) services. However, America's Essential Hospitals urges CMS to provide robust guidance and oversight to states as they work to comply with the requirements and intent of the MHPAEA.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our more than 250 member hospitals provide a disproportionate share of the nation's uncompensated care and devote about half of their inpatient and outpatient care to Medicaid or uninsured patients. Nearly half of patients at essential hospitals are racial and ethnic minorities who rely on the culturally and linguistically competent care that

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essential hospitals are best able to provide. Our members provide this care while operating on margins substantially lower than the rest of the hospital industry: an aggregate operating margin of -3.2 percent, compared with 5.7 percent for all hospitals nationwide.[1] Through their integrated health systems, members of America's Essential Hospitals offer the full range of primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, MH/SUD services, and wraparound services critical to vulnerable patients.

Members of America's Essential Hospitals understand the importance of providing MH/SUD services and have actively responded to patients with these needs. Many patients who suffer from diagnosable mental illnesses also suffer from preventable physical health conditions.[2] Because behavioral and medical health services often operate in siloes, people who have these types of co-occurring conditions might not receive the treatment they need.

To break through the barriers of these siloes, some member hospitals have integrated MH/SUD services with primary care and other medical/surgical services. Further, through integration, many member hospitals are reducing the stigma of seeking MH/SUD care, targeting appropriate care, and encouraging providers across the continuum of care to communicate and collaborate. A member hospital in New York has developed a model that provides four levels of treatment for patients with co-occurring behavioral and physical ailments. Each facility within the system customizes and adapts care based on the treatment needs of its patients and its provider expertise.

Another member, in Minnesota, identified a distinct group of behavioral health patients who were receiving inappropriate care due to the system's fragmented infrastructure. The hospital observed common misuse of services – for example, primary care instead of necessary specialized care – and issues related to follow-up care. To overcome these challenges, the hospital created a system of customized clinics, including a coordinated care clinic where patients can access both primary care and specialty psychiatric care. Both hospitals utilize a mental health and substance abuse screening process upon enrollment to place patients appropriately. Through such efforts, members of America's Essential Hospitals promote a whole-person care approach despite the significant cost of using integrated care models to provide needed care for these patients.

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[1]Reid K, Roberson B, Landry C, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2013. America's Essential Hospitals. March 2015. http://essentialhospitals.org/wp-content/uploads/2015/03/Essential-Hospitals-Vital-Data-2015.pdf. Accessed May 18, 2015.

[2] Schrag, J. How to Integrate Behavioral Health with Primary Care. America's Essential Hospitals. November 4, 2014. http://essentialhospitals.org/quality/how-to-integrate-behavioral-health-with-primary-care/. Accessed May 18, 2015.

As CMS considers its current and future requirements to ensure coverage of and access to MH/SUD services for the Medicaid population, we urge the agency to consider the following comments.

1. CMS should provide robust guidance and oversight to ensure states and MCOs fully comply with the parity requirements of the MHPAEA.

**To ensure equity across states in the provision and coverage of MH/SUD services, CMS should provide robust oversight to states as they work to comply with MHPAEA requirements.** CMS proposes to allow states the flexibility to decide how to ensure MCOs, CHIP, and ABPs comply with the MHPAEA parity requirements. While the association commends CMS for considering state flexibility, there is concern that too much flexibility could lead to an imbalance among states in the approaches they take in determining compliance with the MHPAEA parity requirements.

By allowing states to ensure compliance, the proposed rule also places a significant administrative burden on states. This is particularly true for states that provide medical/surgical benefits and MH/SUD benefits through different delivery systems. States will have to develop an approach to measure whether the plans are in compliance. The Medicaid program is a federal-state partnership and, as the federal partner, **CMS should provide robust guidance and oversight to states as they make compliance determinations. This would guarantee that states and plans are truly providing and covering MH/SUD benefits vital to Medicaid and CHIP beneficiaries.**

2. CMS should ensure that plans do not use administrative processes to deny care to beneficiaries.

**CMS should protect access to MH/SUD care to beneficiaries by ensuring plans are not able to use administrative processes or hurdles to deny care for services.** CMS proposes that plans subject to parity requirements will have to make available medical necessity criteria and reason for denial of payment for services to beneficiaries seeking MH/SUD care. CMS notes that extending this requirement for MH/SUD services should not present a significant administrative obstacle, because Medicaid and CHIP plans are already required to share this information with beneficiaries upon request.

However, for parity to be meaningful, CMS should provide guidance and oversight to ensure that administrative processes are not used to deny care. In addition to requiring that standards be made available, CMS should also require that medical necessity criteria and reason for denial of payment standards are no more stringent than for other types of covered services. This is particularly important for the Medicaid population, who may not have the knowledge or resources to advocate for themselves as they seek needed care. There is precedent of this type of

denial, as illustrated by a decision in a Massachusetts court case centered on service denial due to issues of prior authorization.[3] **CMS, with its state partners, must ensure plans do not leverage administrative processes to deny care to protect access and coverage of MH/SUD services.**

3. CMS should ensure states are complying with the MHPAEA and accurately accounting for the costs associated with providing MH/SUD services, so that payment rates to plans are actuarially sound and preserve access to providers.

**CMS must confirm that states, as they come into compliance with the MHPAEA, are initiating and conducting annual end-of-year reconciliations of the increased costs of MH/SUD services into MCO capitation rates.** Payment rates must be actuarially sound to ensure that plans can viably cover the needs of Medicaid beneficiaries and are able to appropriately reimburse providers for their services. This is especially important as plans expand MH/SUD benefits to comply with MHPAEA requirements. Without such assurances, providers' ability to participate in meeting the needs of program participants and, therefore, access to care, can be seriously jeopardized. Ensuring that Medicaid managed care plan rates are actuarially sound is an essential component of a strong, efficient, and effective Medicaid program.

The vital link between adequate reimbursement for Medicaid providers and access to care for Medicaid beneficiaries cannot be overstated, particularly with the significant expansion of Medicaid coverage under the Affordable Care Act. When Medicaid rates drop too low, many providers choose not to treat Medicaid patients, and those that do are often forced to shift the unreimbursed Medicaid costs onto other payers. While essential hospitals can continue to be relied on to serve the Medicaid population, their ability to do so when they are compensated well below cost becomes severely compromised, directly impacting the care available to Medicaid patients. In short, through a reduction in either the number or capacity of providers serving Medicaid patients, inadequate Medicaid rates restrict beneficiaries' access to care, particularly as compared with the access available to the general population.

As plans broaden their networks to include MH/SUD services to comply with MHPAEA requirements, it is vital that plans are paid actuarially sound rates in order to provide access to these services. Plans and providers have been concerned about the timeliness of rate-setting, noting that states have sometimes delayed updating rates long after requiring new services. Further, in many states there is an overall lack of transparency in state rate-setting processes. **As such, CMS**

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[3] *Ashley Shaw v. Secretary Of The Executive Office Of Health & Human Services & Another*, 71 Mass. App. Ct. 218 (2008), http://masscases.com/cases/app/71/71massappct218.html.

**should ensure states are accurately accounting for the costs associated with MHPAEA compliance to guarantee that payment rates for MH/SUD are actuarially sound and access to providers is preserved.**

4. CMS should continue its efforts to protect access to MH/SUD services by extending the MHPAEA parity requirements to all delivery systems within the Medicaid and CHIP programs.

**CMS should extend the MHPAEA parity requirements to all Medicaid and CHIP coverage options to protect access to vital MH/SUD for all beneficiaries.** The application of MHPAEA parity requirements to MCOs, CHIP, and ABPs signals the importance of these services to the Medicaid population. MH/SUD benefits are a significant part of whole-person care, providing coordinated care for all aspects of a patient's needs. This is especially true for the Medicaid population, which has a high prevalence of MH/SUD care needs, along with other physical ailments. However, MHPAEA parity requirements have yet to be applied to fee-for-service (FFS) Medicaid or for CHIP enrollees covered by Early and Periodic Screening, Diagnostic and Treatment (EPSDT). MHPAEA parity requirements also have yet to be extended to Medicare MCOs that manage coverage for dual eligibles, patients that are eligible for both Medicare and Medicaid coverage. The association is concerned about the assumption that the FFS and EPSDT delivery systems are already meeting parity standards. With state variation in the structure and delivery of benefits, that is not always the case. This was illustrated in Massachusetts with the district court ruling in *Rosie D. v. Romney*. In that case, the court found the state in violation of EPSDT standards because the state denied medically necessary mental health services to a number of children and adolescents.[4]

Without requiring the Medicaid and CHIP programs to wholly comply with MHPAEA parity requirements, we are concerned that a system could be created in which enrollees covered by MCOs, CHIP, and ABPs receive one set of benefits, while FFS and EPSDT enrollees receive another. It is vital that MH/SUD parity is required and equitable throughout Medicaid and CHIP coverage for all beneficiaries. **As such, CMS should work to bring all facets of Medicaid and CHIP coverage into compliance with the parity requirements of the MHPAEA.**

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[4] *Rosie D, et al. v. Mitt Romney, et al*, 410 F. Supp. 2d 18 U.S. Dist. (D. Mass., 2006), https://www.law.berkeley.edu/files/RosieD_v_Romney_410_f_supp2d_18.pdf.

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Beth Feldpush, DrPH, senior vice president of policy and advocacy, at 202-585-0111.

Sincerely,

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President and CEO