National Association of State Alcohol and Drug Abuse Directors, Inc.

May 3, 2010

Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

File Code: CMS-4140-IFC

Dear Sir or Madame:

On behalf of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and our component organizations the National Prevention Network (NPN) and National Treatment Network (NTN), I am writing in response to the Interim Final Rules (IFR) published on February 2, 2010 by the U.S. Departments of Labor (DOL), Treasury and Health and Human Services (HHS) under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 [MHPAEA). We appreciate the opportunity to comment.

The IFR is consistent with the MHPAEA statute and the goals of Congress: to eliminate discrimination in group health plan coverage of mental health and substance use disorder benefits and improving access to care.

The IFR will help to ensure that the MHPAEA is implemented correctly and as Congress intended. Additional guidance is needed to help States best inform consumers and the broader public about the requirements of the MHPAEA.

States would benefit from continued guidance from the Departments to ensure greatest compliance with the MHPAEA. In particular, although the IFR preamble affirms that the MHPAEA does not preempt any State laws except those that would prevent the application of the MHPAEA, additional education and outreach is needed to ensure that managed care organizations continue to comply with State laws that provide greater protections than the MHPAEA.

The IFR's inclusion of both quantitative and non-quantitative treatment limitations in the MHPAEA parity analysis is fully within the scope of the MHPAEA and is consistent with the statute and its legislative history.

Medical management tools, identified in the IFR as non-quantitative treatment limitations (NQTLs), are a fundamental means through which plans limit treatment. NQTLs were determined by both Congress and the regulators as a form of treatment limitation as defined under the law and hence subject to the purview of the statute and regulations.

Limiting the scope of the MHPAEA analysis solely to day or visit limits or frequency of treatment limits would not achieve the legislation's intended result of ensuring that substance use disorders and mental health benefits are not provided in a more restrictive way than benefits for other medical and surgical procedures.

In particular, we believe the Rule should explicitly reference that coverage of residential services is required under the inpatient benefit. As this issue is examined, a general albeit not perfect parallel can be made between substance abuse and mental health residential services and skilled nursing facility (SNF) services. SNF care is explicitly included under Medicare Part A coverage and is specifically indicated when a patient requires "rehabilitation" services subsequent to an inpatient hospital stay. Massachusetts "Connector" plans include coverage for SNF and rehabilitation care on a par with hospitalization. Usually SNF care is short-term (Medicare will reimburse care of up to 100 days a year), and it is explicitly not covered as a domiciliary option.

We understand residential care for mental health and substance use disorder services and SNF does not represent an exact parallel. For example, we recognize that a Medicare SNF stay requires inpatient hospital care of at least three days – and many clients for whom this type of care is indicated do not receive nor require inpatient care. However, we do believe the Rule should explicitly reference that coverage of residential services is required under the inpatient benefit.

The IFR recognizes that excluding certain types of providers from plan networks can significantly limit treatment and that plan practices to restrict network access, including setting low reimbursement rates, constitute non-quantitative treatment limitations that must be subject to the MHPAEA analysis.

Other examples of NQTLs include but are not limited to utilization management; medically necessity criteria; "fail first" requirements; prior authorization; and classifying treatment as experimental.

The Centers for Medicare and Medicaid Services (CMS) should issue guidance clarifying that the IFR applies to Medicaid managed care plans. Separate and different parity standards for Medicaid managed care plans could lead to a disjointed and inefficient approach to service delivery.

The MHPAEA statute and its legislative history do not include any distinction between how the law applies to group health plans and Medicaid managed care plans.

The IFR implements the MHPAEA, and Medicaid managed plans must adhere to the MHPAEA. Therefore they must comply with the IFR.

Until CMS affirms that the IFR applies to Medicaid managed care plans, there may be significant confusion as the MHPAEA is implemented for Medicaid managed care plans. The MHPAEA is in effect, and guidance is needed to ensure the Medicaid managed care plans comply with the requirements of the current law.

The IFR includes a number of references to "generally recognized independent standards of current medical practice" and the need for managed care organizations to use these standards in making decisions about coverage for mental health and substance use disorders.

The substance use disorder treatment field has a body of widely accepted standards of care and evidence-based practices for the treatment of substance use disorders.

In providing additional guidance to plans on standards of care and the scope of services covered in substance use disorder treatment benefits, the Departments should adopt these recognized best practices and standards so that plan decisions best reflect recognized clinically appropriate standards of care for substance use disorder treatment.

Specifically, the Departments should:

- Adopt standards developed by experts in the substance use disorder treatment field, such as the National Quality Forum's "National Standards for the Treatment Of Substance Use Conditions"

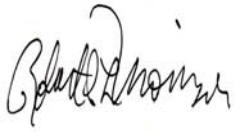
- Explicitly identify these standards and criteria as "generally recognized independent standards of current medical practice," in addition to the Diagnostic and Statistical Manual of Mental Disorders, the International Classification of Diseases, and State guidelines, which group health plans must use to define the services covered in SUD benefit packages.

Should the Departments define a scope of services constituting substance use disorder treatment, the levels of care identified by the American Society of Addiction Medicine (ASAM) (Early Intervention; Outpatient Treatment; Intensive Outpatient/Partial Hospitalization; Residential/Inpatient Treatment; and Medically-Managed Intensive Inpatient Treatment) should be included. Including this full continuum will better ensure that people with substance use disorders receive the appropriate clinically determined type and level of care.

The IFR recognizes that high out-of-pocket spending requirements deter individuals from accessing substance use disorder services. As a result, the IFR correctly recognized that individuals need a combined mental health and substance use disorders and medical deductible to keep out-of-pocket spending requirements at a reasonable level.

We look forward to working with the Administration as these and other issues unfold. Should you have any questions, or require additional information, please do not hesitate to contact me.

Sincerely,



Robert Morrison
Executive Director

Cc: Flo Stein (North Carolina), NASADAD President