

# COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN  
COMMISSIONER



OFFICE OF THE MONTANA  
STATE AUDITOR

May 3, 2010

Centers for Medicare and Medicaid Services  
Department Health and Human Services  
Attn: CMS-4140-IFC, Mail Stop C4-26-05  
7500 Security Blvd  
Baltimore, MD 21244-1850

DELIVERED BY EMAIL ATTACHMENT

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

Dear CMS Staff:

Thank you for providing this opportunity to comment on the above-referenced rules.  
We appreciate the work these rules represent on the part of many.

**The Commissioner of Securities and Insurance, Office of the Montana State Auditor, offers the following comments on the Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.** This comment focuses on the need for a more detailed definition of inpatient and outpatient care for addiction disorders.

The preamble to the federal interim final rules states: "These regulations do not define inpatient, outpatient, or emergency care. These terms are subject to plan design and their meanings may differ from plan to plan. Additionally, State health insurance laws may define these terms." However, the preamble also states: "another potential benefit associated with MHPAEA and these regulations is that use of mental health and substance use disorder benefits could improve. Untreated or under treated mental health conditions and substance use disorders are detrimental to individuals and the entire economy. Day and visit limits can interfere with appropriate treatment thereby reducing the impact of care for workers seeking treatment." The preamble goes on for several pages reiterating that eliminating day and visit limits will improve the health of workers and the economy.

However, the lack of any kind of a definition of "inpatient" and "outpatient" could have the effect of requiring no payment at all for inpatient or even outpatient treatment for addiction disorders. The Montana definition referenced above has been in place since 1999. Even so, this department continues to observe through consumer complaints and policy form review that health insurance issuers sometimes deny any kind of residential treatment for addiction disorders, even if treatment has been identified as "medically monitored" or "clinically managed," unless the department intervenes to enforce the statute.

"Inpatient" treatment for mental health and addiction disorders is often provided in a facility that is separate from a traditional acute-care hospital. These facilities are licensed by state health departments to provide different levels of care. Many acute care hospitals offer medical detoxification treatment (medically managed), but do not offer all types of "inpatient" treatment that is medically indicated for addiction disorders. That treatment is often identified as "high-intensity residential." Medically managed and clinically monitored residential treatment provided in acute care hospitals, if available, would be much more expensive.

The Montana statute, which requires a limited benefit for chemical dependency treatment, provides as follows:

Mont. Code Ann., § 33-22-705 Inpatient and outpatient benefits.

(1) "Inpatient benefits" are benefits payable for charges made by a hospital or freestanding inpatient facility for the necessary care and treatment of mental illness, alcoholism, or drug addiction furnished to a covered person while confined as an inpatient and, with respect to major medical policies or contracts, also includes those benefits payable for charges made by a physician for the necessary care and treatment of mental illness, alcoholism, or drug addiction furnished to a covered person while confined as an inpatient. Care and treatment of alcoholism or drug addiction in a freestanding inpatient facility must be in a chemical dependency treatment center that is approved by the department of public health and human services under 53-24-208.

**Inpatient benefits include payment for medically monitored and medically managed intensive inpatient services and clinically managed high-intensity residential services.**

(2) "Outpatient benefits" are benefits payable for:

(a) reasonable charges made by a hospital for the necessary care and treatment of mental illness, alcoholism, or drug addiction furnished to a covered person while not confined as an inpatient;

(b) reasonable charges for services rendered or prescribed by a physician for the necessary care and treatment for mental illness, alcoholism, or drug addiction furnished to a covered person while not confined as an inpatient;

(c) reasonable charges made by a mental health or chemical dependency treatment center for the necessary care and treatment of a covered person provided in the treatment center. The chemical dependency treatment center must be approved by the department of public health and human services under 53-24-208.

(d) reasonable charges for services rendered by a licensed psychiatrist, psychologist, licensed professional counselor, licensed social worker, or addiction counselor licensed by the department of labor and industry under Title 37, chapter 35. (Emphasis added.)

The Montana definition of "inpatient" includes terms that directly relate to certain American Society of Addiction Medicine [ASAM] levels of care: medically managed (ASAM level IV) and medically monitored intensive inpatient treatment (ASAM level III.7) and clinically managed high intensity residential treatment (ASAM level III.5) and also refers to care provided in facilities that are specifically licensed by the state department of health and human services to offer that level of care. ASAM is the nationally recognized standard for medical professionals diagnosing treatment for addiction disorders. Certain freestanding facilities are licensed by the state health department to provide residential treatment that is medically managed (ASAM level III.7) and clinically managed high-intensity residential treatment (ASAM level III.5).

If the federal rules do not define inpatient and outpatient more specifically, the end result may be that many health plans will deny access to the most widely prescribed and commonly accepted treatment for addiction disorders. We respectfully suggest that the drafters of these regulations determine whether or not that result is contrary to congressional intent and the goals expressed in the preamble. A definition of "inpatient" residential treatment can be limited to (1) certain diagnosis levels as specified in ASAM and (2) treatment provided in state licensed facilities authorized to offer that type of treatment. In addition, every claim that is made for addiction disorder residential treatment can be subjected to a preauthorization requirement and a medical necessity determination (like other physical illness generally). As stated above, residential treatment provided in a fully licensed, freestanding facility can be more cost effective than treatment delivered in an acute care hospital setting.

Our department has not surveyed the states to determine how their inpatient definitions compare to ours. However, if these regulations provide a uniform definition for inpatient and outpatient care, the federal government has the opportunity to continue to set the standard for access to this type of care by defining a minimum standard that the states could follow. Therefore, we offer the Montana definitions as a workable example of statutory language, and our experiences with how insurers cover or fail to cover these types of claims as an example of how the definition of inpatient and outpatient affects access to care.

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We hope that this comment is helpful to those who have the difficult task of crafting regulations to implement this landmark piece of legislation.

Sincerely yours,

A handwritten signature in blue ink, appearing to read "Christina L. Goe". The signature is fluid and cursive, with a large initial 'C' and 'G'.

CHRISTINA L. GOE  
General Counsel