

COALITION FOR WHOLE HEALTH

February 21, 2013

Marilyn Tavenner, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: **CMS-2334-P**, Medicaid, Children's Health Insurance Programs, and **Exchanges: Essential Health Benefits in Alternative Benefit Plans**

Dear Administrator Tavenner:

The Coalition for Whole Health is a broad coalition of local, State, and national organizations in the mental health and substance use disorder prevention, treatment, and recovery communities and allied organizations, including other health reform advocates and faith communities. We appreciate the opportunity to comment on the proposed rule detailing standards related to essential health benefits in Medicaid alternative benefit plans. We thank you for your strong commitment to making mental health (MH) and substance use disorders (SUD) a top priority and for working to ensure that Medicaid enrollees with MH/SUD needs receive quality care.

It is extremely important that all individuals gaining Medicaid eligibility under the Affordable Care Act (ACA) receive health coverage appropriate for their needs, including strong coverage for mental health and substance use disorders. It is also important that traditionally Medicaid eligible populations that may be enrolled in alternative benefit plans are guaranteed adequate coverage.

We are extremely pleased that the ACA included a strong focus on MH/SUD, including the requirement that all enrollees in section 1937 coverage, including all adults gaining Medicaid eligibility for the first time, will be guaranteed coverage for MH and SUD at parity with other covered benefits. Strong implementation of these provisions will result in tremendous progress toward addressing the health needs of millions of Americans with untreated mental illness and/or SUD; will prevent these diseases in millions more; and will provide necessary services to those seeking care for or in recovery from mental illness or SUD, in order to improve their health and wellness and allow them to reach their full potential.

We appreciate the proposed rule's explicit recognition of the ACA requirement that alternative benefit plans must provide the benefits required by the EHB, including MH and SUD benefits in a manner consistent with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). We thank CMS for its continued recognition of these critically important ACA requirements.

We also appreciate the language proposing to codify the flexibility HHS has given to States to use the Secretary-approved option in section 1937 to extend comprehensive Medicaid coverage to the newly-eligible expansion population. We strongly believe that extending full Medicaid benefits to this population, supplemented as needed to comply with the EHB, parity, and other protections in the law, is the best approach for meeting the complex health needs of the low-income adults who will gain Medicaid eligibility under the expansion. We urge you to work with States to ensure that this population's full range of SUD/MH needs and other health needs will be met. We also urge you to include language in the final rule that explicitly restates the requirement that all Medicaid alternative benefit plans must cover mental health services and substance use disorder services for all enrollees.

In addition to our support for the above we have several concerns with the proposed rule. The following is a summary of our concerns and our recommendations for the final rule, followed by more detailed comments and recommendations for your consideration.

1. **Individuals with a substance use disorder should be added to the definition of medically frail.** We appreciate that the proposed medically frail definition includes individuals with a serious mental illness and others with serious and complex medical conditions, including those with a disability determination based on Social Security criteria. Individuals with SUD have similar health needs as those included as medically frail. Moreover, under disability law an individual cannot be determined eligible for Social Security's Supplemental Security Income program if that person's SUD is material to the determination of disability, so even those with the most severe SUD would not be considered medically frail under the proposed definition unless they qualified based on a co-occurring health need. We also recommend that the medically frail definition include all individuals that meet the Medicaid Health Home eligibility requirements in section 2703 of the ACA.
2. **Provide additional detail on how the requirements of MHPAEA apply to alternative benefit plans, including details on how to supplement benchmark or benchmark-equivalent coverage to bring it into compliance with parity and how to identify violations in parity compliance.** State decision-makers continue to express confusion and to ask for additional clarity about how to comply with the parity requirements of the law. Effective compliance with and enforcement of parity requirements will not be possible without a final rule on MHPAEA that provides additional guidance on disclosure and transparency, scope of service, non-quantitative treatment limits (NQTLs) and clinically appropriate standards of care. We continue to urge strongly that CMS and HHS release final MHPAEA regulations as soon as possible.
3. The proposed rule says that if a State designs its alternative benefit plan based on a benchmark option that is missing an EHB category, the alternative benefit coverage must be supplemented. However, as with the EHB regulations governing commercial coverage, **CMS fails to identify a threshold to trigger supplementation of a category and instead suggests that a category could include a single service or benefit and still comply with the law. This is contrary to the parity and non-discrimination** requirements of the EHB, as well as the balance requirement, which require a much stronger minimum set of benefits in each category. We ask CMS to clarify what benefits would constitute coverage in each category and explain how the agency intends to enforce the non-discrimination and balance requirements in this context.

4. Although the proposed rule restates the requirement that the EHB be designed in a way that does not discriminate against individuals, the rule does not identify a standard to determine whether the coverage provided complies with those provisions of the ACA. The proposed rule also fails to establish a process to bring discriminatory benefit design into compliance. CMS should identify a clear non-discrimination standard, provide examples to States of what would constitute violations, monitor alternative benchmark coverage for compliance with the non-discrimination requirements, and enforce these provisions of the law.
5. Allow States the flexibility to provide additional benefits beyond those in the benchmark to any or all populations in alternative benefit plans. The proposed rule would prohibit States from providing wrap-around or other additional benefits to newly-eligible adults but allow States to provide additional benefits for other populations in alternative benefit plans.
6. Finally, we urge CMS to reconsider its intended approach to define the EHB for alternative benefit plans based on benefits offered by commercial plans, and instead define a comprehensive federal EHB for section 1937 coverage that all States would be required to use to supplement their chosen benchmark or benchmark-equivalent coverage.

In the following section, we provide further detail on our above recommendations to improve the proposed rule to ensure adequate coverage for mental health and substance use disorders in all Medicaid alternative benefit plans.

- 1. Add individuals with substance use disorders to the definition of medically frail in the final alternative benefit plan rule. We also recommend that the medically frail definition include all individuals that meet the Medicaid Health Home eligibility requirements in section 2703 of the ACA.**

There was considerable concern among health consumer organizations when the Deficit Reduction Act was debated and passed, creating section 1937 and giving States the flexibility to undermine coverage for large segments of their Medicaid populations. Recognizing this view, Congress designed section 1937 in a way that would protect certain vulnerable beneficiaries from mandatory enrollment in benchmark coverage. These populations include medically frail and special medical needs individuals, as defined by the Secretary.

The proposed regulations define individuals who are medically frail or otherwise have special medical needs as including “individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.” We believe that this is a very important protection, and we thank you for including in the medically frail definition individuals with serious mental illness and children with serious emotional disturbances, among the other populations with special health needs. However, we strongly believe that individuals with substance use disorders should be added to the definition of medically frail.

Individuals with SUD have similar health needs as those with the other complex preventable and treatable health conditions identified in the proposed medically frail definition, and they need the same protections. While Medicaid coverage for SUD varies widely across the country, individuals with SUD often need services that benchmark coverage is less likely to provide, but that Medicaid programs typically cover, including family supports and other supportive services, case management, and transportation. In addition, while parity is a critically important protection, treatment limitations and financial requirements that the benchmark coverage may impose on all covered benefits may continue to be a barrier to fully accessing appropriate SUD treatment. We are particularly concerned about benchmark coverage in States that may choose the weakest available benchmark plan option for their alternative benefit plans in an effort to limit perceived financial risk for the State or for political reasons. Indeed, there are several examples of States that have used the flexibility HHS has given them to select the weakest, least comprehensive benchmark plan for their small group and individual market EHB. There are other examples of States with robust Medicaid coverage for SUD that cannot be matched by benchmark coverage. Weaker coverage can result in individuals being placed in clinically inappropriate levels of care, poorer outcomes, and more costs to health care and other State systems. Requiring all States to give beneficiaries with SUD the flexibility to choose the coverage that best meets their individual needs would provide them a needed layer of protection that would improve their health outcomes.

The proposed rule also defines medically frail to include individuals with a disability determination based on Social Security criteria. We agree that those meeting Social Security disability criteria should be considered medically frail under the regulations. However, it is important to note that an individual with SUD, no matter the severity of his or her SUD diagnosis, cannot be considered disabled under Social Security law if his or her SUD is “a contributing factor material to the determination that the individual is disabled.” (SSA section 1614(a)(3)) This discriminatory restriction was included in the Contract with America Advancement Act and has been in place since 1997. As a result, under the proposed definition of medically frail, an individual with even the most severe SUD could not qualify as medically frail on the basis of their SUD. This is in stark contrast to the range of other disabling conditions that would qualify an individual as medically frail under the proposed definition, and the definition must be changed to protect these individuals from mandatory enrollment into coverage that may not be able to appropriately address their health needs.

We appreciate the inclusion of serious mental illness and other conditions and disabilities in the medically frail criteria, but we disagree strongly with the exclusion of SUD from the definition. We urge CMS to expand the definition of medically frail to include individuals with SUD in the final rule.

- 2. Issue additional guidance, including a final MHPAEA rule, detailing how the requirements of parity apply to alternative benefit plans, how States should supplement benchmark and benchmark-equivalent coverage to comply with parity, and how States, providers, and beneficiaries can identify parity violations.**

With the passage of MHPAEA in 2008, Congress sought to end the long history of discrimination against those with MH and SUD needs in health insurance and Medicaid managed care. As you know, the ACA improved on MHPAEA by extending MH and SUD parity requirements to individual and small group health coverage and Medicaid benchmark plans, and by requiring coverage of MH and SUD services in these plans as essential health benefits. We appreciate the recognition in the proposed rule that these EHB and parity requirements apply to all alternative benefit plans.

Unfortunately, over four years after MHPAEA became law, providers and consumers around the country are still experiencing discriminatory treatment access. While the Interim Final MHPAEA Rule and other guidance have provided important help on a number of implementation issues, additional guidance is urgently needed. In particular, there has been very little guidance from CMS—and nothing in regulations—on how to apply parity to Medicaid managed care as required by the law. As a result, there has been very little movement from most States to come into compliance. We appreciate that CMS recently provided some guidance on the application of parity to alternative benefit plans in its recent State Health Official letter. However, much more detail needs to be provided in Medicaid regulations, and a final rule on MHPAEA is needed as soon as possible to provide the full framework needed to fully implement and enforce the various components of MHPAEA and the application of these requirements under the ACA.

Since final MHPAEA regulations are expected to be released after final regulations on both essential health benefits and Medicaid alternative benefit plans are issued, we urge CMS to include in these final ACA regulations significant detail on how the requirements of MHPAEA apply to the EHB and Medicaid benchmark coverage. We appreciate that the proposed rule on alternative benefit plans restates the statutory requirement applying MH/SUD parity to Medicaid benchmark coverage. However, similar to the proposed regulations governing the application of the EHB to commercial plans, there is no additional detail for how parity applies, how to identify violations in parity compliance, or how to supplement benchmark, benchmark-equivalent, or Secretary-approved coverage to bring it into compliance with the parity requirements of the ACA. States will need this information as they move forward to design benefits for their Medicaid expansion populations. We ask that a detailed framework for determining and enforcing parity compliance be included in the final alternative benefits plan rule. This framework should include a list of requirements that alternative benefit plans must meet, including requirements related to disclosure and transparency, scope of services, non-quantitative treatment limitations, and clinically recognized standards of care.

We also ask that final regulations include examples of parity violations and detailed information on how to supplement Medicaid coverage that falls short of the parity requirements of the law. CMS should also review all alternative benefit plans for compliance with the requirements of MHPAEA and work with States to ensure that all financial requirements and treatment limits on the MH/SUD coverage in each of these plans are no more restrictive than the plan's medical/surgical coverage.

Finally, we have concern with some of the parity language in the proposed regulations. The proposed language in section 440.345, under *EPSDT and other Required Benefits*, says "Alternative Benefit Plans that provide both medical and surgical benefits, and mental health

or substance use disorder benefits, must comply with the Mental Health Parity and Addiction Equity Act.” We urge CMS, in a final rule, to revise this language to make it clearer and more accurate. MHPAEA itself does not apply to section 1937 coverage that is delivered in a non-managed care arrangement; rather the ACA extended the protections of the MHPAEA to this coverage, without amending MHPAEA. Specifically, regarding coverage under section 1937 the ACA requires that “the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act (MHPAEA) in the same manner as such requirements apply to a group health plan.” [Sec. 1937(b)(6)] The final regulations should include similar language.

3. CMS should identify a threshold to trigger supplementation of an EHB category that only includes a minimum set of services in a required category and therefore fails to comply with the various consumer-protection requirements of the law. CMS should provide a more detailed framework to ensure that all ten EHB categories will be adequately covered in compliance with the law.

Similar to the proposed rule on the application of the EHB to commercial coverage, the proposed rule on the EHB and Medicaid fails to define the scope of services within the ten required EHB categories and fails to identify a minimum level of coverage allowable for an alternative benefit plan to remain in compliance. The requirement in the proposed rule seems to be that covering any benefit in a given category—no matter how limited—would meet the EHB requirement. Such a minimal requirement is contrary to the parity, balance, and non-discrimination requirements of the law.

The proposed rule makes clear that States may choose the Secretary-approved option in section 1937 to extend the full range of Medicaid State plan benefits to the expansion population, so long as it complies with the other requirements of section 1937. As stated earlier, we strongly support giving States this flexibility. However, States that take this approach need clear regulatory guidance from CMS in order to adjust this coverage to meet the additional requirements of the ACA that apply to alternative benefit plans. States with Medicaid programs that offer weak coverage for certain EHB categories will need to supplement coverage for their benchmark populations to bring that coverage into compliance with the various coverage requirements of the ACA. This is especially important for required essential health benefits that are not universally covered or not always covered well by State Medicaid programs, such as MH and SUD benefits.

Similarly, States have the option to design alternative benefit plans that are benchmark-equivalent plans, or plans that have an aggregate actuarial value that is at least equivalent to the actuarial value of one of the benchmark benefit packages. Within the benchmark-equivalent framework, States have considerable flexibility to reduce or eliminate coverage of certain services, as long as the benchmark-equivalent coverage maintains at least actuarial equivalence. They must, however, cover all EHB categories and meet other requirements of section 1937, including the requirement that they may not reduce the value of the mental health or prescription drug benefit. It appears that under the proposed rule they can reduce the value of other benefits that must be provided as essential health benefits under the benchmark-equivalent option to any level short of elimination. Clear limits on States’ ability

to use benchmark-equivalent coverage to undermine the EHB protections should be included in regulations.

All States should have adequately robust and detailed alternative benefit plans that ensure full coverage of all medically necessary services across the continuum of care in each of the categories, including the MH and SUD category. We urge CMS to ensure that appropriately comprehensive benefits are provided for all categories for all States' section 1937 beneficiaries, regardless of the alternative benefit plan chosen by the State.

4. The final rule should identify a standard to determine whether the coverage provided complies with the non-discrimination requirements of the EHB. The final rule should also establish a process to identify discriminatory benefit design and bring it into compliance, and include enforcement mechanisms.

The proposed rule rightly references the requirement in section 1302(b)(4) of the ACA that directs the Secretary to address the ACA's non-discrimination standards in defining the EHB. These protections are critically important to individuals with MH and SUD, and to others with chronic illnesses and disabilities. We appreciate the recognition in the proposed rule that coverage through alternative benefit plans must meet these non-discrimination requirements. However, like the proposed rule governing the EHB as it applies to individual market and small group coverage, the proposed rule on the application of the EHB to Medicaid benchmark plans does not identify a standard to determine whether the coverage provided complies with these provisions of the law. It also does not establish a process to bring discriminatory benefit design or practice into compliance.

We believe that more clarity on what constitutes discrimination in this context is needed. We urge CMS to develop more detail in the final regulation defining these protections. We also urge CMS to provide a process for bringing a State's chosen benchmark or benchmark-equivalent option into compliance with the law.

5. Allow States the flexibility to provide additional benefits beyond those in the benchmark plan to any and all populations in alternative benefit plans, including the newly-eligible population.

Section 1937(a)(1)(C) gives States the option to provide "such additional benefits as the State may specify." These are benefits that are not included in the selected benchmark but which the State would like covered. Under the proposed regulation, a State may elect to provide additional coverage to individuals enrolled in alternative benefit plans, except for those newly-eligible individuals who are not exempt from mandatory enrollment in benchmark or benchmark-equivalent coverage.

Contrary to the proposed regulations, it does not appear that the ACA prohibits States from providing additional services to the newly-eligible population. Given that this population will have similar health needs as other eligibility groups, and given identified gaps in the continuum of MH and SUD care in certain benchmark plan options, CMS should allow States the flexibility to provide additional services to all enrollees in alternative benefit plans, including the expansion population, without having to go through the additional process

required for Secretary-approved coverage. If CMS determines that the law prohibits States from providing additional benefits to the newly-eligible population, it should allow States the ability to simply add in these benefits using a streamlined process under the Secretary-approved option or through another mechanism.

States may identify deficiencies and gaps in the commercial benchmark plan options that fall outside parity, non-discrimination, EHB, and other requirements. In this situation, a State should be able to add benefits in easily that it wants covered for its expansion population. CMS should provide States with all available flexibility to do so.

6. We continue to have concerns with the approach HHS has taken to define Essential Health Benefits. We ask CMS to reconsider its intended approach to define the EHB for alternative benefit plans based on benefits offered by commercial plans and instead define a comprehensive EHB that applies to all section 1937 coverage that all States would be required to use to supplement their chosen benchmark or benchmark-equivalent coverage.

As we have stated in previous comments on the application of the EHB to commercial plans, we continue to believe that HHS should take a much stronger role in defining specific services in each of the EHB categories that must be covered. A strong federal floor is needed to ensure that beneficiaries in the Medicaid expansion and others that may be enrolled in section 1937 coverage have a basic level of protection in all States. While we understand that a reconsideration in approach is likely not feasible at this late date, we encourage CMS and HHS to adopt a comprehensive, national EHB in 2016, when the trial period for the current approach is complete. We also urge CMS to signal to States that coverage of comprehensive benefits in each of the EHB categories is required, and to work with States to ensure this minimum standard of coverage is met.

Thank you again for the opportunity to provide comments on the proposed rule on Essential Health Benefits in Alternative Benefit Plans. We strongly support the goals of the ACA to ensure that all Americans have access to high-quality, affordable health care, including comprehensive care for mental health and substance use disorders. We appreciate your careful consideration of our comments and look forward to working with you further on the development and implementation of the Medicaid expansion and related provisions of the ACA. Please contact us if you have any questions or if we can be of further assistance.

Sincerely,

National Organizations

American Association for the Treatment of Opioid Dependence
American Association on Health and Disability
Association for Ambulatory Behavioral Healthcare
Center for Clinical Social Work
Community Anti-Drug Coalitions of America
Community Catalyst

Faces & Voices of Recovery
General Board of Church and Society of the United Methodist Church
Harm Reduction Coalition
Legal Action Center
Mental Health America
NAADAC, the Association for Addiction Professionals
National Alliance on Mental Illness
National Association of County Behavioral Health & Developmental Disability Directors
National Association of Drug Court Professionals
National Association of Psychiatric Health Systems
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council on Alcoholism and Drug Dependence
National Viral Hepatitis Roundtable
No Health without Mental Health
State Associations of Addiction Services
Treatment Research Institute

State and Local Organizations

Aegis Medical Systems
Alcoholism and Substance Abuse Providers, New York State
Amethyst, Inc.
Association for Behavioral Healthcare, Massachusetts
Association of Substance Abuse Programs, Texas
Bridgeway Behavioral Health, Mississippi
California Mental Health Directors Association
Council on Alcoholism and Drug Abuse of Sullivan County
County Alcohol & Drug Program Administrators Association of California
Drug and Alcohol Service Providers Organization of Pennsylvania
Focus on Community
Heartview Foundation, North Dakota
Illinois Alcoholism & Drug Dependence Association
Iowa Behavioral Health Association
Mental Health Association of Maryland
National Council on Alcoholism and Drug Dependence, Maryland
Nationwide Medical Group
NCADD of Middlesex County
Nevada Alliance for Addictive Disorders, Advocacy, Prevention and Treatment Services
New Frontier Treatment Center, Nevada
Ohio Alliance of Recovery Providers
Ohio Citizen Advocates
Ohio Health Benefits Coalition
Recovery Resources of Cleveland, Ohio
Substance Abuse and Addiction Recovery Alliance of Virginia
Substance Abuse Services Center, Iowa
TASC, Illinois
Utah County Department of Drug and Alcohol Prevention and Treatment
Washington Association of Alcoholism and Addiction Programs