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National Association of Social Workers
Office of the Executive Director
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Comments on the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act of 2008, Interim Final Rule
File Code CMS-4140-IFC

The National Association of Social Workers (NASW) applauds the U.S. Departments of Labor, Health and Human Services and Treasury for their attention to the experiences of patients seeking treatment for mental health and substance use disorders (MH/SUD) and the barriers to treatment occasioned by health plan structures and practices. The Interim Parity Rule (IPR) is consistent with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA) without unduly expanding or limiting its application. The IPR supports the purpose of the MHPAEA for the benefit of consumers of MH/SUD services and recognizes the complex and significant relationship between health plan coverage for treatment and access to treatment.

The examples provided by the regulatory agencies offer a useful understanding of how the rules are to be analyzed and applied, although there are some areas where further clarification would be beneficial, as the Departments have suggested in the request for comments. The Interim Parity Rule implements the MHPAEA's groundbreaking measures to improve patient access to MH/SUD coverage in a robust manner. The regulatory agencies have demonstrated responsiveness to the concerns of health care consumers and MH/SUD providers in crafting an Interim Rule that supports the letter and spirit of the MHPAEA and that reflects an understanding of the comments submitted by interested organizations at the initiation of the rulemaking process.

Clinical social workers are the largest single group of mental health providers in the United States and their work encompasses patients and clients in a wide range of treatment and community settings, addressing those of all ages with both mental health and substance use disorders. Clinical social workers' ability to serve patients and clients has been hampered in the past by the inequitable treatment of MH/SUD within health plan protocols. The MHPAEA effectively addressed this for larger employers' health plans and the IFR implements the statute

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with integrity to the letter and the spirit of the law. We strongly support the Departments' regulatory interpretation of the MHPAEA and its groundbreaking measures to improve patient access to care and improve the status of patients with MH/SUD. In response to the IFR, NASW provides the following specific comments:

1. We appreciate that the parity standard devised by the Departments is one that ensures that mental health and substance use benefits are not discriminated against in how health plan benefits are designed. We strongly agree and support retention of the standard for annual and lifetime dollar limits to be treated similarly for MH/SUD benefits and medical/surgical benefits.

2. We appreciate that the Departments address the status of non-quantitative treatment limitations in the IFR. The manner in which provider reimbursement rates, admission to provider networks and methods for determining usual and customary and reasonable (UCR) rates may or may not be applied by health plans to meet parity requirements is of particular interest to clinical social workers and the addition of specific clinical social worker examples to the final rules would be appreciated.

   Licensed clinical social workers are excluded from reimbursement in some health plans although they are licensed by the state to provide mental health services and recognized within the HIPAA regulations and the Medicare program and other federal programs as eligible providers that are covered by federal law. We would appreciate clarification that when health plans provide coverage for MH/SUD benefits they must include clinical social workers and other primary groups of licensed providers that are qualified to provide these services.

   The application of UCR rates to mental health providers has been carried out in a manner that is not transparent so that patients of out-of-network providers are unable to ascertain at the initiation of treatment what will be their level of financial responsibility. The method for determining UCR rates and applying them to patients' coverage needs to be applied equitably for MH/SUD treatment and medical/surgical treatment.

3. NASW agrees that the parity standards should apply to medical necessity exclusions from coverage. The manner in which the IFR addresses medical necessity exclusions is of particular interest to clinical social workers. In the context of MH/SUD treatment, the content of the patient's clinical sessions is crucial to providing service; however, health plan access to highly sensitive personal information also creates significant privacy concerns that impact the patient's trust in the therapeutic process and ultimately the patient's progress toward wellness. We would like for the Departments to provide

examples in the final rule of the acceptable scope of medical necessity reviews for MH/SUD treatment as compared to medical/surgical reviews.

4. We believe that the IPR should clarify that out-of-network providers have a right to the disclosure of a health plan's medical necessity criteria relating to services they have provided for plan participants. The current IPR language specifies that the disclosure requirement extends to "contracting providers." Out-of-network providers who have provided covered services for a health plan member should have access to the medical necessity criteria and the regulations should be revised to require disclosure to "providers who render covered services to plan members."

5. NASW suggests additional clarification on the acceptable and unacceptable parameters for the exclusion of specific conditions or disorders, so that the purpose of the law is not thwarted. May a health plan arbitrarily determine which disorders or conditions to cover, or must a diagnosis-specific exclusion be based on some reasonable, science-based criteria? NASW requests additional discussion of acceptable and unacceptable disorder-specific exclusions from coverage or acceptable and unacceptable examples of the bases on which such exclusions may be made.

We appreciate the opportunity to comment on the Interim Final Rule and look forward to the enhancement in patients' lives due to the increased access to mental health and substance use disorder treatment that the MHPAEA and the implementing rules will provide.

Sincerely,

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