April 29, 2010

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653
U.S. Department of Labor
Attention RIN 1210-AB30
200 Constitution Avenue, NW
Washington, D.C. 20210

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention CMS-4140-IFC
P.O. Box 8016
Baltimore, MD 2124401850

CC:PA:LPD:PR (REG-120692-09), Room 5205
Internal Revenue Services
P.O. Box 7604
Ben Franklin Station
Washington, D.C. 20044

Re: Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (published in 75 Fed. Reg. 5410 et seq.)

VIA EMAIL: E-OHPSCA.EBSA@dol.gov

To 'The Departments':

The Texas Council of Community MHMR Centers, Inc. is an association that represents the thirty-nine (39) public Community Mental Health Centers that serve all 254 counties of Texas.

On behalf of our members, we appreciate the opportunity to submit the following comments on the interim final rules ("IFR") for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), as published in the February 2, 2010 Federal Register:

1. We support the parity standard as proposed by the Departments in the IFR. The standard sets the stage for implementation of the statutory requirement in MHPAEA and ensures mental health and substance use benefits are properly included in health plan benefit design.

2. The IFR reflects the MHPAEA requirement that a group health plan that provides both medical/surgical and mental health/substance use disorder benefits must ensure that the financial requirements and treatment limitations applicable to these benefits are no more restrictive than those requirements or limitations placed on medical/surgical benefits.
3. We support the retention of the parity standard (effective since 1998) related to annual and lifetime dollar limits.
4. We support application of the predominant standard, as described in the IFR, relative to financial requirements and treatment limitations for mental health and substance use disorder services.
5. We recommend clarification that non-quantitative treatment requirements are subject to the Predominant and Substantially all Standard and the Comparable and No More Stringently Standards and ensure that exceptions to these standards are based on independent and objective clinical policies and standards.
6. We recommend adding a requirement that plans disclose the reason for a benefit claim denial *within a specific timeframe*.
7. We agree with the determination of six discrete classifications of benefits in which parity is applied (inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency care and prescription drug coverage) and recommend clarification that all medical/surgical and mental health/substance abuse disorder benefits must be included within the six classifications.
8. We support the specific provision in the IFR that applies the MHPAEA to out-of-network benefits, reflecting clear Congressional intent.
9. We agree with the determination that the MHPAEA prohibits health plans from applying separate deductibles, out-of-pocket maximums or other cumulative financial requirements or mental health/substance use disorder benefits, reflecting clear Congressional intent.
10. We agree with the Departments that a "shift in source of treatment from primary care physicians to mental health professionals could lead to more appropriate care, and thus, better health outcomes".
11. We agree with the Departments commentary to the rule that mental health and substance use disorder providers should not be classified as "specialists" for the purpose of applying higher copayments and recommend inclusion of this statement in the rule.

Thank you for considering our comments.

Sincerely,

Danette Castle, CEO
Texas Council of Community MHMR Centers