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General Comment

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
US Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
Attention: MHPAEA Comments

The Pennsylvania Community Providers Association (PCPA) is a trade association representing more than 200 community based agencies across Pennsylvania that provide mental health, intellectual disability and addiction services for children and adults. PCPA represents providers on legislative and administrative matters, serves as a forum for the exchange of information and experience and serves as a point of contact with other related statewide organizations. PCPA members provide services to almost one million Pennsylvanians each year.

PCPA members and those they serve appreciate Congressional efforts to ensure that mental health and substance use disorder services and supports are covered adequately by insurance through the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Act). Too often there is a financial barrier that prevents access to needed services. Lack of coverage exacerbates reluctance to seek services due to issues of stigma and fear.

PCPA is concerned that definitions of mental health and substance use disorder benefits may exclude services and supports that have proven effective, but present very differently from the general framework of treatments most understood by insurers.

- Services such as psychiatric rehabilitative services, peer support, mobile therapies and treatment should be covered.
- Access to a full array of medications is needed.
- Community standards of care and service, as well as evidence-based practices, should be followed.
- Treatment, duration of treatment, and new treatments should be driven by an independent panel of mental health and substance use disorder experts, rather than individuals employed or engaged by insurers.
- Covered services should not be static. As with medical/surgical services, new and innovative services and supports must be encouraged and covered by the Act.

Medical necessity criteria must be made available so that all know what to expect.

- Narrow medical necessity criteria can, and often does, limit and exclude needed services, particularly services that are costly.
- Language in regulation must be carefully crafted to minimize denials of services based on overly stringent medical necessity determinations.
- It is not sufficient to only make available the reason for denials. The information used to make the determination should also be provided.
- A timely and responsive grievance and appeal process must be readily accessible.

Other means that are often used to limit access to services must be addressed.

- Fail first policies should not be used. The appropriate services, determined by the provider/practitioner and the individual, should be accessible when needed.
- Utilization management must be done by persons with expertise in the respective behavioral health services. A timely independent review process for denials must be instituted.
- Where state law and regulations are more stringent than federal law and regulations, state requirements should prevail.

Limitation of network providers is also a means of excluding real coverage for services.

- Requirements must include language related to adequacy of provider networks based on geographic location, services provided, and wait time for services.
- Community providers of behavioral health services (mental health and

substance use disorder) must be included in the networks to provide the broad array of services needed by individuals.
• For those instances when a network provider is not readily available for the needed service or support, reasonable access to out-of-network providers must also be afforded. The process must not be so onerous as to actively discourage individuals from seeking needed services from an out-of-network provider. Nor can it be a prior authorization process for which services are never authorized.
• A mechanism is needed for expedited appeals in urgent and emergency situations. Coverage should not be denied when the urgency of the situation makes prior approval infeasible.

Low rates offered to providers can also effectively limit coverage. Rates must be fair and competitive so that qualified mental health and substance use disorder service providers can participate in provider networks.

The language of insurance is very confusing. Standard notification letters, denial letters, and other types of communication should be developed to minimize confusing language and make the information conveyed clear and understandable.

As more and more research supports the importance of treatment of mental health and substance use disorders to the physical health of the person, there are provisions in the Act that allow for exemption from coverage. It may be impossible for very small employers to provide health care coverage, but if coverage is available, then coverage for behavioral health services should be included. Overall costs should be less if the whole person is served, rather than treating only physical health issues that may not be effectively treated if behavioral health issues impede full participation in the treatment regimen. Small employers could continue exemption from coverage for behavioral health services for years to the detriment of their employees.

Thank you for this opportunity to comment on the Act and we look forward to real equity and parity for physical health, mental health, and substance use disorder service coverage.

Sincerely,

George J. Kimes
Executive Director