



AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

June 9, 2015

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
ATTN: CMS-2333-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Tavenner:

The American Psychological Association Practice Organization (APAPO) appreciates the opportunity to comment on proposed regulations (80 FR 19418, published April 10, 2015) applying the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to health insurance coverage offered by Medicaid managed care organizations (MCOs), the Children's Health Insurance Program (CHIP), and Medicaid alternative benefit plans (ABPs). The APAPO is an affiliate of the American Psychological Association (APA), the largest scientific and professional organization representing psychology in the United States. APA's membership includes more than 122,000 clinicians, researchers, educators, consultants and students.

APAPO supports the application of strong MHPAEA parity protections to Medicaid enrollees receiving services in MCOs, ABPs, and for children and women enrolled in the CHIP, and we believe the proposed rule largely meets this goal. Medicaid has long been the single largest source of insurance payments for mental health services. Consequently, it is imperative that its policies ensure parity of coverage for its beneficiaries, estimated at 70 million Americans.

We support the proposed rule's requirement that MHPAEA protections be applied to all enrollees in Medicaid MCOs, regardless of whether mental health and substance use disorder (MH/SUD) services are provided through the MCO or through another service delivery system or contract, such as prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), or fee-for-service programs. Without this requirement, states and managed care

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companies would be able to meet MHPAEA requirements by reconfiguring contracts, instead of by increasing access to mental health services. We also support your decision not to extend MHPAEA's cost exemption provision to Medicaid and CHIP plans, and to allow inclusion of the cost of providing MH/SUD services beyond those specified in state plans within the payment rates developed for MCOs, pre-paid inpatient health plans (PIHPS), and pre-paid ambulatory health plans (PAHPs) that provide MH/SUD services, to enable them to come into compliance with MHPAEA.

However, APAPO and other parity stakeholders have had years of experience in trying to enforce MHPAEA provisions within private sector health insurance plans, and as a result of this experience we are concerned that the proposed rule for MHPAEA application to Medicaid MCOs does not establish an adequate framework for effectively enforcing compliance. Implementation of the Affordable Care Act (ACA) is severely taxing federal and state agencies with complex responsibilities, leaving them with scarce resources to enforce parity. This makes it imperative that CMS provide clear, sufficient, structured guidance to states on how to investigate the often complex question of whether mental health services are being provided at parity with medical/surgical services, and to take enforcement action when necessary. Additionally, as explained below, parity stakeholders must be provided with enforcement action information in order to effectively advocate for the protection of Medicaid beneficiaries, who often do not have a full understanding of their rights under MHPAEA.

We have the following specific recommendations for strengthening the proposed rule.

Enforcement Responsibility

Effective enforcement of MHPAEA requirements is essential to the success of the law. We believe the rule should be strengthened by providing more specificity regarding the monitoring, documentation, and enforcement required to ensure compliance. There are three ways the proposed rule should be strengthened in this area:

- Invest in vigorous interagency collaboration on parity enforcement and compliance initiatives, including ongoing information sharing and technical assistance. The Departments of Labor, Treasury, and Health and Human Services have accumulated a wealth of experience in jointly enforcing MHPAEA in the private insurance/self-insured market, as have some of the state insurance agencies. We have serious concerns about the ability of CMS to effectively carry out this role for state Medicaid programs largely on its own, given its many current responsibilities and meager resources. In light of this, we encourage CMS to provide detailed guidance to state Medicaid programs on the information requirements, documentation, and reporting required to effectively demonstrate compliance. Similarly, we encourage CMS to issue guidance recommending that states develop interagency compliance enforcement initiatives that draw on the expertise of state insurance agencies, which have taken the lead on enforcement of MHPAEA within private sector health insurance plans.
- Require that states provide documentation to CMS—and to stakeholders—showing how the MCO, PIHP, and PAHP contracts used are in compliance with the requirements

subpart K. The proposed rule allows CMS to defer federal financial participation on expenditures for MCO contracts that are not in compliance with MHPAEA requirements. However, we are concerned that this enforcement mechanism is unlikely to be used, given its extraordinary nature. We believe that sharing documentation with both CMS and with stakeholders will encourage compliance, and make it easier to hold both MCOs and state Medicaid agencies accountable for providing beneficiaries with parity of access to MH/SUD services.

Performance-based Parity Enforcement

We believe that the most important area of enforcement is with respect to non-quantitative treatment limitations (NQTLs), for the obvious reason that limitations that are not directly quantifiable are much harder to identify and address. Moreover, NQTL issues are the primary parity problems we see with private insurance. There are several different ways that managed care plans can restrict access to mental health and substance abuse services while appearing to adhere to MHPAEA requirements regarding quantitative coverage limits, including by reducing reimbursement rates for mental health service providers, restricting participation on provider panels, using “phantom panels” which include providers who are not actually participating in the health plan, increasing utilization review rates, and increasing service denial rates.

In order to allow comparison of the effects of non-quantitative treatment limitations on access to care for the two categories of medical/surgical treatment and mental health and substance use disorder treatment, the building blocks and effects of NQTLs must be turned into numbers. We believe the proposed rule would be greatly strengthened by requiring MCOs, ABPs, and CHIP programs to cooperate with State Medicaid agencies in developing performance-based measures of parity of access to care in addition to measures focusing on plan processes. Performance-based measures—such as survey data on average wait times for services, difficulty in finding participating providers, and rates of use of specific mental health and substance use disorder services—could be extremely helpful in identifying gaps in network adequacy in terms of both availability of providers and in the provision of specific services.

Your agency has already adopted extensive surveying requirements state Medicaid agencies must meet under the Medicaid Eligibility Quality Control program, and detailed at §431.810 through §431.822. We also note that your agency proposed collection of access review data, within a new paragraph §447.203(b), as part of the proposed rule on methods for assuring access to covered Medicaid services (76 FR 36342, May 6, 2011). States should be required to collect access review data for mental health and substance use disorder services as part of the final rule on MHPAEA application to Medicaid, ABP, and CHIP programs.

Transparency

Major parity stakeholders, including APAPO, state psychological associations, and other mental health provider and consumer groups, are an essential ally in ensuring the goals of MHPAEA are achieved. These stakeholders are generally very familiar with a plan’s constraints on mental health care, but typically lack access to information on the parallel constraints on medical care.

In situations where the parity enforcement agencies are not able to promptly investigate legitimate parity complaints, the complaining party is left in limbo, with little ability to verify a plan's unsupported assertions that restrictions on mental health care are at parity with medical restrictions. Information regarding enforcement actions should be provided to parity stakeholders. We urge the development of a common methodology for federal and state regulators to provide de-identifiable transparent information on parity compliance investigations in order to encourage uniform compliance practices.

Provider Reimbursement Rates

One of the most direct, immediate, and effective methods health plans use to circumvent prohibitions on NQTLs is through reducing reimbursement rates for mental health services. Reports from our members and basic economics show a direct link between Medicaid reimbursement rates and access to treatment, including for mental health services. Recent health services research has shown that increased Medicaid reimbursements to primary care providers, as established under the Affordable Care Act, were associated with improved appointment availability among participating providers, without generating longer waiting times.¹ It is especially important to guard against inappropriately low reimbursement rates and reimbursement rate reductions for MH/SUD services, as compared to those for other health care services, in promoting parity of access to MH/SUD services within fee-for-service delivery systems for Medicaid ABP benefits.

Unfortunately, excessively low reimbursement rates remain one of the most widely used and unaddressed of mental health parity violations. We have been working to reverse mental health treatment reimbursement rate cuts for several years, and we know that such cuts proliferated after adoption of interim final rules applying MHPAEA requirements to private sector plans. We raised the issue of inadequate reimbursement rates in our April 2013 and January 2104 comments regarding the November 2013 final rule implementing MHPAEA (Final Rule), and in subsequent meetings with the federal parity agencies.

We strongly support the inclusion of the Final Rule NQTLs in the proposed rule, and specifically the inclusion of “standards for provider admission to participate in a network, including reimbursement rates” and “standards for providing access to out-of-network providers” in the illustrative list of NQTLs at §438.910(d)(2). The Medicaid parity rule must retain this definition, and the important explanation of what parity reimbursement means in the preamble to the Final Rule. Without parity in reimbursement, there will not be parity in access to providers.

However, any prohibition against discriminatory reimbursement rates will be meaningless without information on what reimbursement rates are. We believe the proposed rule should require state agencies to collect reimbursement rate information from MCOs, ABPs, and CHIP contractors, consistent with §447.203 and §447.204. This requirement was contemplated in the 2011 proposed rule on methods for assuring access to covered Medicaid services mentioned

¹ Polsky, D., Richards, M., Bassey, S., Wissoker, D., Kenney, G. M., Zuckerman, S., & Rhodes, K. V. (2015). Appointment Availability after Increases in Medicaid Payments for Primary Care. *New England Journal of Medicine*.

earlier. We recommend adoption of the 2011 proposed rule's protections, especially proposed section §447.203(b)(1)(iii)(B) on review of Medicaid payment data, for documenting parity of access to mental health and substance use disorder services and medical/surgical services.

Given the centrality of provider reimbursement rates, data on such rates is essential to enable mental health consumers, providers, advocacy organizations, researchers, and your agency's staff to effectively monitor enforcement. A way to gather this useful information may be to ask the MCOs, ABPs and CHIP contractors for a listing of the top ten most billed codes by diagnosis and the top five providers who bill those codes the most.

We would be happy to meet with the Agencies to discuss refinements to our suggestions above and/or alternative means of achieving the goal we believe you share with us – making the application of MHPAEA to Medicaid Managed Care Organizations more enforceable and of more tangible benefit for mental health patients. Plans should not be allowed to exploit loopholes and lack of enforcement to discriminate against Medicaid beneficiaries with mental disorders, who are often particularly vulnerable.

We appreciate the work that your Department has put into developing the Proposed Rule and we thank you for this opportunity to share our thoughts on this issue. If you have questions please contact Alan Nessman, Esq. at anessman@apa.org or Shirley Ann Higuchi, Esq. at shiguchi@apa.org. They can both be reached at (202) 336-5886.

Sincerely,

A handwritten signature in dark ink, reading "Katherine C. Nordal". The signature is written in a cursive, flowing style.

Katherine C. Nordal, Ph.D.
Executive Director for Professional Practice