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CLASP's Comments on the Mental Health Parity and Addiction Equity Act of 2008; the Application to Medicaid Managed Care, CHIP and Alternative Benefit Plans (CMS-2333-P)

The Center for Law and Social Policy (CLASP) appreciates the opportunity to provide comments on the proposed rule applying the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid managed care organizations, Medicaid Alternative Benefit Plans, and Children's Health Insurance Programs. CLASP thanks the Centers for Medicare and Medicaid Services (CMS) for the hard work developing these proposed rules and for their thoughtful review of comments.

CLASP's perspective on these regulations arises from our commitment to reducing poverty, improving the lives of poor people, and creating ladders to economic security for all. Our expertise spans early childhood and youth policy, income and work supports, pathways to economic success through education and work, and policies that support low-wage workers. As we have worked extensively at the federal, state, and community levels on all these issues, we have seen the crucial role that improved access to mental health and substance use treatment for low-income individuals, especially those with young children, plays in enabling them to succeed. Therefore, we commend CMS for the proposed rules, which represent an important step forward for low-income families that need mental health treatment or substance use treatment in order to succeed in work or school and to be healthy parents to their young children.

Overall, we would like to highlight the crucial role that access to mental health and substance abuse treatment plays for low-income individuals and families, and hence the particular importance of this rule governing parity in Medicaid and CHIP. Therefore, we strongly urge CMS to maintain the strength of the protections for access in the final rule. Specifically:

- Strong protections for mental health access are key to addressing maternal depression, a major public health problem with high incidence among low-income mothers that, when untreated, places young children's development and school readiness at risk and stymies mothers' educational and career success.

Depression is widespread among poor and low-income mothers, including mothers with young children. One in nine poor infants lives with a mother experiencing severe depression and more than half live with a mother experiencing some level of depressive symptoms.[i] While depression is highly treatable,[ii] many low-income mothers do not receive treatment—even for very severe levels of depression. Indeed, more than one-third of low income mothers with major depressive disorder get no treatment at all.[iii] Unfortunately, untreated maternal depression is damaging to

children, particularly young children, placing at risk their safety and cognitive and behavioral development. In addition to the health complications caused by depression, such as frequently occurring with comorbid medical conditions, depression is also associated with unemployment or underemployment.

- Improved access to care for parents with mental health or substance use disorders is also key to improving outcomes for children in or at risk of entering the child welfare system. Parents involved with the child welfare system have high rates of mental health problems and substance use, yet today, far too few receive any services at all and even fewer the full services that they need. Increasing parents' access to mental health and substance use treatment for highly vulnerable families could prevent maltreatment and involvement with the child welfare system; for families where maltreatment has occurred, access to mental health and substance use treatment through Medicaid will likely be a key factor in successful reunification. In addition to the crucial benefits to children, improved access to mental health and substance use treatment could potentially save the state money due to a shorter length of involvement in the child welfare system and healthier families once reunification occurs.

- Improved access to treatment has the potential to improve life prospects for the most highly vulnerable youth and young adults, because mental health problems including the effects of trauma are reported widely by youth growing up in high poverty communities, including youth of color. For example, between 30 and 40 percent of youth exposed to community violence develop posttraumatic stress symptoms, such as re-experience (nightmares, intrusive thoughts, and flashbacks); avoidance of traumatic triggers and emotional numbing (constriction of affect); and physiological hyper arousal (hyper vigilance, insomnia, and behavioral problems).[iv]

Consistent with this overall recommendation to maintain the proposed rule's strong protections for access, CLASP offers the following comments on specific provisions:

Non-Quantitative Treatment Limits (NQTLs): §438.910

CLASP supports the application of parity requirements to Non-Quantitative Treatment Limits (NQTLs). Reducing as many barriers to care as possible is important to ensure that Medicaid enrollees are able to receive mental health and/or substance use treatment. Applying the same parity standards to NQTLs as to quantitative treatment limitations is a significant step toward reducing barriers to care and is a positive step forward in achieving parity. Requiring Medicaid plans to apply the same criteria for such services as inpatient admission, outpatient treatment, and prescription formularies as is followed for medical/surgical benefits will increase access to appropriate and timely care for Medicaid enrollees seeking mental health or behavioral health treatment. For example, based on evidence about effective treatments for maternal depression, access to effective medications will likely be crucial to achieving the benefits described above for both mothers with depression and their young children. Additionally, the parallel decision making structure between medical/surgical and mental health/substance use disorder helps enrollees navigate the healthcare system and their benefits.

CLASP supports the addition of NQTL standards in accessing out-of-network providers in Medicaid managed care states. Because network adequacy can be a limiting factor in seeking care, especially when seeking care for mental health or substance use, requiring Medicaid managed care entities to allow out-of-network care using the same processes, strategies, evidentiary standards, or other factors as are used in providing out-of-network access for medical/surgical benefits will help alleviate some of the access issues created by a shortage of in-network providers. This provision may be particularly important for Medicaid enrollees seeking in-patient treatment when they can only find available treatment space in an out-of-network facility. Given the shortage of treatment facilities in some geographic areas, the ability to receive treatment from an out-of-network provider/facility is critical to ensuring parity.

All MCO enrollees receive MH/SUD on a parity basis: §438.920

CLASP supports the requirement in the proposed rule to require that MCO enrollees be provided access to a set of benefits that meets the requirements of the proposed rule regardless of whether the mental health/substance use disorder services are provided by the MCO or through another service delivery system. Requiring that mental health/substance use disorder services meet parity requirements regardless of whether the benefits have been "carved out" of the MCO contract is vital to achieving the intent of the proposed rules and adhering to the spirit of the law. Without this provision in the rules, states and MCOs would be able to easily side-step parity for mental health/substance use disorder by simply carving out their mental health/substance use disorder services to a subcontractor. Therefore, it is critical that the final rule maintain this provision requiring that MCO enrollees be provided access to benefits that meet the parity requirements, regardless of whether mental health/substance use disorder benefits are provided through the MCO or another service delivery system.

In order to ensure access to mental health/substance use disorder treatment in line with the requirements of the rule, CLASP also supports requiring states, when offering mental health/substance use disorder benefits to MCO enrollees through fee-for-service to ensure that mental health/substance use disorder benefits comply with MHPAEA when combined with benefits provided by the MCO. As with the provision requiring that mental health/substance use disorder benefits provided through "carve outs" , requiring states with Medicaid managed care but using FFS for MH/SUD benefits to also meet the parity standards will ensure that the spirit of the law and intent of Congress is met. In short, ensuring that all MCO enrollees receive mental health/substance use disorder benefits that meet parity guidelines, regardless of whether those benefits are included in the MCO contract or carved out, is appropriate and necessary to ensure access to care.

Given the potential complexity of parity being realized when mental health/substance use disorder benefits are provided through a "carve out", CLASP supports the requirement in the proposed rule that states provide evidence of compliance when they submit MCO contracts to CMS. CLASP believes that provisions of these contracts providing evidence about how parity will be achieved should be made available to the public and their development should engage stakeholders throughout the process.

Availability of Information: §438.915

CLASP supports the provisions in the proposed rules that increase transparency by requiring that MCOs share, upon request, their medical necessity criteria with any enrollee, potential enrollee, or contracting provider. CLASP also supports the provision requiring MCOs to make available the reason for any denial of reimbursement or payment for services for mental health/substance use disorder benefits to the enrollee. Together, these two provisions are critical components to ensuring that mental health/substance use disorder benefits are available with no more restrictive criteria than comparable medical/surgical benefits.

Implementation timeline: §438.930

While CLASP recognizes that a thorough implementation process, including the engagement of stakeholders, takes time to do well, we urge CMS to ensure that final implementation is achieved in as timely manner as possible. During the 18 months between publication of the final rule and states' compliance, low-income mothers with depression or in need of substance use treatment may not have access to needed services, potentially leading to many of the negative effects for them and their children as outlined in our opening paragraphs.

Throughout these proposed regulations and other activities including technical assistance and policy guidance, CLASP encourages CMS to continue examining avenues for strengthening provider networks, especially those serving low-income mothers and families in need of mental health or substance use treatment. A robust provider network is a critical component to realizing the potential positive impact of strong policy advancements, such as these proposed rules. Mental health and substance use treatment are needed in a timely and accessible manner. Barriers created by inadequate provider networks, such as lengthy waiting lists or the need to travel a great distance, impede access to benefits that enrollees are entitled to receive. CLASP commends CMS for their on-going commitment to improving access to care for mental health and substance use, and encourages CMS to explore avenues for strengthening provider networks as you continue to work toward improving access to care.

Thank you for the opportunity to provide comments. If you have questions about these comments or would like additional information please contact Suzanne Wikle (swikle@clasp.org), Senior Policy Analyst.

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[i] Veriker, Tracy, Jennifer Macomber, and Olivia Golden. "Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve." The Urban Institute, 2010.

[ii] National Research Council and Institute of Medicine (NRC/IOM). Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. 2009.

[iii] McDaniel, Marla, and Christopher Lowenstein. "Depression in Low-Income Mothers of Young Children: Are They
Getting the Treatment They Need?" The Urban Institute, 2013.

[iv] "Investing in Boys and Young Men of Color: The Promise and Opportunity", CLASP 2014