PUBLIC SUBMISSION

As of: May 04, 2010
Received: May 03, 2010
Status: Draft
Category: State Government - G0010
Tracking No. 80ae5df2
Comments Due: May 03, 2010
Submission Type: Web

Docket: CMS-2009-0040
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: CMS-2009-0040-0048
Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Document: CMS-2009-0040-DRAFT-0105
PA

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General Comment

See attached file(s)

Attachments

CMS-2009-0040-DRAFT-0105.1: PA

May 3, 2010

TO:
Internal Revenue Service
Department of the Treasury

Employee Benefits Security Administration
Department of Labor

Centers for Medicare and Medicaid Services
Department of Health and Human Services

FROM:
The Office of Mental Health and Substance Abuse Services (OMHSAS)
Pennsylvania Department of Public Welfare

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-OHPSACA.EBSA@dol.gov

To The Departments:

The Office of Mental Health and Substance Abuse Services (OMHSAS) appreciates the opportunity to comment on the interim final rules (IFR) for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) published on February 2, 2010 in the Federal Register. We are optimistic that, with the passage of this seminal legislation, health insurance discrimination against individuals needing treatment and seeking equity in coverage for mental health and substance use disorders will be mitigated.

1. **We agree with and support the parity standard devised by the Departments as one that ensures that persons who utilize mental health and substance use benefits are not discriminated against in health plan benefit design. We also agree with the Departments' determination that the MHPAEA prohibits health plans from applying separate deductibles, out-of-pocket maximums or other cumulative financial requirements on mental health/substance use disorder benefits.**

We agree that the parity standard devised by the Departments fully and appropriately implements the statutory requirement by MHPAEA. Specifically, 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 mental

health/substance use disorder benefits are no more restrictive than those requirements or limitations placed on medical/surgical benefits. While the statutory language of MHPAEA is ambiguous concerning separate deductibles, out-of-pocket maximums and other financial requirements, the IFR makes clear that the goal of the legislation was to end benefits discrimination against mental health and substance use disorder services in enacting the law. Hence, plans that apply separate deductibles, out-of-pocket maximums or other requirements on plan enrollees for mental health/substance use disorder services, when such requirements are not imposed on other services, are engaging in a form of discrimination banned by the new parity law. Insofar as individuals and families seeking behavioral health treatment often faced additional costs associated with seeking services, this disparity often created a barrier forcing many to forego care. By prohibiting separate cumulative financial requirements, OMHSAS is optimistic that the MHPAEA will result in increased access to treatment for many individuals and their families.

2. **Additional clarification is needed concerning the applicability of both MHPAEA and the IFR on Medicaid funded managed care plans**

As a State which has implemented Medicaid funded behavioral health managed care statewide, we are keenly interested in the applicability of both the MHPAEA and the IFR to our current system. We understand that insofar as the IFR does not contain an exemption for Medicaid managed care plans and that the Medicaid statute requires that Medicaid managed care plans comply with the parity provisions of the Act, we understand that the MHPAEA applies to states that contract with one or more MCOs or PIHPs to provide medical as well as mental health and substance abuse benefits. We further understand that the Act does not apply to a state's Medicaid State Plan if a state does not use MCOs or PIHPs to provide these benefits. However, if a state uses one or more MCOs or PIHPs in some but not all areas of the state, does the MHPAEA apply only to those areas where both medical and behavioral health are administered through an MCO and/or PHIP? Additional clarification would be helpful in this regard.

3. **Greater Clarification needed concerning scope of Service Parity and Clarification of Benefits**

The regulations create six classifications of benefits for the purpose of applying the parity rules; 1) inpatient, in network, 2) Inpatient- out of network, 3) Outpatient in-network 4) Outpatient out-of network 5) Emergency Care, 6) prescriptions.

The rule does not define levels of care, provider types or service levels beyond the broad definition of "Classification of benefits." Provider types in Pennsylvania vary greatly in public sector behavioral health-there are many more providers that may not hold professional credentials and there are no comparable medical

services associated with a medical plan's 100% RBRVS. For example, peer support, case management or intensive in-home services may be delivered by consumers or paraprofessionals. Additional clarification may be needed concerning whether these provider types fall within the scope of services subject to parity. Additionally, greater clarity may be needed concerning how services which seem to fall outside of the defined categories will be classified.

4. **More clarification needed regarding Treatment Limitation: Quantitative v. Non-Quantitative Service Limitation**

The rule defines treatment limitations to include both quantitative treatment limitations (a limitation that is expressed numerically, such as an annual limit of 30 outpatient visits) and non-quantitative limitations (a limitation that is not expressed numerically, but otherwise limits the scope, time or duration for treatment benefits). The IFR provides that a permanent exclusion of all benefits for a specific condition or disorder is not a treatment limitation. It could be argued that a plan could totally exclude coverage for a mental health and/or substance use disorder and not violate MHPAEA. Once a plan covers such benefits, however, such coverage must be in parity with the coverage for medical/surgical benefits under the same plan.

More guidance is needed on the non-quantitative treatment limitations that have to be "comparable to and applied no more stringently than the processes/factors used to apply MH and SUD benefits in the same classification". Assuming the IFR is applicable to managed care environments, this would impact how medical management determinations are made at the plan level.

While the IFR seems clear in the preamble that managed care practices continue to help reduce the cost of care, it also states that no findings will be made regarding the differences between the type and nature of treatment needed for medical surgical care and the nature of treatment needed for mental health and substance abuse. Insofar as the IFR does not appear to recognize distinctions between types of care, is it anticipated that two very different types of care be treated identically? It is unclear how plans will accomplish and manage compliance in this regard.

Thank you for your consideration of our comments.