FIRST FOCUS
MAKING CHILDREN & FAMILIES THE PRIORITY

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June 9, 2015

Centers for Medicaid and Medicare Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

FOR ELECTRONIC SUBMISSION

RE: RIN 0938-AS24
Medicaid, Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act (MPHAEA) of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans; Proposed Rule
80 Fed. Reg. 19417 (April 10, 2015)
File Code: CMS-2333-P

Dear Secretary Burwell:

On behalf of First Focus, I appreciate the opportunity to comment on the proposed rule concerning Medicaid Managed Care Organizations (MMCOs), CHIP and mental health parity. Long awaited, these proposed rules will help protect the children and adolescents who suffer from mental health disorders, substance abuse disorders, and other behavioral health challenges. First Focus is a bipartisan children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions. Our core mission is to ensure that all of our nation's children are able to get the services they need and deserve. Our comments focus on issues related to children and adolescents and we urge you to strongly reconsider the presumption that EPSDT meets the proposed parity requirements universally.

1. Application of Proposed Rule to Child and Adolescent Enrollees in Fee-for-Service Arrangements

We recognize that through this proposed rule CMS would extend the application of mental health parity to the vast majority of Medicaid and CHIP enrollees. However, the proposed rule excludes parity protections for children and adolescents receiving Supplemental Security Assistance (SSI) and foster care assistance as well as other children with chronic mental health and substance abuse disorder (MH/SUD) conditions, who are in fee-for-service (FFS) arrangements. We urge CMS to reconsider this exclusion, at least for children and adolescents. According to the 2013 SSI Annual Statistical Report, 1.3 million children and adolescents (10 to 18) were receiving SSI, and two thirds of them have mental disorders.[1] The Adoption and Foster Care Analysis and Reporting System reports that 402,000 youth were in foster care in 2013,[2] and more than 60% of these youth have a mental health condition.[3] Many of these vulnerable children and adolescents, as well as others in waiver programs, continue to receive Medicaid coverage through FFS arrangements. We do not believe that Congress meant to exclude these children and adolescents, who are certainly among the most in need. In fact, we recommend that CMS use the parity rule to clarify the availability of Medicaid

reimbursement for therapeutic foster care provided to the 50,000 youngsters in the child welfare system identified as having the most serious mental and emotional disturbances.

2. Development of Actuarially Sound Rates to Comply with Mental Health Requirements

In developing actuarially sound rates to comply with the proposed mental health parity requirements, we recommend CMS instruct states to establish cost rates specifically for children and adolescents. This is necessary for two reasons: 1) to assure sufficient participation from child and adolescent psychiatrists, psychologists, social workers, and substance abuse counselors; and 2) to recognize the amount of MH/SUD services provided by pediatric medical providers who are seldom recognized as MH/SUD service providers, particularly in states using mental health carve-outs. Further, we urge CMS to require states to take into account the range and intensity of MH/SUD services covered under EPSDT in establishing actuarially sound rates for this age group.

3. Presumption that EPSDT in Medicaid and CHIP State Plans will Meet Proposed Parity Requirements

We strongly urge CMS to amend the proposed rule to incorporate EPSDT as a medical/surgical service with the same parity requirements that are applied to other Medicaid and CHIP services. A state's *belief* that its CHIP plan "provides coverage of EPSDT benefits" is not sufficient to constitute compliance with EPSDT, CHIP, or parity requirements. Based on the number of EPSDT class action lawsuits pertaining directly to the lack of intensive home and community-based services for Medicaid-insured children and adolescent with serious emotional impairments,[4] we cannot agree with CMS that required compliance can be presumed in EPSDT, despite the broad scope of medically necessary MH/SUD screening, diagnostic and treatment services mandated under this benefit.

4. Compliance Dates

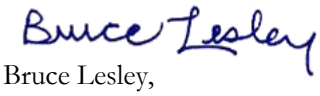
We urge CMS to shorten the timeframe for states to comply with applicable requirements in this rule. The proposed rule provides 18 months for states to come into compliance with these requirements. Given how long ago the statutory requirements that this rule implements were enacted, an additional 18 months from the effective date of the final rule seems an inordinately long period of time for states to comply. We urge CMS to shorten this timeframe—at least for states with budget cycles that do not require such a lengthy period to achieve compliance—and expedite its consideration of any state plan amendments that states may seek in order to comply with this rule.

5. Application of Proposed Parity Rules to Non-Quantitative Treatment Limits

We support CMS for providing detailed examples of non-quantitative treatment limits (NQTLs) and for eliminating in-network and out-of-network distinctions. We request that in the final rule, CMS offer direction to states about NQTLs as they relate specifically to children and adolescents and also provide relevant examples. Of particular significance are NQTLs pertaining to pediatric formularies, standards for network adequacy of child and adolescent providers, policies for accessing child and adolescent MH/SUD services that are out-of-network, and EPSDT medical necessity and prior authorization policies for MH/SUD services.

Thank you for the opportunity to comment on this proposed rule. Generally we are pleased with the direction CMS is taking with these and look forward to answering any questions or concerns that may arise.

Sincerely,



Bruce Lesley,
President

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[1] *SSI Annual Statistical Report, 2013*. Washington, DC: Social Security Administration, September 2014.
[2] *The AFCARS Report.* Washington, DC: Administration for Children and Families, July 2104.
[3] *Health Care of Youth Aging Out of Foster Care.* Elk Grove Village, IL: American Academy of Pediatrics, 2012.
[4] EPSDT lawsuits related to the lack of intensive behavioral health services have been filed in Massachusetts (Rosie D), California (Kate A and Emily Q), and Washington (T.R.).