California Association of Social Rehabilitation Agencies
815 Marina Vista, P.O. Box 388, Martinez, CA 94553
925-229-2300 (voice); 925-229-9088 (fax)
www.casra.org

April 27, 2010

Centers for Medicare and Medicaid Service
U.S. Department of Health and Human Services
Attention: CMS-4140-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Re: Comments on the Mental Health Parity & Addiction Equity Act Interim Final Rule

Thank you for the opportunity to comment on the Mental Health Parity and Addiction Equity Act (MHPAEA) Interim Final Rule (IFR). We appreciate your willingness to consider a wide range of perspectives in crafting the regulations that will govern this important legislation.

The California Association of Social Rehabilitation Agencies (CASRA) is a statewide association of not-for-profit, community-based organizations dedicated to providing services to persons diagnosed with serious mental illness to help them move beyond the disabling effects of their disability and obtain employment and community integration. CASRA member agencies serve over 75,000 adult clients of the California public mental health system each year.

Scope of Services/Categories of Care are not Defined

The language *generally recognized independent standards of current medical practice* and *accepted in the relevant medical community* is ambiguous and could be ill-fitting guidance for mental health and substance use (MH/SU) service providers. There are many conditions and services that do not fit appropriately under the category of "medical" standards. Medical definitions do not fully capture the essence of recovery-oriented services as recovery incorporates elements of well being and satisfaction that cannot be measured simply by a reduction in symptoms. CASRA and the agencies we represent urge CMS to adopt more specific language that could include generally accepted, evidence-based, non-hospital, non-medical standards of practice and service provision. Essentially, it is important that regulation language include other standards of care that are not solely based on medical definitions and include psychiatric rehabilitation and recovery practices and principles.

No Enumeration of Conditions, Types of Services or Types of Provider Covered

In the IFR's *classification of benefits* section, there is a notable lack of definition regarding which types of mental health/substance use (MH/SU) conditions are covered, which types of MH/SU services can be utilized to treat those conditions and which provider entities can provide that treatment. Using the six general classifications listed in the IFR allows for flexibility for states and plans to define which MH/SU

conditions plans must cover and which treatment options they must provide at parity, but there risks involved with this lack of definition. Allowing plans to permanently exclude all benefits for particular conditions or disorders could result in increased costs to states in the areas of law enforcement, jails/prisons, and hospital emergency room services as people with MH/SU needs are not able to find appropriate services through their insurance plan.

In addition, plan definitions regarding scope/types of services covered may be too narrow to include appropriate, recovery-oriented services which could undermine effective, well-balanced health treatment for persons with complex physical and MH/SU conditions. As a corollary, the IFR's broad language allows plans to define, for example, *inpatient* in such a way that might only cover stays in certain medical facilities in situations where a person may have been more effectively treated in a residential treatment or other alternative facility.

Finally, allowing states and plans to define which provider types can deliver coordinated care could result in a total lack of treatment by providers delivering recovery-oriented, cost-effective, evidence-based coordinated care in respite care facilities, crisis residential treatment facilities, and in those facilities that provide residential support services.

Application to Small Employers

The IFR does not apply to employers with fewer than 50 employees. Small employers employ a significant portion of the working population in this country. If small employers are not required to secure or provide MH/SU coverage at parity with physical health coverage, this may considerably limit employment options for persons in recovery from mental illness. We would welcome application of parity to small employers.

We appreciate the magnitude of drafting such complex and far-reaching regulations. CASRA looks forward to increased healthcare coordination that aligns physical health priorities with MH/SU concerns and these regulations are one tool in the effort to realize improved cost-savings and health outcomes. We hope the Departments responsible for drafting the IFR will make every effort to ensure the greatest access to recovery-oriented, non-"medical" MH/SU services for all Americans.

If we can be of service to you in your efforts, please do not hesitate to contact us. Thank you again for the opportunity.

Sincerely,

Betty Dahlquist
Executive Director