June 8, 2015

Centers for Medicaid and Medicaid Services
Department of Health and Human Services
Attn: CMS-2333-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organization, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans.

Dear Secretary Burwell:

We the undersigned organizations are pleased to submit comments on CMS' proposed rule applying mental health parity to Medicaid managed care organizations, Medicaid Alternative Benefit Plans, and CHIP. We commend CMS for the specificity and comprehensiveness of the proposed mental health parity rule. Further, we applaud CMS' requirements to extend the proposed rule regardless of whether mental health and substance use disorder (MH/SUD) services are provided by a managed care organization or through another delivery system. We do, however, urge you to emphasize mental health and primary care integration as a key principle underlying parity protections for children and adolescents, especially in carve-out arrangements. Publication of these rules has the potential to substantially improve access to mental health and substance abuse services. Our comments highlight specific areas of concern related to children and adolescents, including the exemption of fee-for-service (FFS) enrollees, the definition of MH/SUD conditions and services, and the presumption that EPSDT meets proposed parity requirements. We offer specific suggestions regarding the proposed rule and its oversight.

1. Application of Proposed Rule to Child and Adolescent Enrollees in Fee-for-Service Arrangements

We recognize that through this proposed rule CMS would extend the application of mental health parity to the vast majority of Medicaid and CHIP enrollees. However, the proposed rule excludes parity protections for children and adolescents receiving Supplemental Security Assistance (SSI) and foster care assistance as well as other children with chronic MH/SUD conditions, who are in FFS arrangements. We urge CMS to reconsider this exclusion, at least for children and adolescents. According to the 2013 SSI Annual Statistical Report, 1.3 million children and adolescents (10 to 18) were receiving SSI, and two thirds of them have mental disorders.[1] The Adoption and Foster Care Analysis and Reporting System reports that 402,000 youth were in

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

foster care in 2013,[2] and more than 60% of these youth have a mental health condition.[3] Many of these vulnerable children and adolescents, as well as others in waiver programs, continue to receive Medicaid coverage through FFS arrangements. We do not believe that Congress meant to exclude these children and adolescents, who are certainly among the most in need.

2. Development of Actuarially Sound Rates to Comply with Mental Health Requirements

In developing actuarially sound rates to comply with the proposed mental health parity requirements, we recommend CMS instruct states to establish cost rates specifically for children and adolescents. This is necessary for two reasons: 1) to assure sufficient participation from child and adolescent psychiatrists, psychologists, social workers, psychiatric clinical nurse specialists/psychiatric nurse practitioners, and substance abuse counselors; and 2) to recognize the amount of MH/SUD services provided by pediatric medical providers who are seldom recognized as MH/SUD service providers, particularly in states using mental health carve-outs. Further, we urge CMS to require states to take into account the range and intensity of MH/SUD services covered under EPSDT in establishing actuarially sound rates for this age group.

3. Presumption that EPSDT in Medicaid and CHIP State Plans will Meet Proposed Parity Requirements

We urge CMS to amend the proposed rule to incorporate EPSDT as a medical/surgical service with the same parity requirements that are applied to other Medicaid and CHIP services. Based on the number of EPSDT class action lawsuits pertaining directly to the lack of intensive home and community-based services for Medicaid-insured children and adolescent with serious emotional impairments,[4] we cannot agree with CMS that required compliance can be presumed in EPSDT, despite the broad scope of medically necessary MH/SUD screening, diagnostic and treatment services mandated under this benefit.

4. Definition of Mental Health and Substance Use Disorders and Services in Medicaid

We strongly recommend that CMS define the scope of MH/SUDs under the final parity rule to be consistent with the psychiatric diagnoses listed in the new DSM-5 and also in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. We also recommend that CMS define Medicaid's medical/surgical outpatient services specifically for children and adolescents to ensure consistent implementation of the proposed requirements. This is important since states have used so many different mandatory and optional benefit categories to cover outpatient MH/SA services for children and adolescents – eg, physician services, outpatient hospital services, FQHC services, rural health clinic services, EPSDT, other practitioner services, nurse practitioner services, occupational services, and rehabilitative services. We also recommend that the proposed rule retain long term care services for children and adolescents in the definition of medical/surgical services. Many Medicaid-insured children and adolescents receive MH/SUD services in home and community-based

[2] *The AFCARS Report.* Washington, DC: Administration for Children and Families, July 2104.
[3] *Health Care of Youth Aging Out of Foster Care.* Elk Grove Village, IL: American Academy of Pediatrics, 2012.
[4] EPSDT lawsuits related to the lack of intensive behavioral health services have been filed in Massachusetts (Rosie D), California (Kate A and Emily Q), and Washington (T.R.)

alternative settings, including inpatient psychiatric services for individuals under age 21, because of the therapeutic significance of these treatment sites.

5. Application of Proposed Parity Rules to Non-Quantitative Treatment Limits

We applaud CMS for providing detailed examples of non-quantitative treatment limits (NQTLs) and for eliminating in-network and out-of-network distinctions. We request that CMS, in its final rule, offer direction to states about NQTLs as they relate specifically to children and adolescents and also provide relevant examples. Of particular significance are NQTLs pertaining to pediatric formularies, standards for network adequacy of child and adolescent providers, policies for accessing child and adolescent MH/SUD services that are out-of-network, and EPSDT medical necessity and prior authorization policies for MH/SUD services.

6. CMS and State Medicaid Oversight Activities to Ensure Compliance with Parity Requirements

We urge CMS in its final rule to specify oversight of children and adolescents as a distinct population group. We also encourage CMS and state Medicaid agencies to obtain input on parity oversight activities from child and adolescent MH/SUD providers, including pediatric medical providers. In addition to monitoring states' definition of MH/SUD conditions and services for children and adolescents, we strongly urge that CMS and states regularly monitor pediatric MH/SUD network adequacy, MH/SU access standards for children and adolescents (including inpatient admission), EPSDT service coverage mandate and prior authorization criteria, data showing number of and reasons for child and adolescent denials, and pre and post utilization patterns by children of intensive home and community-based services, and inpatient MH/SA services.

We would welcome the opportunity to work with you on implementing and monitoring the application of mental health parity to low income and disabled children and adolescents who are covered by Medicaid and CHIP. If you require any additional information or have any questions, please contact Peggy McManus at The National Alliance to Advance Adolescent Health by e-mail at mmcmanus@thenationalalliance.org or by phone at (202)223-1500.

The National Alliance to Advance Adolescent Health
Ambulatory Behavioral Healthcare
American Academy of Pediatrics
American Academy of Child and Adolescent Psychiatry
American College Health Association
American Federation of State, County, and Municipal Employees
American Foundation for Suicide Prevention/SPAN USA
American Group Psychotherapy Association
American Nurses Association
American Orthopsychiatric Association
America's Essential Hospitals

Autism Speaks
Boston Children's Hospital, Division of Adolescent and Young Adult Medicine
Children's Defense Fund
Children's Health Fund
Children's Home Society of America
Children's Leadership Council
Children Now
Clinical Social Work Association
DC Chapter, American Academy of Pediatrics
Family Voices
First Focus
NAADAC, The Association for Addiction Professionals
National Alliance on Mental Illness
National Association of Pediatric Nurse Practitioners
National Association of Social Workers
National Health Care for the Homeless Council
National Hispanic Medical Association
School-Based Health Alliance
School Social Work Association of America
Society for Adolescent Health and Medicine
The Children's Partnership
The Jewish Federations of North America