May 28, 2009

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4140-NC/CMS-4137-NC
P.O Box 8017
Baltimore, MD 21244-8010

To Whom It May Concern:

Reference: File code CMS-4140-NC/CMS-4137-NC

The Coalition of Behavioral Health Agencies, Inc. is submitting the following comments on the "Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008", published in the Federal Register on April 28, 2009.

The Coalition of Behavioral Health Agencies, Inc. is the umbrella trade association and public policy advocacy organization of New York's behavioral health community, representing over 120 non-profit behavioral health agencies. Taken together, these agencies serve more than 350,000 adults and children and deliver the entire continuum of behavioral health care in every neighborhood of a diverse New York City and its environs.

The Coalition's member organizations sustain some of New York's most vulnerable citizens: persons with HIV, struggling families, the fragile elderly, people living with co-morbid health conditions, people discharged from psychiatric hospitals and detoxification units, prison discharges and troubled children. They provide a full continuum of behavioral health services including: ACT, AOT, case management, clinic treatment programs, community residential programs, continuing day treatment programs, crisis outreach and intervention services, drop-in centers, family support services, home and community based services, homeless outreach, mobile crisis intervention programs, on-site rehabilitation, psychosocial clubs, school based programs, supportive housing, transitional employment placement, transitional management services, vocational and social rehabilitation and vocational services for adolescents.

The Coalition strongly supports the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Below, please note the Coalition's specific recommendations as they pertain to the comments solicited:

Comments Regarding Economic Analysis, Paperwork Reduction Act and Regulatory Flexibility Act

There has been debate in the field regarding whether or not there should be a single deductible that includes both physical health care services and mental health care services, or "separate but equal" deductibles for these services. Given that the primary goals of parity legislation are to prohibit discriminatory insurance practices and affirm that mental health and substance use disorder treatments are integral components of comprehensive health care, creating discrete but equal deductibles undermines these goals by suggesting that it is necessary to treat physical and mental health services differently. We strongly suggest that one single, inclusive deductible for physical health care and mental health services is necessary to avoid further discrimination.

Comments Regarding Regulatory Guidance

Clarification is needed regarding the application of the parity law to Medicaid managed care plans. Uncertainty in the field continues to exist, despite statutory language or references in Medicaid to the 1996 parity Act. Explanation is also needed to affirm that parity applies to SCHIP plans, as provided by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

In Network Access: Reducing Cost-Shifting to Consumers

Provider credentialing and network characteristics affect cost-sharing and timely access to the appropriate type or scope of service. Restrictive provider network designs often are used to help manage risk for adverse selection but they also increase consumer cost-sharing for out-of-network services. Given that the intent of MHPAEA was to protect consumers from unequal access, cost-sharing, and scope of treatment, the MHPAEA implementing regulations should include guidance to health plans on how to ensure in-network access to mental health and addiction services in addition to addressing other critical issues of out of network care and medical management of the benefit. We recommend that the regulations address the following:

- Require that applicable health plans enroll "essential community providers" in their network in order to assure access for high-risk or special needs clients/patients. By definition, this would include behavioral health providers who are trained, licensed or credentialed to serve the needs of individuals with serious mental illness and addiction disorders. Adoption of this concept would ensure that behavioral health providers would be included in the network offered by a health plan.

- Provider competencies and scope of practice of enrolled providers and treatment programs should match the benefit design. Restrictions on the type of mental health and substance abuse providers and services included in the network commonly limit access and increase consumer cost-sharing unequal to what other health services. To

cover a type of treatment, but not enroll providers would be illogical and inconsistent with the purpose of the MHPAEA.

Treatment Limitations on Benefits

Clear explanations indicating how to compare mental health and addiction to health with regard to limits on a benefit package and cost-sharing requirements are also necessary. For example, Section 512(a)(3)(A)(i) states that financial requirements for mental health and addiction benefits should be "no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan;" there is almost identical language in subsection (ii) with respect to treatment limits. What do these terms mean? The regulations must clarify and explain these terms in order to ensure that any limits on mental health and addiction services are appropriate given the overall coverage (including limits and financial obligations of the insured) in a particular plan.

Not all treatments are analogous, and mental health and addiction services that are offered on an office outpatient basis, for example, should be treated the same as medical or surgical outpatient visits. This is straightforward for some benefits – medication management, coverage of prescription drugs. It is less clear for some other benefits. However, the term "no more restrictive than" should mean that coverage and cost sharing are equal even when, for example, a mental health service, such as a psychotherapy visit, is not strictly identical to a medical-surgical service, such as a 10-minute office visit. A second example would be if the plan chooses to cover intensive outpatient services or residential treatment. The intensive outpatient treatment should be compared with a standard medical-surgical visit for purposes of out-of-pocket costs or limits on number of visits. The residential treatment service should be considered analogous to inpatient hospital stays.

Our member organizations have identified a range of treatment limitations often used to deny or make care more difficult to access, including: limits on yearly sessions and/or requiring more paperwork after a certain number of sessions; requiring providers to be in-network (on their panel) for coverage/reimbursement, the practical effect of which is to force chronic patients to choose another provider leading to lack of continuity of care and doctor/patient relationship; requiring prior-authorizations for out of network services that are rarely, if ever approved; and medical necessity criteria that effectively restrict appropriate and timely care. In addition, the following are specific examples of practices that often result in limitations in MH/SU care:

- Annual and lifetime caps
- Deductibles
- Coinsurance
- Out-of-pocket expenses
- Limits on the frequency of treatment, number of visits, and days of coverage
- Utilization review
- Coverage based on completing assessment/review with exceedingly short time frames (as little as an hour) or in face to face assessments in the state of the plans' corporate headquarters

- Pre-authorization practices
- Medical necessity and appropriateness criteria, including ever-changing criteria lacking clear definitions for specific levels of care such as "inpatient," "rehab" or "residential"
- Coverage requirements based on patient completing an entire course of treatment
- "Fail first" policies such as the patient has to fail 1 – 2 times at outpatient treatment within the last year to be eligible to use detoxification or residential benefits
- Utilization review being conducted by professionals with no training in mental health or addiction
- Exclusion of certain levels of care like residential treatment or partial hospitalization (in or out of network)
- Review of treatment services as to whether or not services are evidence-based
- Review of treatment as to whether or not services are experimental
- Review of treatment as to whether or not services are cost effective
- Fee schedules that do not enlist an adequate supply of providers to assure access
- Limit on specific providers or geographic licensure requirements in the state of the plan's corporate headquarters
- Preferred provider networks (including elimination of providers from network if they allow a plan participant to self pay for care deemed "not medically necessary" by plan)
- Prohibiting plan coverage for eating disorders
- Prohibiting plan coverage for MH/SUD services required due to court order

Scope of Treatment

While frequency, duration or number of visits or days of coverage can be objectively measured, what is meant by "scope of treatment" will require more definition in the regulations. The regulations should provide guidance and clarification on the types of covered treatment and how other services whether new or long established become accepted. It is the intent of the MHPAEA that the scope of services offered under the mental health and addiction benefit are consistent with the level applied to substantially all medical-surgical benefits. Although "services" are referenced throughout the statute, additional guidance is necessary to ensure that the covered treatment and services are of sufficient type, duration, frequency, and intensity to "correct or ameliorate" the episode of illness for the covered conditions.

The regulations should articulate that the covered services and level of care should be appropriate to the covered diagnoses. Services recognized as community standards or evidenced-based practices for a given condition should be covered. For example, for major depression, coverage of only medications prescribed through primary care would restrict access to psychotherapy in the benefit design, thus shifting the cost for this benefit to the patient. Similarly, for medication-based addiction treatment, coverage of only medications would leave patients without access to critical psychosocial rehabilitation services, a community standard. Medication for the treatment of mental health and addiction disorders has been proven to be critical to an individual's recovery and should be part of the scope of treatment offered under the benefit, no less than for medication for other medical and surgical conditions.

The regulations should recognize that the scope of treatment for mental illness and addiction disorders should be no more restrictive than what is available substantially for other chronic health conditions such as diabetes, epilepsy, heart disease, or respiratory conditions. Comprehensive disease management, chronic care, or packages of services with proven efficacy for treatment and rehabilitation services for people with serious mental illness, addictions and emotional disturbance should be covered if similar approaches are covered for substantially all other chronic health conditions. Comprehensive approaches that organize and coordinate packages of care can structure copayments and other cost-sharing to provide an incentive to active engagement in treatment.

State Pre-emption Issues

As the regulations are drafted special attention must be given to ensure that Federal parity regulations pre-empt weaker state laws, but do not supplant state laws that provide more protection to enrollees. Specific areas to consider include States with weaker substance abuse treatment requirements and State laws that limit parity to certain conditions versus MHPAEA that may apply parity to a broader list of disorders.

It is particularly important to provide examples that illustrate how broader mandates that remain in effect in States interact with the new federal law. For example, any mandate to cover mental health services (whether only for people with certain serious mental disorders or only for a certain number of days) should remain in force. The federal law would then preempt any inappropriate limits on those services, and thus a mandate for 30 days of inpatient care would become a mandate for coverage of inpatient mental health care at parity with other inpatient health services. Additionally, statements that explain how a mandated minimum benefit becomes a parity benefit and how mandated coverage of serious mental illness remains in effect and becomes mandate for parity for serious mental illness are necessary.

Medical Necessity

Medical necessity determinations are critical to equal access to appropriate care. Denials of care are denials of payment to the provider—directly shifting responsibility to the patient to either seek another plan of care or pay out of pocket for an otherwise covered benefit. Further, restrictive utilization management has the potential to shift risk and cost to government programs once a patient qualifies. The parity law regulations must provide guidance and predictability to healthplans, consumers and providers regarding how medical necessity is defined and criteria used to make utilization management decisions.

The regulations should require:

- There must not be a “fail-first” policy. If a service is necessary and appropriate, failure in another service should not be required as a prerequisite to authorization.
- Health plans to make information available to providers on covered benefits, limitations, and authorization procedures so that they can verify before initiating a plan of care.

- Health plans to make mental health/substance use disorder medical necessity criteria available to current or potential beneficiaries and providers upon request.
- No pre-emption of stronger State laws: Federal regulations regarding utilization review and definition of medical necessity should not pre-empt criteria defined in state statute that provides more benefit and consumer protections.
- Medical necessity should be based on local community standards and expert consensus opinion. Benefits and scope of services covered should be defined to include those necessary to sustain or maintain functioning when without the service the patient would deteriorate.

Appeals and Independent Review of Denial of Reimbursement or Payment for Services

Information about how to access internal member services or ombudsman assistance, appeals procedures and independent review must be made readily available to enrollees and easy to access. The MHPAEA regulations must provide guidance and standards for appeals and independent review that provide no less consumer protections than those that would exist for other health services. We recommend that the regulations specify:

- Independent review must be available to re-consider utilization management decisions within a specified time period. The appeal or review process must be communicated to patients and the requesting provider. Summary results of review decisions must be available to plan members, network providers, state regulators, and the public.
- If state law requires medical necessity criteria for various services to be publicly available without request, the state law pre-empts the federal statute.
- Otherwise covered services/treatment should be covered while an appeal is pending.
- Health plans and providers must inform consumers through an "advanced beneficiary notice" that they may be liable for the cost of services when denied or limited by management decisions.
- Health plans should not be able to deny or limit an otherwise covered service without also recommending another allowable plan of care to the patient and/or provider.
- There should be a mechanism for expedited appeal for situations in which a crisis or urgency that cannot be delayed without putting the patient at risk. Coverage should not be denied in situations where an emergency or urgency made prior approval unfeasible.

CONCLUSION

We would like to thank The Centers for Medicare & Medicaid Services (CMS) and the Department of Labor (DOL) for the opportunity to submit comments on the implementation of MHPAEA. We hope you will take our recommendations under careful consideration as regulations are developed.

Sincerely,

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