

# PUBLIC SUBMISSION

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The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

**Comment On:** CMS-2009-0040-0048

Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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DE

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## General Comment

Comments

on

Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity Act and Addiction Equity Act of 2008

Issued February 2, 2010

File Code CMS-4140-IFC

E. General Applicability Provisions (Page 5417)

It is clear from reading the various enacted pieces of legislation, the Congressional Record and the supplementary information that accompanied this set of regulations, that the intent of Congress with regard to mental health parity was to “improve access to mental health and substance use disorder benefits by eliminating discrimination” by prohibiting “health insurers from placing discriminatory barriers on treatment” FR Vol. 75, No. 21, 2/2/2010, page 5422). It is also clear from the sections of the US Code that were amended to achieve this goal and the fiscal analyses conducted by the Departments, that these statutory changes were only intended to apply to ERISA-covered group employer health plans and public, non-federal employer group plans sponsored by state and local governments (FR Vol. 75, No. 21, 2/2/2010, page 5421). It is clear that no cost data from State Medicaid plans was used in the development of the fiscal notes related to either the increased cost of providing health benefits, the increased health plan implementation costs or the increased premium costs (FR page 5427). Medicaid programs

typically do not charge premiums like private health insurance.

Therefore, many states were surprised to learn in a State Health Official letter from CMS dated 11/4/09 that this legislation, which appeared to be targeted at private employment and government-sponsored insurance plans, applied to state Medicaid programs to the extent that they deliver care through a health plan as defined in section 2705 of the Public Health Service Act. We believe that this an unintended consequence of the legislation and does not take into account how mental health services are delivered under a state “health care system” of which Medicaid-f

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## **Attachments**

**CMS-2009-0040-DRAFT-0056.1: DE**

Comments  
on  
Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity  
Act and Addiction Equity Act of 2008  
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Therefore, many states were surprised to learn in a State Health Official letter from CMS dated 11/4/09 that this legislation, which appeared to be targeted at private employment and government-sponsored insurance plans, applied to state Medicaid programs to the extent that they deliver care through a health plan as defined in section 2705 of the Public Health Service Act. We believe that this an unintended consequence of the legislation and does not take into account how mental health services are delivered under a state “health care system” of which Medicaid-funded health plans are just one component.

Our state has been operating under an approved Section 1115 Demonstration Waiver, to enable it to provide Medicaid coverage under a managed care delivery system. Most Medicaid recipients in the state are covered under this waiver. Under the 1115 waiver, the state chose to include some inpatient and outpatient mental health and substance abuse services in the benefit package provided by commercial health plans (i.e. Managed Care Organizations or MCO). All other mental health and substance abuse services are “carved out” of the MCO benefit package and are paid for directly by the state Medicaid program on a fee-for-service basis outside the MCO benefit package. Most of those behavioral health services are provided by state agencies that provide behavioral health services to both children and adults, through a robust continuum of care delivered through a well-developed provider network. The state believes that many Medicaid clients enrolled with MCOs receive improved overall health care if there is a balance between including some of the mental health services in the benefit package while excluding other services to be provided by our state agency delivery system. When

viewed together, the combination of Medicaid (and CHIP) behavioral health benefits in the commercial Medicaid managed care organization (MCO) benefit package and those provided via state agencies as Medicaid fee for service results in a full set of behavioral health benefits for which there are no pre-defined limits by amount or duration.

Behavioral health benefits are only limited by medical necessity and there are no more restrictions on their use than those applied to comparable medical/surgical benefits.

Using this standard of a “benefit package” that is defined more broadly than just the health plan services administered by commercial MCOs, we believe that our state’s Medicaid program would be viewed as meeting the parity requirement, but we are unclear as to how such a system would be viewed by federal compliance reviewers (the regulation does not indicate which agency is responsible for ensuring compliance).

The regulations appeared to contemplate such an arrangement when they stated on page 5417 and 5418 that “all medical care benefits provided by an employer or employee organization constitute a single group health plan” and “if an employer with a single benefit package for medical/surgical benefits also has a separately administered benefit package for mental health and substance abuse benefits, the parity requirements apply to the combined benefit package and the combined benefit package is considered a single plan for purposes of the parity requirements.” The state’s RFP for commercial managed care and the member handbooks of the MCOs currently under contract clearly indicate that behavioral health benefits in the MCO benefit package and those provided by state agencies are both available to clients as part of the state Medicaid program’s comprehensive behavioral health care program.

While we do not agree that Congress intended for the parity provisions to apply to state Medicaid programs, if the parity standard is to be applied to a Medicaid program such as we have outlined, then it should be applied to all Medicaid health benefits available to individuals who are enrolled in a health plan, even if those benefits are not administered by the health plan. We recommend that the separate “benefit package” of behavioral health services administered by state agencies on behalf of the Medicaid agency be viewed in combination with the MCO benefit package as representing the set of benefits that should be measured against the parity requirements. If allowed under the regulations, we believe that our state’s Medicaid program would meet the goal of the parity requirement. This structure of having separately administered sets of benefits that together constitute a comprehensive benefit package is not a common arrangement among employer/employee sponsored health care delivery systems, but we believe that it occurs in multiple state Medicaid programs. We believe that the restriction of the parity rule to “health plans” is further evidence that the law was not intended to apply to state Medicaid programs. We recommend that the Departments codify the type of health care delivery arrangement described in our comments within the regulations. This would enable states like ours, which offer a full continuum of mental health benefits across their Medicaid and CHIP *healthcare delivery systems* of which comprehensive MCO health plan benefits are just one component, to be permitted to demonstrate compliance with the parity requirements within the aforementioned framework.

Because of some perceived technicality in the law, our state’s Medicaid program should not be forced to choose between delivering all behavioral health services either with the contracted MCOs or with the state agency delivery system. If the state Medicaid program is forced to make such a choice, it is most likely that we will remove all behavioral health services from the managed care program and rely solely on the state delivery system. We do not believe the intent of the law was to force state Medicaid programs to make such a choice. If, on the other hand, the intent of the law is to achieve parity of mental health benefits with physical health benefits, we believe we have already achieved that in our Medicaid program.

As further evidence of the challenge state Medicaid programs will face in trying to comply with Mental Health Parity, we offer the following statutory contradiction between Title XIX of the Social Security Act and the Mental Health Parity law that will create an unfunded mandate for states. State Medicaid programs are required to cover inpatient hospital services per section 1905(a)(1) of the Social Security Act but are prohibited from covering inpatient hospital services in an Institution for Mental Diseases (IMD) for individuals between the ages of 21 – 64. Psychiatric hospitals and substance abuse treatment facilities with more than 16 beds are, by definition, IMDs, and therefore, states are prohibited from receiving federal funds for behavioral health services delivered in these settings. In order for state Medicaid programs that provide care via one or more health plans to comply with Mental Health Parity, states would be required to add a non-Medicaid-covered service to an MCO benefit package and pay 100% of the cost of this service, as FFP is not available. For state Medicaid programs, the increased cost of the health plan, will not be funded by increased premiums paid by employers and employees, but rather it will have to be funded by taxpayers. This will create an unfunded mandate for any state that offers inpatient hospitalization within a health plan.

#### *G. Increased Cost Exemption (page 5418)*

If the Departments are not persuaded by our argument to view the state’s entire Medicaid delivery system as the “health plan” to which the parity standard is applied, then the funds we are currently spending on behavioral health services outside of the MCO benefit package would have to be considered “increased costs” to the health plans in order to comply with the parity requirements. If this is the case, then our state would apply for the 2% increased cost exemption allowed under MHPAEA because the majority of the behavioral health benefits covered under our Medicaid and CHIP programs are currently provided outside the MCO benefit package. If we are not allowed to consider these benefits as part of the “health plan” benefits and must add them to the MCO benefit package so that they too can be delivered as part of that financial arrangement, then we calculate that this would result in approximately a 6% increase in the total cost of the benefit package and would likely qualify for the exemption.

#### *H. Unfunded Mandates Reform Act (Page 5430)*

If the regulations are not revised to acknowledge the existence of the type of healthcare delivery system operated by our state Medicaid program, which includes health-plan-

provided services as part of a more comprehensive network, then we respectfully disagree with the Departments' assessment that this set of regulations is designed to be the least burdensome alternative for state, local and tribal governments consistent with the Unfunded Mandates Reform Act. If the regulations remain unchanged, then in order to comply with Mental Health Parity, states like ours will be forced to either amend contracts with managed care organizations to include all of the behavioral health care services that are currently provided outside of the managed care benefit package or they will have to remove all behavioral health services from the MCO benefit package and administer them all as fee for service. Either option will represent significant administrative costs to the state, as Medicaid MCO rates must be determined to be "actuarially sound" as per 42 CFR 438.6(c). Currently, those actuarially sound rates do not currently include all of the behavioral health services offered by the state's Medicaid program and will have to be recomputed to either include them or exclude them. Other state Medicaid programs that have a similar bifurcated delivery system will also incur significant costs at a time when states are experiencing record deficits.

As mentioned previously, in order to comply with the Mental Health Parity law, some states which currently provide Medicaid through contracts with commercial health plans will have to begin covering IMD services for which no federal matching funds can be used. This truly represents an unfunded mandate.