EPSTEIN BECKER & GREEN, P.C.

ATTORNEYS AT LAW

1227 25TH STREET, NW, SUITE 700
WASHINGTON, DC 20037-1175
202.861.0900
FAX: 202.296.2882

May 28, 2009

<u>**FILED VIA E-RULEMAKING PORTAL**</u>

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

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
Attention: CMS-4137-NC
200 Independence Avenue, SW
Washington, DC 20201

Internal Revenue Service
Courier's Desk
CC:PA:LPD:PR (REG-120692)
1111 Constitution Avenue, NW,
Washington, DC 20224

RE: **Comments** on the Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
Published at 74 Fed. Reg. 19155 (April 28, 2009)

Dept. of Labor EBSA File No.:	Attention MPSAEA Comments
Dept. Health & Human Servs. CMS File No.:	CMS-4137-NC
Dept. of Treasury IRS File No.:	CC:PA:LPD:PR (REG-120692)

Dear Sirs and Madam:

Epstein Becker & Green, P.C. is writing on behalf of its client, the Watershed Addiction Treatment Programs ("**Watershed**"), to respond to the above Departments' Request for Information (**"RFI"**), published in Volume 74 of the Federal Register at page 19155 on April 28, 2009, regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (**"MHPAEA"**). Watershed appreciates this opportunity to share with the

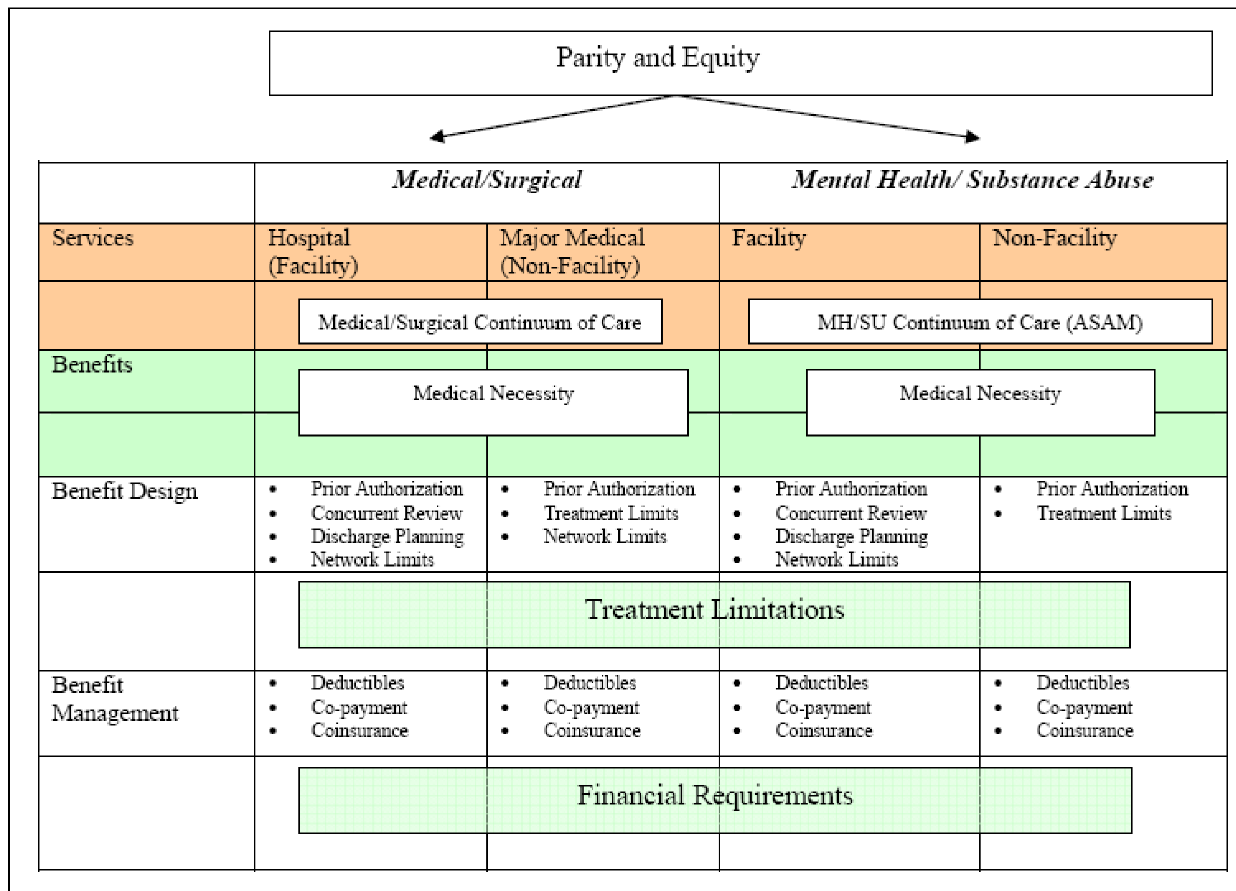
Departments both its first-hand knowledge and experience with ways in which plans have historically applied and currently apply both financial requirements and treatment limitations under substance use disorder benefits in manners not on par with medical and surgical benefits, and its suggestions regarding regulatory guidance for implementation of MHPAEA.

By way of background, Watershed is a Joint Commission accredited, state licensed, full service healthcare provider of substance use disorder as well as co-occurring mental health condition treatment services. Watershed has been in operation since 1998 and is recognized as a premier provider of a full continuum of care including medical detoxification, intensive inpatient (rehabilitation), residential treatment, partial hospitalization and intensive outpatient levels of care. Watershed's treatment services are provided by a team of highly skilled professionals, including psychiatrists, nurses, psychologists, licensed mental health counselors and case managers. Watershed's complete continuum of professional treatment services provides patients with continuity of care, with the goal of affording each patient the optimum clinical environment in which to embark upon long-term recovery. Millions of Americans are afflicted with substance use disorders that impact their jobs, families and our society. Substance use disorders are chronic diseases, requiring lifetime management. As reported during the U.S. Senate Committee on Finance's April 21, 2009 Roundtable to Discuss Reforming America's Health Care Delivery System, it is estimated that, in this country today, 5% of the chronically ill represent 50% of all Medicare costs. By receiving comprehensive, quality care, individuals suffering from the chronic disease of substance abuse, can and do recover.

Watershed recognizes that successful implementation of MHPAEA will help to achieve Congress' goal of parity and equity between healthcare coverage for mental health and substance use disorder (**"MH/SU"**) treatment services and healthcare coverage for medical and surgical (**"med/surg"**) treatment services, including out-of-network coverage. Accordingly, Watershed is very encouraged that MHPAEA requires that financial requirements and treatment limitations applied to MH/SU benefits can be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all med/surg benefits.

Watershed also is pleased with the RFI's request for information on the types of limitations currently experienced by MH/SU providers, such as Watershed. Watershed believes that for the Departments to understand those limitations, it is important to acknowledge that there are unique aspects in the design and management of MH/SU benefits, as distinct from the design and management of med/surg benefits of health insurance benefit plans. For example, it is Watershed's experience that inpatient substance use disorder treatment services are often provided in duly licensed and accredited free-standing residential treatment facilities rather than hospital facilities, in part, because these residential treatment facilities provide the appropriate level of care within the continuum of care for substance use disorders. Watershed believes that these differences in facility and non-facility licensing and accreditation should not be used as a mechanism to limit inpatient treatment. Nor can parity be achieved if the implementing MHPAEA regulations do not prohibit these types of treatment limitations.

Indeed, as the following chart depicts, both med/surg and MH/SU benefits cover a range of facility and non-facility services which span a continuum of care and result in coverage of a particular service based on a health plan's evaluation of whether or not the services are "medically necessary."



Yet despite the commonalities, it is Watershed's experience that, historically, MH/SU benefits have been administered and managed by plans and employers in a manner so as to limit the actuarial risk associated with covering the facility and professional services often comprised in the MH/SU benefit. For example, med/surg benefits are seldom subject to absolute, prospective treatment limits or caps, such as limiting treatment to a specific number of physician visits or hospital admissions per year without regard to the covered individual's specific health care needs. In contrast, MH/SU benefits frequently establish treatment limits or caps such as a defined number of office visits per year or a requirement that outpatient treatment fail before inpatient services can be provided, all without regard to the patient's medical condition or need. In addition, it is Watershed's experience that there are inappropriate restrictions as to the different types of providers in the MH/SU benefit. Similarly, there are differences in the

patient's financial obligation for services related to the med/surg benefit as compared to the MH/SU services.[1]

Watershed recognizes the unique challenge that health plans face as they try to strike the right balance between providing equity and parity of benefits, while also managing the rate of growth in health insurance premiums. While MHPAEA allows for an exemption if an employer's or health plan's total costs of achieving parity or equity exceed two percent in the first year or one percent in the second year, Watershed believes that the federal Office of Personnel Management **("OPM")** in its Federal Employee Health Benefit Program (**"FEHBP"**) Call Letter dated April 20, 2009 ("**Call Letter**") offered health plans important guidance on this issue which should be reflected in the MHPAEA implementing regulations. In particular, OPM stressed the importance of health plans identifying value-based solutions to managing the health insurance benefit, including med/surg benefits and the MH/SU benefit, as well as the use of managed care organizations such as the Managed Behavioral Healthcare Organization (**"MBHO"**).[2]

The central role of the MBHO in the FEHBP Call Letter also highlights another important difference between the two benefits that must be acknowledged if parity is to be achieved. That is, with MH/SU benefits, plans often have the MBHO take a more visible and active role with MH/SU providers, whereas with med/surg benefits, plans predominantly use management organizations in a much less active, less visible role. For example, in contrast to the more "pervasive" role that the MBHO has in MH/SU benefit management, a managed care organization (**"MCO"**) is often seen as "invisible" to the patient who is accessing physician or hospital services. More recently, however, specialized benefit managers such as a pharmacy benefit manager (**"PBM"**) or a radiology benefit manager (**"RBM"**), which focus on targeted patients or disease conditions, are playing a role which is more consistent with the MBHO role.

---

[1] As noted in a comprehensive report funded by the Substance Abuse and Mental Health Services Agency (**"SAMSHA"**), mental health services are disproportionately paid by public funds from local, state and federal sources, in part because of the coverage restrictions which were implemented by private payers in the 1990's. The SAMSHA report data conversely indicates that the costs for substance abuse services are borne by the patient, in the form of out-of-pocket spending associated with both treatment limitations and requirements. (Rosenbaum, S., Kamoie, B., Mauery, D. R., Walitt, B. Medical Necessity in Private Health Plans: Implications for Behavioral Health Care, Substance Abuse and Mental Health Services Administration (SAMHSA) DHHS Pub. No. (SMA) 03-3790, 14, (Nov. 2003))

[2] It is important to this discussion to understand that the substance abuse provider community has a long history of providing substance abuse services with a strong, upfront role for managed care organizations, such as the MBHO. Indeed, in response to the existing treatment and financial requirements currently experienced by the MH/SU provider community, the MH/SU provider community, supported by funding from SAMSHA and other agencies within the Department of Health and Human Services, developed an evidence-based managed care approach to providing the appropriate level of service across the continuum of care. In the substance abuse area, this continuum of care is represented by the Patient Placement Criteria of the American Society of Addiction Medicine (**"ASAM"**). These criteria, first published in 1991, provide a common language to develop a broader continuum of care that has been used by health plans and substance abuse providers alike.

Based upon the important role and cost containment that can be achieved through the use of managed care organizations, Watershed believes that value-based decisions for managing both med/surg and MH/SU benefits should be factored into the methodology for calculating the actual costs of coverage for purposes of determining whether a plan qualifies for a cost exemption under MHPAEA. The more visible and active role of MBHOs in MH/SU benefits could be a standard applied to the med/surg benefit as well. Watershed believes that the implementing regulations addressing the cost exemption should require an assessment as to whether or not there is an equitable use of benefit management for med/surg and MH/SU services. In addition, Watershed believes that the implementing regulations addressing treatment limitations and/or financial requirements should require consistency in the processes by which medical necessity determinations are made for med/surg services as well as MH/SU service. The processes span the range from the publication of criteria and their use by appropriately trained reviewers through the timeliness of appeals processes. Continued use of different utilization management practices for med/surg and MH/SU benefits would be inconsistent with MHPAEA.

MHPAEA was designed to address broad inequities related to the establishment of treatment limitations and financial requirements as described above in general terms. However, given the complexities of the issues, as well as the nuanced distinctions between benefits and services, Watershed believes that the regulations which implement MHPAEA must be prescriptive and strive to balance the historical inequities in benefit design and management, many of which are discussed below. In particular, Watershed believes that the implementing regulation should provide specific guidance to health plans and employers on a wide range of regulatory issues including, but not limited to: 1) appropriate reference point for a “plan”; 2) standards for compliance with reporting obligations; and 3) examples of what constitutes the appropriate reference point for defining a “predominant” limitation. For example, Watershed believes that the implementing regulations should require health plans and employers to publish the admission and medical necessity criteria used by the plan or employer. Additionally, Watershed believes that the implementing regulations should provide examples of predominant financial requirements that clearly proscribe the types of conduct that are considered compliant with MHPAEA. For example, if the most common or frequent financial requirement for a hip replacement is a $500 co-pay for the entire treatment plan (spanning both the inpatient and outpatient treatment plan), then this same limitation (and nothing more) should apply to a substance use disorder treatment plan.

In summary, Watershed believes that the regulation should develop specific regulatory guidance which is grounded on the common elements between the med/surg and MH/SU benefits. These common elements include the use of facility and non-facility services across the continuum of care for med/surg services and MH/SU services. Healthcare spending data indicate that hospital services are the most significant component of facility costs for the med/surg benefit while physician services are the most significant component of non-facility costs. As a result, Watershed believes that, in determining whether there is parity and equity with regard to treatment limits, the evaluation should consider which type of medical necessity determination is predominant. For example, are most services subject to a prior authorization process, or are most

services subject to a "post-payment" review process. Similarly, the predominant form of financial requirements for the facility and non-facility services of the med/surg benefit should apply to the MH/SU benefit. For example, if a specific deductible level is the predominant financial requirement for a hospital stay, a comparable deductible would be appropriate for a MH/SU facility stay.

With that background in mind, we have organized the next section of this letter to address **the six areas identified in the RFI where the Departments have indicated a need for additional information**.

RFI Number 1. THE STATUTE PROVIDES THAT THE TERM "FINANCIAL REQUIREMENT" INCLUDES DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND OUT-OF-POCKET EXPENSES, BUT EXCLUDES AN AGGREGATE LIFETIME LIMIT AND AN ANNUAL LIMIT. THE STATUTE FURTHER PROVIDES THAT THE TERM "TREATMENT LIMITATION" INCLUDES LIMITS ON THE FREQUENCY OF TREATMENT, NUMBER OF VISITS, DAYS OF COVERAGE, OR OTHER SIMILAR LIMITS ON THE SCOPE OR DURATION OF TREATMENT.

DO PLANS CURRENTLY IMPOSE OTHER TYPES OF FINANCIAL REQUIREMENTS OR TREATMENT LIMITATIONS ON BENEFITS? HOW DO PLANS CURRENTLY APPLY FINANCIAL REQUIREMENTS OR TREATMENT LIMITATIONS TO (1) MEDICAL AND SURGICAL BENEFITS AND (2) MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS? ARE THESE REQUIREMENTS OR LIMITATIONS APPLIED DIFFERENTLY TO BOTH CLASSES OF BENEFITS? DO PLANS CURRENTLY VARY COVERAGE LEVELS WITHIN EACH CLASS OF BENEFITS?

As a treatment provider of substance use disorder services for over 10 years, Watershed has first-hand experience with ways in which plans have historically applied and currently apply both financial and treatment limitations to MH/SU benefits. Watershed believes that the Departments' implementing regulations should provide specific guidance to health plans and employers on what constitutes a treatment limitation and what constitutes a financial requirement.

Below, we describe Watershed's experiences with financial requirements and treatment limitations and offer Watershed's recommendations as to the type of guidance that, based on Watershed's experience, would result in a successful implementation of Congress' intent to eliminate structural differences between the med/surg benefit and the MH/SU benefit.

A. Examples of Watershed's Experience with Financial Requirements.

1) *Pre-authorization penalties under the MH/SU benefit that are not present or equally applied under the med/surg benefit*.

   It is Watershed's experience that many insured plans contain financial pre-authorization penalty provisions that apply when a healthcare provider of substance use disorder treatment services is unable to or does not obtain a pre-authorization for services prior to

admission under the MH/SU benefit. Such financial penalties can range from $500 to complete denial of coverage. Conversely, under the med/surg benefit, plans do not typically impose these penalties for noncompliance, particularly in urgent/emergent situations where a provider is unable to obtain the required prior authorization.

Watershed Recommendation.—The unequal application of pre-authorization controls results in more restrictive financial requirements on MH/SU benefits than are applicable to med/surg benefits, thereby violating the plain language and intent of MHPAEA. The Departments' implementing regulations should specify that pre-authorization requirements applicable to MH/SU benefits must be no more restrictive than those applicable to med/surg benefits in order to be in compliance with MHPAEA. In addition, the implementing regulations should specify that the criteria on which grants of pre-authorization for MH/SU benefits are based should be no more restrictive than those applicable to med/surg benefits.

2) *Requiring completion of treatment regimen under the MH/SU benefit as a condition of coverage without a similar requirement under the med/surg benefit*.

It is Watershed's experience that many plans require that a member complete the treatment regimen as set forth in the plan of care, (for example, a 28 day treatment program), as a condition of coverage and payment (*i.e*., in order for the services to be covered and paid under their MH/SU benefit, the patient must complete the full treatment regimen as set forth in the plan of care). There exists no such program completion requirement under the med/surg benefit.

To illustrate, under such a plan, a member could receive detoxification, intensive inpatient (rehabilitation) and residential treatment for a total of 16 days, and leave treatment against medical advice. Because the member did not complete a 28 day treatment program, ***none*** of the treatment would be covered and paid. In this situation, the member must pay out-of-pocket for the entire course of treatment services.

Conversely, under the med/surg benefit, a member could be recovering from knee replacement surgery and be prescribed a series of 28 therapy sessions, yet stop at the 16th session. On the med/surg side, the 16 treatment sessions would be covered and paid and the member would not be required to pay the same out-of-pocket expenses.

Watershed Recommendation.—A requirement that a member complete a treatment program set forth in the plan, in order for *any* of the treatment services to be covered and paid under the MH/SU benefit, is both a separate treatment limitation and results in a *defacto* financial requirement that does not exist under the med/surg benefit. The Departments' implementing regulations should specify that completion of treatment regimens as a condition of coverage and payment is a form of treatment limitation and *defacto* financial requirement and, to the extent insured plans apply such restriction to

MH/SU benefits, they must be no more restrictive than those applicable to med/surg benefits in order to be in compliance with MHPAEA.

3) *Treatment caps result in defacto financial requirements as any treatment needed beyond such caps must be paid out-of-pocket*.

The SAMSHA report data demonstrates that the high level of personal spending for substance use services are associated with paying for services that exceed the number proscribed by the treatment caps, as well as the co-payments or co-insurance rates which are typically higher than those required for med/surg services.[3]

Watershed Recommendation.—The Departments' implementing regulations should specify that treatment caps be eliminated, or to the extent treatment caps are applied to MH/SU benefits, similar caps should be applied to med/surg benefits.

4) *Restrictions on out-of-network MH/SU providers with no parallel restrictions for med/surg out-of-network are defacto financial requirements*.

Watershed has experienced problems where a coverage policy appears on paper to be equal treatment but in reality requires members to pay out-of-pocket. For example, a policy which restricts access to providers who are licensed only in the state in which the plan is written is a *de facto* financial requirements, regardless of whether it is defined as a financial requirements or a treatment limitation. Similarly, coverage of services which are subject to fee schedules that are set so low on the MH/SU side that no out-of-network provider would ever accept payment should be defined as a financial requirement if a different fee schedule is used to pay for services under the med/surg benefit.

Watershed Recommendation.—The Departments' implementing regulations should specify that MH/SU benefits which restrict access to providers based on the geographic location of the plan in which it was issued is a financial requirement and/or treatment limitation. The regulations should specify that access be available to out-of-network MH/SU healthcare providers consistent with the med/surg benefit although both are subject to the financial requirements relative to out-of-network versus in-network benefits.

More specifically, it is suggested that the implementing regulations clarify that MHPAEA parity provisions be applied equally to benefit coverage for out-of-network providers of MH/SU services, as it is applied to benefit coverage for out-of-network providers of med/surg services. As Congress expressed:

---

[3] Rosenbaum, S., Kamoie, B., Mauery, D. R., Walitt, B. Medical Necessity in Private Health Plans: Implications for Behavioral Health Care, Substance Abuse and Mental Health Services Administration (SAMHSA) DHHS Pub. No. (SMA) 03-3790, 14, (Nov. 2003).

> H.R. 1424 makes clear that equity in financial requirements, treatment limitations, and *out of network coverage* is essential to a strong federal mental health parity law.[4]

Thus, if an insured plan with med/surg and MH/SU benefits, provides out-of-network coverage on the med/surg side, it must also provide on par out-of-network coverage on the MH/SU side in a manner that is consistent with the requirements of MHPAEA.

5) *Both Inpatient and Outpatient benefit under Med/Surg - Only Outpatient benefit under MH/SU*.

Many healthcare plans containing both med/surg and MH/SU benefits, provide both an inpatient and outpatient benefit on the med/surg side; however, only an outpatient benefit on the MH/SU side. Watershed has experienced this scenario and the patient has borne the financial requirements. This situation would be contrary to the language and intent of MHPAEA. While MHPAEA does not mandate group health plans to provide a MH/SU benefit, if a plan does provide such a benefit, that benefit must be on par with substantially all benefits provided on the med/surg side, including out-of-network coverage.[5]

To permit plans to contain a significant limitation on the number of visits, days of coverage and scope and duration of treatment, such as an *outpatient only* benefit on the MH/SU side, while providing an *inpatient and outpatient* benefit on the med/surg side, (perhaps under the guise that MHPAEA does not mandate a MH/SU benefit), would be contrary to the plain language and intent of MHPAEA.

Watershed Recommendation.—The Departments' implementing regulations should specify that an outpatient only MH/SU benefit imposes an inequitable financial requirement unless the predominant med-surg benefit is also restricted to outpatient services.

B. Examples of Watershed's Experience with Treatment Limitations.

1) *Treatment Limitations resulting from disparities in type of criteria used to determine medical necessity*.

---

[4] Economic Stabilization, Pub. L. No. 110-343, House Report 110-374 (Part 1), p.23. (emphasis added).

[5] The legislative history for Emergency Economic Stabilization, Pub.L.No. 110-343, House Report 110-374 (Part 1), III. Summary of the Bill, p. 24, speaks to the intent of MHPAEA. The bill [H.R.1424] does not mandate group health plans to provide any mental health coverage; however, if the group health plan does offer mental health coverage then there must be equity between mental health coverage and all comparable medical and surgical benefits that the plan covers. H.R. 1424 makes clear that equity in financial requirements, treatment limitations, and out of network coverage is essential to a strong federal mental health parity law.

As noted in the first comment related to financial requirements, the pre-authorization process can also result in a treatment limitation because of the inappropriate criteria used to determine the medical necessity of MH/SU benefits compared to the med/surg benefit.

Specifically, it is Watershed's experience that, on the med/surg side, pre-authorization determinations are based on "medical necessity" while, on the MH/SU side, pre-authorization determinations are based on the setting in which the care is provided, rather than whether or not the service is medically appropriate. Watershed's experience is consistent with the observation made in the SAMSHA sponsored report on medical necessity issues related to behavioral healthcare.[6]

2) *Failing to provide for the full continuum of care on the MH/SU side, such as an exclusion of residential treatment, despite the offering of a full continuum of care through the med/surg benefit*.

Residential treatment consists of a 24 hour structured live-in environment with rehabilitative treatment services, and is an integral part of the continuum of care for substance abuse treatment. While medical necessity determinations must always be made, excluding the level of care provided by state licensed residential treatment facilities from plan coverage would be an inappropriate treatment limitation that is more restrictive than predominant treatment limitations placed on the med/surg side. Watershed has experience with these types of determinations which make create a financial hardship for a plan member.

To illustrate, a member obtaining substance abuse treatment may typically be admitted to detoxification level of care, followed by intensive inpatient care (rehabilitation) and monitoring, followed by residential treatment, followed by out-patient day treatment, followed by out-patient group therapy. Unfortunately, Watershed's experience indicates a great deal of variability in the coverage of services across the continuum of care for MH/SU services. For example, some plans restrict access to some facility services or to a particular level of care by setting treatment limits while other plans may use the financial requirements described to limit access to the same or a different level of care. In contrast, a member obtaining med/surg care which span the continuum of care from inpatient surgery, followed by intensive care in a monitoring unit, followed by continued hospitalization in a regular patient room, and eventually followed by outpatient therapy do not face such idiosyncratic restrictions. Without equitable coverage across the continuum of care, albeit with appropriate utilization management protocols, the

---

[6] Rosenbaum, S., Kamoie, B., Mauery, D. R., Walitt, B. Medical Necessity in Private Health Plans: Implications for Behavioral Health Care, Substance Abuse and Mental Health Services Administration (SAMHSA) DHHS Pub. No. (SMA) 03-3790, 14, (Nov. 2003).

treatment limits and financial requirements should be comparable in order to be consistent with MHPAEA.

MHPAEA clearly provides that there be "no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits."[7] Thus, if a plan provides MH/SU benefits, as well as med/surg benefits, Watershed believes that the plan may not impose limitations on the scope or duration of treatment under the MH/SU benefit that are more restrictive than those imposed under the med/surg benefit.

Watershed Recommendation.—The Departments' implementing regulations should specify that, if a plan covers every level and type of med/surg care for substantially all med/surg benefits (*i.e*., a full continuum of care), but allows for the exclusion of a certain level or type(s) of care, such as residential care, for MH/SU benefits, such plan would violate the MHPAEA's "no more restrictive" standard. In addition, the regulatory guidance should include guidance for determining when other similar types of unequal restrictions on covered levels of care would violate the MHPAEA's "no more restrictive" standard.

3) *Restrictions on the scope of services offered, such as an outpatient only benefit on the MH/SU side, while providing an inpatient and outpatient benefit on the med/surg side*.

As noted above (see also comment #5 above regarding financial requirement examples), substance use disorder treatment typically involves a continuum of care beginning with detoxification, followed by intensive inpatient care and monitoring and residential care, followed by outpatient care, etc. This is no different than a surgical orthopedic procedure beginning with the surgery, intensive inpatient physical therapy and additional less intensive physical therapy in a residential setting such as a nursing facility, followed by outpatient therapy. While MHPAEA does not mandate group health plans provide a mental health and/or substance use disorder benefit, it does not require parity with regard to "substantially all" benefits in each category.

Watershed Recommendation.—The Departments' implementing regulations should specify that if a plan does provide such a MH/SU benefit, that benefit must be on par with substantially all benefits provided on the med/surg side. Therefore, the regulation should address the requirement for plans to provide substantially all med/surg benefits on the one hand, and substantially all MH/SU benefits on the other hand and specifically prohibit any treatment limit associated with a MH/SU outpatient only benefit when the med/surg benefit contains both inpatient and outpatient benefits.

[7] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A § 1185a(a)(3)(A)(i), (ii) (2009).

4) *Facility/Clinician type restrictions under MH/SU benefit not on par with Med/Surg benefit*.

It is Watershed's experience that many insured plans, (and several state law mandates), providing for MH/SU benefits, restrict such benefits to services rendered only by hospitals or facilities affiliated with such hospitals, as defined by the plan. As a result, many insured plans do not include appropriately licensed and accredited free-standing residential treatment facilities in their definition of "hospital" or "qualified treatment facility." Substance abuse treatment facilities that are properly licensed for each level of care they provide are the equivalent of properly licensed hospitals on the med/surg side. This treatment limitation, as contained in many insured plans, deprives members of the ability to obtain covered treatment from those healthcare providers that specialize in, and are specifically licensed to, render those services the member requires.

Similarly, some group health plans provide coverage for medical services rendered by substantially all types of licensed professional clinicians such as physicians, nurses, and physical rehabilitation therapists under the med/surg benefit. However, the same plan may exclude coverage for substance use disorder services rendered by substantially all types of licensed professional MH/SU providers such as psychiatrists, psychologists, mental health counselors, social workers and certified addiction professionals under the MH/SU benefit.

Watershed Recommendation.—The Departments' implementing regulations should require that insured plans accommodate the different types of licensed facilities, such as residential treatment facilities, and professionals, such as licensed mental health counselors, who provide services which are uniquely appropriate to the MH/SU benefit. As noted in a recent Health Affairs issue, the President of CIGNA Health Solutions noted that a major challenge for health plans in implementing mental health parity is the elimination of "any vestiges of structural differences between coverage of MH/SA treatment benefits and benefits for general medical care"[8]. The implementing regulation, by acknowledging the inherent differences in the settings and types of providers which are unique to MH/SU care, will go a long way in providing technical guidance to plans which is consistent with the Congressional intent of MHPAEA.

5) *Level of care exclusions under the MH/SU benefit not on par with the Med/Surg benefit*.

In addition to the treatment limits which are based on the facility and provider characteristics (see also comment #4 above regarding treatment limitation examples), many insured plans providing both a med/surg and a MH/SU benefit, exclude from

---

[8] Keith Dixon, "Implementing Mental Health Parity: The Challenge For Health Plans", Health Affairs, 28(3):663 (May-Jun 2009).

coverage the rehabilitation and/or residential levels of care on the substance use disorder side, requiring patients to go directly from detoxification into an outpatient setting.

There exists no such corresponding exclusion on the med/surg side. Residential treatment, for example, consists of a 24 hour structured live-in environment with rehabilitative treatment services, and is an integral part of the continuum of care for substance abuse treatment. While medical necessity determinations need always be made, the exclusion from coverage altogether of a state licensed rehabilitation or residential level of care, is a treatment limitation that is more restrictive than predominant treatment limitations placed on the med/surg benefit.

To illustrate, a member obtaining substance abuse treatment may typically be admitted to detoxification level of care, followed by intensive inpatient rehabilitation and monitoring, followed by residential treatment, followed by outpatient day treatment and group therapy. To analogize, a member obtaining med/surg care typically will be admitted for surgery, followed by intensive care in a monitoring unit, followed by continued hospitalization in a regular patient room, followed by outpatient therapy. Every such level of med/surg care is a covered benefit, while the rehabilitation and residential levels of substance use disorder treatment are often excluded.

This type of treatment limitation reflects a vestige of the historical difference between the practice of covering med/surg services which span the continuum of care while using a more targeted and limited approach to defining the MH/SA benefit, including the use of treatment limits and significant financial requirements.

MHPAEA addresses *substantially all* med/surg benefits on the one hand and *substantially all* MH/SU benefits on the other hand. To permit plans to contain a significant treatment limitation based on the number of visits, days of coverage and/or scope and duration of treatment, such as an exclusion for rehabilitation and/or residential levels of care on the MH/SU side, while providing a full continuum of care on the med/surg side, would be contrary to the plain language and intent of MHPAEA.

Watershed Recommendation.—The Departments' implementing regulations should specify that an insured plan that excludes coverage for a level of care, such as rehabilitation and/or residential treatment, under the MH/SU benefit that allows for coverage of services for the full continuum under the med/surg benefit, will be deemed in violation of MHPAEA. In these situations, the plan should be required to provide corresponding levels of care on the MH/SU side as offered on the med/surg side in order to be in compliance with MHPAEA.

RFI Number 2. WHAT TERMS OR PROVISIONS REQUIRE ADDITIONAL CLARIFICATION TO FACILITATE COMPLIANCE? WHAT SPECIFIC CLARIFICATIONS WOULD BE HELPFUL?

Two areas which require additional clarification include the need for guidance as to the definition of a plan which will be subject to the MHPAEA requirements, as well as transparency requirements regarding plan information. Watershed provides recommendations for the type of guidance that would be helpful in each of these two areas.

A. Guidance Regarding Definition of a Health Plan.

1. *Carve-Out Plans and Separate EAP's To Be Aggregated*.

MHPAEA requires that employers and health plans which offer both MH/SU and med-surg benefits establish parity and equity between the two categories of benefits. Currently, many large national employers may offer several health plans from which their employees may choose, while for behavioral healthcare services, the employer may have a single "carve out" benefit for MH/SU services. Among some employers, the "carve out" benefit for MH/SU services may be integrated with an employee assistance program (**"EAP"**).

Watershed Recommendation.—It is suggested that the implementing regulations clarify that carve out behavioral health benefits, including those which have been integrated into an employer's EAP to the extent that it is deemed a group health plan, or other group health plans offered by an employer providing a MH/SU disorder benefit, should be aggregated with the employer's group plan providing only a med/surg benefit for purposes of parity requirements.[9] In light of the language and intent of MHPAEA, any "non-aggregation" of these separate plans would necessarily result in an evasion of the parity requirements of MHPAEA.

2. *No requirement to access EAP prior to primary group plan*.

EAP's , which have a MH/SU "carve-out" benefit associated with them, typically provide limited professional services, such as outpatient therapy, and typically designate the professional healthcare providers the employee is permitted to use. Conversely, under a group health plan providing an out-of-network benefit, the employee is able to choose

[9] *See* Proposed Rule, 69 Fed Reg 78800, 78807 and 78817 (Dec. 30 2004). Under these proposed regulations, generally, all of the medical care benefits provided by an employer are considered to be a single group health plan, unless: "(A) It is clear from the instruments governing the arrangement or arrangements to provide health care benefits that the benefits are being provided under separate plans; and (B) The arrangement or arrangements are operated pursuant to such instruments as separate plans." Prop. Labor Reg. §2590.732(a)(2)(i) and Prop. Treas. Reg. §54.9831-1(a)(2)(i), 69 Fed Reg at 78807 and 78817. Similarly, "[i]f a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion." Prop. Labor Reg. §2590.732(a)(2)(iii) and Prop. Treas. Reg. §54.9831-1(a)(2)(iii), 69 Fed Reg at 78817.

their healthcare provider. In addition, if an employee is required to access the EAP benefit first, the foreseeable tendency will be to require the employee to obtain outpatient care, as provided under the EAP, before permitting the employee to access the inpatient benefit under the primary group health plan. This requirement creates a stumbling block to the employee's direct access to inpatient care. MHPAEA was enacted to remedy a specific problem, namely, "the discrimination that exists under many group health plans with respect to mental health and substance-related disorder benefits."[10] To require an employee to access and exhaust the EAP benefit prior to being eligible for the MH/SU benefit under the primary group health plan imposes an impermissible, separate treatment limitation in violation of MHPAEA.

Watershed Recommendation.—In addition to the recommendation regarding aggregation of carve-out plans which are integrated with an EAP, it is suggested that the implementing regulations clarify, in the case of a separate EAP providing a MH/SU benefit, and a separate insured plan providing both a med/surg benefit and a MH/SU benefit, to the extent that the EAP is permitted to remain as a separate plan (not impermissible under the anti-abuse laws), that there be no requirement that employees utilize the MH/SU benefit under the EAP before being eligible to access the MH/SU benefit under the primary group health plan. Such an eligibility requirement would be an impermissible separate treatment limitation, which imposes an eligibility requirement not in parity with eligibility requirements under the med/surg benefit, prohibited by MHPAEA.

B. Guidance Regarding Transparency of Plan Information.

Transparency is an important element of ensuring meaningful compliance with the parity requirement of MHPAEA. Congress anticipated the need for plans to provide sufficient information to current or potential participants, beneficiaries or contracting providers and to provide information as to the reason for any denial under the plan with respect to MH/SU benefits.

Watershed Recommendations.— With regard to MHPAEA §512(a)(4), "Availability of Plan Information," Watershed requests that the implementing regulations address the ways in which plans will be monitored to ensure compliance with MHPAEA and the manner in which the public and relevant stakeholders may access information on MHPAEA compliance.

It is suggested that the regulation be specific as to what plan information must be made available to current or potential participants, beneficiaries or providers. The regulation should distinguish between the type of information available generally, and the type of

[10] H.R. REP. NO. 110-374, pt. 2, at 12 (2007) (Ways & Means Comm.).

information which needs to be provided at the point of service, when a determination of medical necessity is being made.

With regard to the latter, it is particularly important to establish timeline requirements in the regulation. Specifically, as required under MHPAEA § 512(a)(4), the regulations should address the manner and timeliness of plans providing access to the criteria for medical necessity determinations made under the plan to current or potential participants, beneficiaries or providers. In particular, in order to ensure that compliance with parity is meaningful and transparent, it is suggested that the regulations require plans to provide public access to their medical coverage policies (including policies on utilization management such as prior authorization), the criteria for making policies on medical coverage, the process for review of claims for payment, and the appeals process for any denials of claims by posting such information electronically on their website in an easily accessible manner. Specifically, the implementing regulations may ensure compliance by barring a plan from relying upon any medical coverage policies that are not posted.

Watershed believes that the language of MHPAEA contemplates that the implementing regulations can require both ERISA plans and health plans to provide important information under the provision related to "Availability of Plan Information." It is suggested that ERISA's "full and fair review" process provides an important structure for specifying the type of information that should be available from ERISA plans and health plans. In addition, as discussed more fully in Watershed's response to **RFI Number 3**, Watershed suggests that the regulation address the definition of medical necessity for both med/surg and MH/SU benefits to ensure any requirements based on medical necessity are applied consistently and equitably across MH/SU and med/surg benefits.

The need to readily access this information is particularly relevant to out-of-network providers who need to make timely and informed decisions on whether to furnish medical services and items. As discussed more fully below in Watershed's response to **RFI Number 3**, it is vitally important to have a timely process to resolve differences between published criteria and individual modifications that a plan or MBHO may apply at the point-of-service. Otherwise, serious inequities occur at a time when the health plan member is in crisis and is attempting to access services which are appropriate to the situation in an accredited facility licensed to provide critical MH/SU services, using nationally recognized ASAM placement criteria.

RFI Number 3. WHAT INFORMATION, IF ANY, REGARDING THE CRITERIA FOR MEDICAL NECESSITY DETERMINATIONS MADE UNDER THE PLAN (OR COVERAGE) WITH RESPECT TO MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS IS CURRENTLY MADE AVAILABLE BY THE PLAN? TO WHOM IS THIS INFORMATION CURRENTLY MADE AVAILABLE AND HOW IS IT MADE AVAILABLE? ARE THERE INDUSTRY STANDARDS OR BEST PRACTICES WITH RESPECT TO THIS INFORMATION AND COMMUNICATION OF THIS INFORMATION?

Medical necessity determinations are a critical aspect of establishing equity and parity between med/surg and MH/SU benefits. The determinations are made in the context of a specific service along the continuum of care. In general, the outcome of a positive medical necessity determination defines a "covered service," a term which is understood by health plans, providers and patients alike.

One of the most difficult and oftentimes frustrating aspects of medical determinations is the fact that the definition of the term varies across health plans, although there is a consensus as to the various dimensions that are considered as part of a medical necessity determination. A critical issue for the implementing regulation to provide guidance on is the need for a plan to have an equitable process as to the medical necessity criteria used under the med/surg and MH/SU benefits alike.

The Substance Abuse and Mental Health Services Administration (**"SAMSHA"**) issued a Special Report on "Medical Necessity in Private Health Plans: Implications for Behavioral Health" (the **"SAMSHA Medical Necessity Report"**) which is an exhaustive review of research findings and case law as well as state and federal laws pertaining to medical necessity reviews and determinations.

The SAMSHA report noted above lists five dimensions that can be considered as part of medical necessity determinations including: contractual scope, standard of practice, patient safety and setting, medical service and cost. In the report, Sabin and Daniels addressed the unique aspects of defining the medical necessity of mental health services and concluded that the "most rational model is one that treats a medically defined diagnosis, such as one delineated in the DSM-IV, to decrease the impact of disease or disability."[11]

The SAMSHA report suggests that a major challenge in making medical necessity determinations for MH/SU services, compared to med/surg services is an underlying debate among health plans and review organizations as to whether "medical necessity" is the appropriate term, or, whether "clinical appropriateness" is a more accurate term for evaluating services under the MH/SU benefit. Therefore, medical necessity reviews for MH/SU benefits are more likely to focus on an assessment of "what level of services in which settings are most clinically appropriate for a given patient in light of his or her clinical social needs."[12] Thus, medical necessity determinations of MH/SU services often focus on the "form and manner" of treatment, rather than whether treatment will be provided.

The SAMSHA report also notes that in "behavioral health, unlike general medicine, most inpatient admissions are unplanned and occur because a person (or family member or

---

[11] Rosenbaum, S., Kamoie, B., Mauery, D. R., Walitt, B. Medical Necessity in Private Health Plans: Implications for Behavioral Health Care, Substance Abuse and Mental Health Services Administration (SAMHSA) DHHS Pub. No. (SMA) 03-3790, 14, (Nov. 2003).

[12] *Id.*

provider on behalf of that person) seeks emergency crisis admission." [13] Although these types of services may be approved initially, disputes about the medical necessity of subsequent services are common. Certain disputes are resolved with additional documentation, but most often, in Watershed's experience, they are related to the review criteria which are considered to be "guideposts" used by utilization review staff who may or may not have adequate training.

Watershed interacts with utilization review programs routinely and finds that review criteria are frequently available from the review organization, however, the criteria are not used consistently, or there may be some adjustments made by the review staff which appear to be inconsistent.

As an example, Watershed had a patient whose intensive inpatient rehabilitation level of care was denied based upon the review of a physician whose level of expertise was as a Board Certified Gynecologist. Putatively, the denial was based on an assessment that the patient did not meet the ASAM Placement Criteria. Watershed consistently uses these criteria since the State of Florida's licensing requirements are "cross-walked" to the ASAM criteria. Upon further follow-up with the MBHO, it was clear that the patient had met the ASAM Placement Criteria, however, unlike the criteria, the medical necessity determination was based on a requirement that the patient tries and fails an outpatient level of care before the admission to inpatient would be "medically necessary." The additional criterion related to outpatient treatment failure was neither tied to the patient's presenting medical state, nor was made available to Watershed prior to admission.

As this example demonstrates, the "public" criteria that are available are used only as guideposts and are not the entire criteria set applied by plans. This example reflects two of the top ten problems in medical necessity determination processes.[14] Specifically, the claims reviewer was not appropriately trained and there was insufficient information provided in the initial determination.

Watershed Recommendation.—It is critical for the implementing regulation to require health plans to use an evidence-based continuum of care framework in making medical necessity determinations for services in the med/surg and MH/SU benefit alike. The criteria should be transparent to the health provider and the training of the reviewers should be appropriate.

RFI Number 4. WHAT INFORMATION, IF ANY, REGARDING THE REASONS FOR ANY DENIAL UNDER THE PLAN (OR COVERAGE) OF REIMBURSEMENT OR PAYMENT FOR SERVICES WITH RESPECT

[13] *Id.* at 15

[14] Rosenbaum, S., Kamoie, B., Mauery, D. R., Walitt, B. Medical Necessity in Private Health Plans: Implications for Behavioral Health Care, Substance Abuse and Mental Health Services Administration (SAMHSA) DHHS Pub. No. (SMA) 03-3790, 22, (Nov. 2003).

TO MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS IS CURRENTLY MADE AVAILABLE BY THE PLAN? TO WHOM IS THIS INFORMATION CURRENTLY MADE AVAILABLE AND HOW IS IT MADE AVAILABLE? ARE THERE INDUSTRY STANDARDS OR BEST PRACTICES WITH RESPECT TO THIS INFORMATION AND COMMUNICATION OF THIS INFORMATION?

Unfortunately, the current standards for providing information for denials are entirely inconsistent. The SAMSHA Medical Necessity Report reviews the industry practices and notes that while general information is available to the public, most of the definitions and procedures are found in contracts and internal documents which are considered to be proprietary and confidential. The SAMSHA report also reviewed the federal laws pertaining to medical necessity reviews and explored the "full and fair review" procedural requirements that all ERISA health plans must meet, which can be used as a starting framework for implementing MHPAEA. The SAMSHA report indicates that ERISA addresses eight of ten medical necessity utilization review and appeals procedures which are critical to a "full and fair review."

Watershed Recommendation.—As noted in Watershed's comments regarding the need for transparency of plan information, Watershed suggests that the implementing regulation for MHPAEA address the obligation of plans to provide timely information as to the reason for denial. Specifically, the implementing regulation should require plans to provide information as to the medical necessity criteria used for the MH/SU benefit as compared to the med/surg benefit. In addition, MHPAEA should require that health plans provide plan information which is structured along the lines of the ten utilization and review procedures which are an integral part of the full and fair review required under ERISA. By requiring that this type of detailed information be provided to all stakeholders, the departments will facilitate a process by which beneficiaries, plans and MH/SU providers will be able to collaborate more effectively in achieving the parity and equity goals of MHPAEA.

RFI Number 5. TO GATHER MORE INFORMATION ON THE SCOPE OF OUT-OF-NETWORK COVERAGE, THE DEPARTMENTS ARE INTERESTED IN FINDING OUT WHETHER PLANS CURRENTLY PROVIDE OUT-OF-NETWORK COVERAGE FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS. IF SO, HOW IS SUCH COVERAGE THE SAME AS OR DIFFERENT THAN OUT-OF-NETWORK - COVERAGE PROVIDED FOR MEDICAL AND SURGICAL BENEFITS?

As noted in the fourth example of a financial requirement which is currently imposed, Watershed's experience is that facility licensure restrictions, resulting in geographic restrictions, as well as member/beneficiary residency restrictions, are common examples of out-of-network coverage limitations currently imposed by plans. As noted in the recent Health Affairs article, addressing this issue is one of the significant administrative challenges that health plans face as they prepare for the implementation of MHPAEA.[15] Specifically, many group health plans that contain both med/surg and MH/SU benefits include

[15] Keith Dixon, "Implementing Mental Health Parity: The Challenge For Health Plans", Health Affairs, 28(3):665 (May-Jun 2009).

requirements for state-specific facility and clinician licensure on the MH/SU side that are not included on the med/surg side.

Under such plans, members are covered only if they receive treatment from facilities and/or clinicians licensed by the state from which the plan is issued. This licensure limitation on the MH/SU side results in geographic restrictions, and therefore treatment limitations, not on par with the med/surg benefit. For example, members may seek medical and surgical treatment from out-of-state healthcare providers, including centers of healthcare excellence. However, on the MH/SU side, the member cannot leave the state in which the plan is issued in order to receive covered treatment. In contrast, the med/surg benefit in such plan only requires that facilities and/or clinicians are appropriately licensed by the state in which the providers are located and accordingly in which the services are rendered.

Similarly, certain insured plans require that the member be a resident of the state from which the plan is issued in order to obtain covered treatment on the MH/SU side, thereby creating treatment limitations (again, often prompted by state mandates). The med/surg benefit in such plans contains no such restriction. Thus, for example, a member insured under a Massachusetts plan, who resides in the neighboring state of Connecticut, would be covered for medical and surgical care, but would not be covered for mental health or substance use disorder treatment services.

These group health plans oftentimes include such restrictions, as prompted by state law mandates and mandated offerings.[16] These mandates are preempted to the extent that they prevent the application of MHPAEA.[17] As set forth in the legislative history for Economic Stabilization, Pub. L. No. 110-343, House Report 110-374 (Part 1), pp.21, 23:

> Since 1996, a key principle for Congress has been to incrementally reform private health coverage by establishing a federal floor of protections for workers and their families. Through a federal standard that is a floor, not a

---

[16] Currently, numerous state laws impose licensure restrictions on permissible coverage, and the form in which that coverage may be offered, for MH/SU benefits. Examples of such state law restrictions/restricted offerings include, but are not limited to, Connecticut, Kansas, Louisiana, Mississippi, North Dakota, Ohio, Oregon, Pennsylvania, South Dakota, Utah, Virginia, Vermont, and Washington.

Similarly, other state law restrictions and restricted offerings related to MH/SU benefits require that the member be a resident of the state in which the plan is issued in order to obtain covered MH/SU treatment, thereby creating a situation in which residential requirements lead to an out-of-network determination that is not equally applied on the med/surg side. Examples of such state law restrictions/restricted offerings include, but are not limited to, Massachusetts, Montana, and New Hampshire.

[17] MHPAEA amends both the federal Employee Retirement Income Security Act of 1974 (**"ERISA"**) and the Public Health Service Act (**"PHSA"**) by incorporating mental health parity provisions into these acts. The preemption clauses applicable to ERISA at 29 U.S.C. §§ 1144 (a) and (b) (2) and 1191 and to PHSA at 42 U.S.C. § 300gg-23 are applicable to these MHPAEA amendments and specify that state law shall be superseded to the extent the law prevents the application of an ERISA or PHSA requirement.

> ceiling, Congress has recognized that state policymakers may determine that to protect patients in state-regulated plans, a stronger set of standards are necessary than those provided in federal law. In fact, many states now require insurance companies to cover mental health services.
>
> * * *
>
> The bill [H.R. 1424] generally would not preempt state laws that do not "prevent the application" of federal mental health parity standards… The bill also specifically does not intend to preempt state laws containing benefit mandates…

Thus, these state law mandates and mandated offerings are preempted to the extent that they prevent the application of MHPAEA. Specifically, to the extent the licensure (hence geographic) and residency restrictions in state law mandates create treatment limitations applicable only to (or disparately to) MH/SU benefits, then such restrictions would undermine the parity of MH/SU benefits required under MHPAEA and should be preempted in order for state laws to reach the federal parity floor, in compliance with MHPAEA.

Watershed Recommendations.—The Departments' regulatory guidance should confirm that state law licensure and residency restrictions are preempted to the extent such limitations are applicable only to (or disparately) to MH/SU benefits. It is suggested that model state laws be proposed in order to provide guidance to state legislators and regulators regarding revisions to state parity and mandate laws necessary to effectuate compliance with MHPAEA.

RFI Number 6. WHICH ASPECTS OF THE INCREASED COST EXEMPTION, IF ANY, REQUIRE ADDITIONAL GUIDANCE? WOULD MODEL NOTICES BE HELPFUL TO FACILITATE DISCLOSURE TO FEDERAL AGENCIES, STATE AGENCIES, AND PARTICIPANTS AND BENEFICIARIES REGARDING A PLAN'S OR ISSUER'S ELECTION TO IMPLEMENT THE COST EXEMPTION?

Watershed recognizes that health plans will be seeking to strike a balance between providing equity and parity of benefits, while also managing the rate of growth in health insurance premiums. As noted earlier in these comments, Watershed believes that the U.S. Office of Personnel Management **("OPM")** in its Federal Employee Health Benefit Program (**"FEHBP"**) Call Letter dated April 20, 2009 ("Call Letter"), offered health plans with important guidance on this issue which should be reflected in the MHPAEA implementing regulations. In particular, OPM stressed the importance of health plans identifying value-based solutions to managing the health insurance benefit, (including both the med/surg benefit and the MH/SU benefit), as well as the use of managed care organizations such as the Managed Behavioral Healthcare Organization (**"MBHO")**.[18] The Call Letter specifically

[18] It is important to this discussion to understand that the substance use disorder treatment provider community has a long history of providing substance use disorder services with a strong, upfront role for managed care organizations, such as the MBHO. Indeed, in response to the existing treatment limitations and financial requirements currently experienced, the MH/SU provider community, supported by funding from SAMSHA

directs plans to "demonstrate that you have evaluated your proposed benefit changes with regard to their influence on promoting the most effective care (i.e., the care that generally produces the best health outcomes), not just with respect to cost." (Call Letter, p.2, I. Introduction).

The central role of the MBHO in the FEHBP Call Letter also highlights another important difference between the two benefits that must be acknowledged if parity is to be achieved. That is, with MH/SU benefits, plans often have the MBHO take a more visible, active role with MH/SU providers; however, with med/surg benefits, plans predominantly use management organizations in a much less active, less visible role. For example, in contrast to the more "pervasive" role that the MBHO plays in MH/SU benefit management, a managed care organization (**"MCO"**) is often seen as "invisible" to the patient who is accessing physician or hospital services. More recently, however, specialized benefit managers such as a pharmacy benefit manager (**"PBM"**) or a radiology benefit manager (**"RBM"**), which focus on targeted patients or disease conditions, are playing a role which is more consistent with the MBHO role.

As discussed previously, based upon the important role and cost containment that can be achieved through the use of managed care organizations, Watershed believes that value-based decisions for managing both med/surg and MH/SU benefits should be considered as an important factor in implementing the parity provisions of MHPAEA. In addition, the implementing regulatory provisions regarding treatment limitations and financial requirements should require an equitable use of benefit management, and consistency in the processes by which medical necessity determinations are made for med/surg services as well as MH/SU service. The processes span the range from the publication of criteria and their use by appropriately trained reviewers, to the timeliness of appeals processes. Continued use of different, inequitable utilization management practices for med/surg and MH/SU benefits would be inconsistent with the intent of parity in terms of financial requirements and treatment limitations under MHPAEA.

Watershed Recommendations.—The Departments' regulatory guidance should provide a clear statement that value-based decisions must be factored into the methodology for calculating the actual costs of coverage for purposes of determining whether a plan qualifies for a cost exemption under MHPAEA. Watershed believes that in keeping with Congress' intent to provide parity, the cost exemption should not be used to maintain existing MH/SU management limitations without trying to improve the management and efficiencies of the med/surg benefit. Specifically, as previously discussed on pages 4 and 5, the implementing

and other agencies within the Department of Health and Human Services, developed an evidence-based managed care approach to providing the appropriate level of service across the continuum of care. In the substance abuse area, this continuum of care is represented by the Patient Placement Criteria of the American Society of Addiction Medicine (**"ASAM"**). These criteria, first published in 1991, provide a common language to develop a broader continuum of care that has been used by health plans and substance abuse providers alike.

regulatory provision regarding the cost exemption should require an assessment as to whether or not there is an equitable use of benefit management for med/surg and MH/SU services.

In addition, the implementing regulatory provision regarding treatment limitations and/or financial requirements should require consistency in the processes by which medical necessity determinations are made for med/surg services as well as MH/SU service. The processes span the range from the publication of criteria and their use by appropriately trained reviewers through the timeliness of appeals processes. Continued use of different utilization management practices for med/surg and MH/SU benefits would be inconsistent with MHPAEA

* * * * *

CONCLUSION:

Watershed appreciates the opportunity to comment on the MHPAEA RFI. The six areas of interest reflect the implementation challenges which are associated with establishing parity and equity between MH/SU and med/surg benefits. Watershed's hope is that it has provided you with important information for you to use in developing an implementing regulation. As a provider of MH/SU services, Watershed would like to offer suggestions as to the level of specificity that would be helpful to ensure that health plans are able to design benefit offerings that meet the legislative intent of MHPAEA and offer their members the opportunity, if needed, to benefit from necessary MH/SU services which are provided at the appropriate level on the continuum of care. Watershed recognizes the how the differences between med/surg services and MH/SU services and the unique history of the coverage of these services and management of the two benefit categories create a challenge in implementing the parity and equity intent of MHPAEA. For that reason, Watershed has provided a construct and recommends the use of the common elements of both benefits. Specifically, it is important to focus on the need to provide an appropriate, yet unique, continuum of services associated with the med/surg and MH/SU benefits. In addition, the regulatory guidance needs to provide the necessary level of specificity with regard to the definition of predominance to ensure that there is parity and equity in access to services at the appropriate level of care.

In summary, Watershed's recommendations for MHPAEA regulatory guidance predominantly are focused on the need for several specific clarifications related to the application of treatment limitations. Specifically, Watershed believes that the implementing regulation should include the following guidances.

- Require that plans which offer both an inpatient and outpatient benefit for med/surg services across the continuum of care, must offer both an inpatient and outpatient benefit for MH/SU services across the continuum of care. This provision will eliminate "front-end" use of both a treatment limitation and a financial requirement to restrict important

inpatient MH/SU services that are medically necessary for persons with coverage by a health plan that offer a MH/SU benefit. The requirement to provide for the full continuum of care for MH/SU benefits should eliminate a common exclusion of residential or inpatient rehabilitation treatment commonly found in insurance contracts, primarily as a means of limiting the cost of the health benefit.

- Require that plans acknowledge the licensing and accreditation differences between the types of providers of services covered under a med/surg benefit and a MH/SU benefit. Specifically, plans should not apply restrictions to a MH/SU benefit that is based on provider type, such as exclusions for care rendered in duly licensed and accredited free-standing residential treatment facilities or non-hospital facilities. These restrictions constitute a treatment limitation.

- Similarly, the regulation should eliminate geographic restrictions on MH/SU benefits, by limiting access to any provider which is not licensed in the state in which the plan is issued unless the same in-state licensing limitation is applied to the med/surg benefit.

With regard to the guidance for the determination of financial requirements, Watershed suggests a specific construct for identifying the predominant form of financial requirements for med/surg benefits which should be used for the MH/SU benefit.

- With respect to the improper application of financial requirements, Watershed underscores the point that, in general, the "predominant" use of deductibles and coinsurance (or co-payments) for the majority of services covered under the med/surg benefit should apply to MH/SU services when a plan offers both types of health benefits. Specifically, the predominant financial requirements for hospital and physician services covered by a med/surg benefit should be applied to the facility and non-facility services along the continuum of services covered by the MH/SU benefit.

Additionally, there is a need for the implementing regulation to address financial requirements based on compliance with treatment protocols.

- Specifically, plans should eliminate treatment completion requirements for reimbursement of services rendered under the MH/SU benefit that do not exist under the med/surg benefit.

Cutting across the treatment limitations and financial requirements is a need for the regulatory guidance to address:

- Access to plan information which results in parity and equity between the MH/SU benefit with the med/surg benefit. Specifically, the implementing regulation should require information which builds upon the "full and fair review" requirements of ERISA by establishing a definition of medical necessity which incorporates the continuum of care

which is appropriate for med/surg and MH/SU benefits and acknowledges the different types of services and providers appropriate to each.

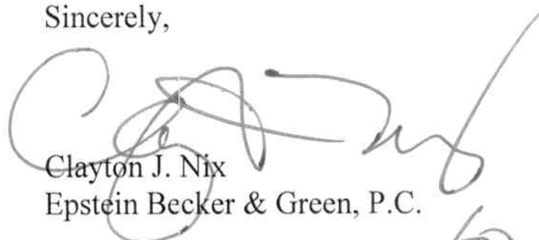
- Compliance issues which allow for a transparent review of the implementation of MHPAEA generally, and more specifically, to improve the process and timeliness by which medical necessity determinations are made, reviewed and reconsidered.

- The requirement that carve-outs, including those which are incorporated in an EAP which provide only a MH/SU benefit, be aggregated with employer plans providing only a med/surg benefit, such that the aggregated employer insured plan is required to comply with MHPAEA.

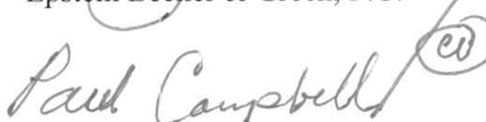
- Not require employees to access EAP benefits before being eligible for MH/SU benefits under the employer's primary health plan, as imposing an impermissible treatment limitation on MH/SU benefits.

Please feel free to contact us if you have any questions or require further information regarding Watershed's response to the RFI on MHPAEA or any additional comments provided herein.

Sincerely,



Clayton J. Nix
Epstein Becker & Green, P.C.



Paul M. Campbell
EBG Advisors

cc: Patrick Kirse, Watershed
Beth Ann Middlebrook, Watershed
Rebekah Plowman, EBG
Lynn Shapiro Snyder, EBG