American Society of Addiction Medicine

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Treat Addiction ● Save Lives

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 American Society of Addiction Medicine (ASAM) is pleased to have the opportunity to comment on the Proposed Rule on the Affordable Care Act's (ACA) Essential Health Benefits (EHB) for Alternative Benefit Plans.

Established in 1954, ASAM has nearly 3,000 members and chapters that cover 42 states. Our members specialize in the treatment of addiction and practice in a wide range of primary care and specialty care settings. As such, we feel uniquely qualified to comment on the provisions of this proposed rule that have the potential to increase patient access to mental health and substance use disorder treatment.

Unfortunately, a long history of insurance discrimination against those with substance use and mental health disorders (SUD/MH) has prevented many individuals from receiving the clinically appropriate care needed to get and stay well. There is also an unacceptably large treatment gap for SUD/MH. 19.3 million Americans were classified as needing treatment for a substance use disorder in 2011, but did not receive it.[1] The Affordable Care Act (ACA) holds tremendous promise for significantly reducing SUD/MH treatment gaps, but without a robust EHB in alternative benefit plans and other protections to ensure access to medically necessary SUD and MH care this potential will go largely unfulfilled.

Implementation of this rule is particularly important because 66% of the Medicaid population has addictive disorders and are frequent users of emergency department services.[2] Recent studies have demonstrated the cost savings associated with treatment. For example, a study of the Washington State Medicaid program on the effect of access to SUD/MH treatment found that:

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ental Health Services Administration, *Results from the 2011 National Survey on Drug Use lational Findings*, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, d Mental Health Services Administration, 2012.
J, Felver B. Frequent emergency room visits signal substance abuse and mental illness. Research and Data Analysis Division, Olympia, WA. Updated June 2004.

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- Medicaid costs were reduced by 5% ($4,500 less over a five-year follow up period).[3]
- Inpatient and emergency department costs declined by 39% following treatment.[4]
- Total medical costs per patient per month went from $431 to $200.[5]

It is essential that all individuals, both those gaining Medicaid eligibility under the ACA and those who are already eligible, receive health coverage appropriate for their needs, including strong coverage for substance use disorders.

KEY PROVISIONS IN THE PROPOSED RULE

- We applaud the proposed rule's explicit recognition of the ACA requirement that alternative benefit plans must provide the EHB 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 rule's proposal to codify that States are permitted 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, MHPAEA, 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 believe that this increased access to appropriate addiction treatment will lower the overall medical costs of these individuals.

PROPOSED MODIFICATIONS FOR INCLUSION IN THE FINAL RULE

ASAM members respectfully offer the following 4 recommendations to the Department in response to the proposed rule. Our consideration of these issues is informed by our experiences with health insurance expenditures for SUD/MH, which have historically been at extremely low levels or nonexistent. The following is a summary of our recommendations for final EHB guidance for your consideration:

1. **Additional guidance on how the requirements of MHPAEA apply to alternative benefit plans, including guidance on how to supplement benchmark or benchmark-equivalent coverage to bring it into compliance with parity and how to identify violations in parity compliance should be provided**. 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 and additional guidance on Medicaid managed care parity as soon as possible.
2. **Clarification should be provided on what constitutes coverage in each category and how the agency intends to enforce the non-discrimination and balance requirements.** 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

[3] Luchansky, Bill & Longhi, Dario, "Cost Savings in Medicaid Medical Expenses: An Outcome of Publically Funded Chemical Dependency Treatment in Washington State," Washington State Dept. of Social and Health Services, June 1997.
[4] Parthasarathy, S. et al. *Association of Outpatient Alcohol and Drug Treatment with Health Care Utilization and Cost: Revisiting the Offset Hypothesis* Division of Research, Kaiser Permanente Medical Program, 2001.
[5] Parthasarathy, S., et al., "Utilization and Cost Impact of Integrating Substance Abuse Treatment and Primary Care." *Medical Care*, 41(3):357-367, March 2003.

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.

3. **CMS should clearly identify a 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**. 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.
4. **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 allows States to provide additional benefits for other populations in alternative benefit plans.

1. Recommendation: 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. The ACA improved on MHPAEA by extending MH and SUD parity requirements to individual and small group health coverage and Medicaid alternative benefit 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, near five years after MHPAEA became law, providers and consumers around the country are still experiencing discriminatory treatment access. While the MHPAEA Interim Final Rule and other guidance have provided clarification 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.

Although the MHPAEA regulations went into effect for all commercial plans on January 1, 2011, plans, consumers and providers remain confused about how SUD/MH benefits should be designed and administered. Importantly, providers and consumers still experience inconsistent and discriminatory application of the law. One ASAM member reports that his practice regularly encounters plans that require patients to be suicidal before they become eligible for SUD treatment, even when meeting nationally recognized patient placement criteria for an intensive level of care.

As the Department works to implement the EHB, it should recognize that there are still significant problems in implementation of existing parity regulations, and work to mitigate these issues in EHB regulations and prevent similar problems from occurring in the Medicaid program:

- Some plans are claiming to be parity compliant by providing sparse or single levels of inpatient services, sparse or very limited levels and types of outpatient services, and/or disproportionate restrictions on MH/SUD prescription drugs (e.g., “fail first” policies and/or restricted formularies). These cost-containment techniques appear to be applied more stringently with respect to SUD/MH benefits than to other medical benefits. These and other barriers to access are hurting

individuals today and may jeopardize access to SUD/MH benefits for Medicaid enrollees in alternative benefit plans. While placing barriers to access for addiction treatment may seem to be "cost-saving" for health plans, the fact is that total health care costs go up when co-occurring addiction is not recognized early and treated effectively; the best way to save costs is to remove barriers that preclude access to addiction care.

- Patients and providers are often unclear about how parity is being applied by plans, and plans often refuse to disclose the MH/SUD medical necessity criteria until a denial is made and withhold the medical/surgical criteria used by the plan to make benefit determinations so a parity compliance test can be performed.

Unfortunately, MHPAEA compliance concerns are evident in the benchmark plans states have selected for qualified health plans and we are concerned about similar problems arising in alternative benefit plan benchmarks. Examples of non-compliance include:

- Annual limits on outpatient and inpatient mental health and addiction treatment visits when a comparable limit is not evident on the medical side.
- Exclusion of coverage for inpatient and residential substance use disorder treatment services when a full range of treatments for medical/surgical conditions is covered.
- Exclusion of coverage for partial hospitalization and/or intensive outpatient program addiction rehabilitation services when a full range of comparable treatments for medical/surgical conditions is covered (such as day treatment for pulmonary rehabilitation, cardiac rehabilitation, stroke rehabilitation, or spinal cord injury rehabilitation).
- Exclusions or limitations of coverage for pharmacotherapies for addiction that are more stringent than limits on other pharmacotherapies.
- More stringent medical management on the addiction and mental health benefit than on the medical/surgical benefit; one plan required concurrent review for the addiction and mental health benefit without having a comparable requirement on the medical/surgical benefit.

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 SUD/MH 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.

To address these issues, we recommend that:

- The Department establish a clear process for how states can modify a plan to ensure parity compliance if it is not compliant today.
- The Department clarify that the term “treatment limitation” includes both quantitative and non-quantitative treatment limitations and includes limits on scope of service and duration of treatment.

- The final rule require full disclosure of benefit and medical management criteria from states and plans to ensure MHPAEA compliance in alternative benefit plans.
- The final rule ensure that alternative benefit plans may not apply a financial requirement or treatment limitation, either quantitative or non-quantitative, to SUD/MH benefits in any classification, that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.
- The final rule must ensure that alternative benefit plans may not apply separate cost sharing requirements or treatment limitations that are applicable only with respect to SUD/MH benefits.
- The final rule should include examples of parity violations and detailed information on how to supplement coverage that falls short of the parity requirements of the law.
- CMS should review all alternative benefit plans to ensure 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.

2. Recommendation: 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.

3. **Recommendation: 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.

4. **Recommendation: 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.

In closing, the American Society of Addiction Medicine wants to emphasize its thanks to the Department for the opportunity to submit comments regarding this important issue. We look forward to a continued collaboration on advances in and increased access to alcohol, nicotine, and other drug addiction treatment.

Sincerely,

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Acting President, American Society of Addiction Medicine