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May 28, 2009

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
United States Department of Labor
Room N-5653
200 Constitution Ave. NW
Washington, D.C. 20210

Attn: MHPAEA Comments

Dear Sir or Madam:

We are writing in response to the Request for Information (RFI) issued April 28, 2009 as part of the regulations-writing process for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). On behalf of our memberships, we thank you for the opportunity to aid in the development of the MHPAEA regulations by providing the background information requested in the RFI.

NAADAC, the Association for Addiction Professionals is the primary association for addiction-focused counselors, educators and other health care professionals. We have 10,000 members and affiliates in 47 states. NAADAC's mission is to lead, unify and empower addiction professionals through education, advocacy, ethics, professional standards and research.

The National Association of Addiction Treatment Providers (NAATP) is the primary trade association for private addiction treatment programs. We represent over 300 members across the United States, Mexico and Canada. NAATP's mission is to promote, assist and enhance the delivery of ethical, effective and research-based treatment for alcoholism and other drug addictions.

NAATP and NAADAC work in partnership on public policy issues. In order to provide the most accurate information possible, we conducted an informal survey of our members' experiences with the issues raised in the RFI; over 50 programs and professionals from across the country participated. We have included a sampling of their comments, arranged in the same format of this letter, as Attachment A. The full list of the respondents can also be found in Attachment A.

It is our hope that this information provides you with a better understanding of the way that insurance coverage of addiction treatment affects the way that care is provided in the field.

1. Financial Requirements, Treatment Limitations and Addiction Treatment

There are several significant ways in which treatment limitations and financial requirements for addiction services differ from other medical treatment.

A. **Residential Versus Inpatient Treatment.** Many health plans that include an "inpatient" treatment benefit only cover inpatient services in acute care hospitals, not in sub-acute residential addiction treatment programs. Residential treatment is a more appropriate treatment setting than a hospital for many patients. Residential treatment allows for more comprehensive and structured treatment models than are often available in inpatient acute care settings. Such programs hold national accreditations (often the same accreditations that hospitals use) and state licenses.

B. **Limits on the Number or Types of Services per Day.** Some health plans impose limits on the number or type of sessions that may be provided on the same day. For example, some patients in outpatient programs are not allowed to be seen for an individual counseling session and a group session the same day.

C. **Pre-Existing Condition Exclusions.** Loosely defined pre-existing condition exclusions risk invalidating most substance use disorder and mental health coverage. Both sets of disorders are chronic conditions, and most people only seek treatment long after the onset of the disease (people who seek treatment for alcohol dependence, for example, begin treatment an average of ten years after the disease's onset).[1] Insurance plans should explicitly exempt substance use disorders and chronic psychiatric conditions from their pre-existing conditions exclusion.

D. **Court-Ordered Treatment Exclusions.** Many health plans explicitly exclude coverage of medical services if they are court-ordered. This exclusion affects treatment for substance use disorders and mental illness almost exclusively (other court-ordered treatment would include exceptional cases involving medical interventions on children and disabled adults when it is opposed by their guardians and certain situations involving the termination of life-sustaining treatment). Thus this exclusion is a de facto and discriminatory limitation against treatment for substance use disorders and mental illness. It goes strongly against the intent of the MHPAEA.

   If a given treatment is deemed medically necessary by a treating physician and covered under the benefit plan, there is no reason that it should be excluded because

[1] NIH News. 2 July 2007. "Survey Reveals 'Lost Decade' Between Ages of Disorder Onset and Treatment." http://www.nih.gov/news/pr/jul2007/niaaa-02.htm.

the beneficiary was referred by a court. Beneficiaries expect their plans to cover all medically necessary care included in their benefit, and court-ordered treatment has been demonstrated to be at least as effective as non-court-ordered treatment.[2] Some states (such as Colorado and Minnesota) have already taken steps to ensure that people referred to treatment as a result of the legal process can access their benefits.

E. **Alcohol and Drug Trauma Exclusions.** Many health plans will deny reimbursement to providers (particularly in emergency departments and trauma centers) that treat individuals who were using alcohol or other drugs at the time of their injury. (In some cases, up to half of people admitted to emergency departments are there for reasons related to alcohol or other drug use.) At one time more than half of the states allowed such exclusions, although more recently several states have repealed these laws. Alcohol and Drug Trauma Exclusions not only discriminate against people in need of addiction treatment, but they also provide the perverse incentive for treating clinicians to *avoid* screening for drug or alcohol use. This means that people may not receive the most appropriate care possible at the time of their injury, and it almost certainly means that window of time between the onset of the disease and its treatment will be extended.

F. **Requirement to Complete Treatment.** Some health plans will not reimburse providers for any services they provide unless the patient completes the entire course of treatment. If the patient receives inpatient treatment, for example, but then does not complete the outpatient visits required, the inpatient treatment program may not be reimbursed. Often, patients do not complete treatment because the financial obligations become too great or it is too logistically difficult for them to do so. In practice, the requirement to complete treatment is discriminatory to the extent that it affects substance use disorder and mental health treatment more than most other medical services. Health benefits should cover any addiction services that are deemed medically necessary at the time they are provided regardless of whether the beneficiary later decides to stop their treatment.

2. Terms and Definitions

A. The intent of the MHPAEA is that the term "parity" refers to treatment of *both* mental health conditions *and* substance use disorders. A plan cannot provide parity *only* for mental health benefits or *only* for substance use disorder benefits and be considered in compliance. This applies with respect to both in-network and out-of-network benefits.

B. If a plan chooses to suspend parity because of the cost exemption clause in the MHPAEA, it must issue notification to all plan participants informing them of the change. This process should be outlined in the regulations.

[2] National Institute on Drug Abuse (2006). "Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide," p 18. Available online: http://www.nida.nih.gov/PODAT_CJ/faqs/faqs1.html#5.

C. Previous studies of state-level parity have demonstrated that extensive public education and consumer outreach is essential to realize parity's potential. The Secretaries of Labor, the Treasury and Health and Human Services should be required to establish a website and toll-free hotline for use by consumers and providers to report denials of benefits protected by the MHPAEA. Both the website and hotline should offer information about the rights of plan participants under the MHPAEA and provide resources that would enable them to appeal their plans' decisions and pursue alternative treatment services immediately, if needed (for example, through publicly funded programs). Similarly, a notice in writing from the Secretaries should be provided to each plan participant summarizing the changes in mental health and substance use disorder benefits under the MHPAEA. A public service announcement campaign (using as many different forms of media as possible) should be undertaken as well to educate the public about the MHPAEA and encourage people to seek treatment if needed.

D. State laws that provide stronger protections for people in need of mental health or substance use disorder services should be protected—the MHPAEA sets a federal "floor," not a "ceiling." The MHPAEA should not pre-empt state laws (such as Pennsylvania's) that have mandated minimum treatment limits for state-regulated plans. The pre-emption language could mirror applicable language in the HIPAA privacy regulations 45 CFR 160.202-205.

E. "Parity" as defined in the MHPAEA means that treatment limitations and financial requirements for mental health and substance use disorder benefits must be "no more restrictive" than medical limitations and requirements. However, mental health and substance use disorder benefits may be *less* restrictive than other medical benefits.

F. "Financial requirements" in the MHPAEA include the cost-sharing between plans and participants regarding prescription medication that is part of a beneficiary's mental health or substance use disorder treatment plan.

G. "Substance use disorder benefits" include the full range of treatment interventions appropriate for people with substance use disorders, including assessment, stabilization, detoxification, outpatient treatment, intensive outpatient treatment, partial hospitalization, inpatient residential treatment, medication-assisted treatment and recovery support services.

3. Medical Necessity Criteria

A. The medical necessity criteria used by different health plans vary significantly. Many (but certainly not all) criteria are based on the American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC); however, the use and interpretation of the ASAM PPC are far from consistent from plan to plan. MHPAEA regulations could help clarify that treatment will be deemed medically necessary if

prescribed by the treating physician in accordance with a clinically-based patient placement criteria.

B. The availability of medical necessity criteria to providers varies significantly. In some cases, the criteria are available on the health plan's provider portal website (which non-contracting providers cannot always access). In others, they are available to the provider upon request (some providers report being given the provisions by phone but not in writing). In other situations, however, the criteria are labeled "internal property" or "proprietary" and not shared with providers. In such cases, the patient is often forced to become the intermediary between the plan and the provider.

C. The interpretation of medical necessity criteria often matter more than the criteria themselves. They are frequently written ambiguously and open to a great deal of interpretation by the plan. As part of the transparency requirements in the MHPAEA, plans should be required to provide all the information that would be needed for a beneficiary or provider to understand whether or not medical necessity criteria have been met for each level of mental health or substance use disorder treatment, including information about how the plan interprets its medical necessity criteria if necessary. Plans should also be required to provide advance written notice to plan administrators and beneficiaries when there are changes to the medical necessity criteria.

D. Some health plans do not consider inpatient detoxification services for certain drugs medically necessary under any circumstances. This is an extremely selective and arbitrary use of medical necessity criteria.

E. One of the most counterproductive uses of medical necessity criteria involves the requirement that a beneficiary *fail* at a less intensive level of care before being eligible for a given level of care, regardless of their symptomology. For example, many plans will require that someone attempt (and fail) at outpatient treatment before they can be admitted to a residential treatment program. This policy is perverse for patients who meet all the objective medical necessity criteria for residential treatment; it throws them back into an environment where their treatment is highly unlikely to succeed. In the meantime, they may be at high risk of having their situation worsen. Some plans require *multiple* failures at less intensive treatment before authorizing residential treatment.

4. Reasons for Denial

Reasons for denials are generally made available to the treatment provider. Possible reasons include:

a. Failure to meet the plan's internal medical necessity criteria
b. Failure to obtain pre-authorization
c. Level of care not included in benefits
d. Exhaustion of benefits

e. Court-ordered treatment exclusion
f. Pre-existing condition
g. Level of care not authorized without a treatment history that shows the patient failing at less intensive treatments (sometimes it is required that they fail more than once)

An explanation of benefits (EOB) letter is normally sent by the insurance plan to the provider and beneficiary explaining the reason for denial (and spelling out the process for appeal). However, EOB letters are only available after treatment has already been denied. Further clarification of due process rights (perhaps modeled on Pennsylvania's Act 106) would provide much-needed consumer protections for plan participants.

5. Out-of-Network Coverage

Some plans provide out-of-network coverage for addiction treatment. The financial burden that falls on a patient receiving out-of-network care is often significantly higher than if they received care in-network, and the payments to out-of-network providers are significantly lower. These costs can be prohibitive for many beneficiaries. Reimbursement for both providers and beneficiaries is often much slower than when a provider is in-network. When a provider is out-of-network, some treatment programs will try to negotiate "ad hoc" or "single-case" agreements with the insurance plans so that inpatient rates will apply—these arrangements are not always possible.

An additional problem arises when a program is in an insurance provider's network but not in a managed care company's network. If a plan is managed by a managed care company that a treatment provider is not contracted with, then the treatment provider is out-of-network even if it is contracted with the insurance provider itself. This can lead to a great deal of confusion.

Finally, as with other areas of health care, arbitrary limits on the number or type of providers allowed on panels forces some people to seek services out-of-network. Because plans' financial requirements have historically been more burdensome for addiction services than other medical care, the added cost of going out-of-network for addiction treatment is an even greater barrier to care than it is for other medical services. The inability of beneficiaries—particularly in rural areas—to access treatment in their geographical area forces some people to choose between paying the higher out-of-network rates or foregoing treatment altogether.

6. Additional Comments

A. **Reporting.** The mandated Report to the Secretary of Labor should include the following data, itemized by diagnosis and age group, to provide the best possible picture of the MHPAEA's effects:

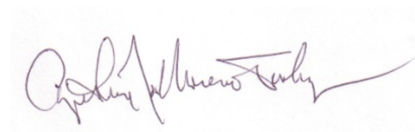
a. The number of beneficiaries seeking treatment for mental health conditions or substance use disorders
b. The type and duration of care provided
c. Reasons for denial of care
d. The number and success rates of appeals
e. A description of the educational and informational materials provided to plan participants describing their coverage under the MHPAEA
f. The cost of care to the plan and the beneficiary
g. The treatment settings in which services are delivered
h. The change in the rates of usage and expenditures before and after the MHPAEA
i. The number of plans that did not implement the MHPAEA and their reasons for not doing so (i.e. cost exemption, dropping mental health and substance use disorder benefits altogether, etc.) and the usage rates and expenditures of those plans' participants on mental health and substance use disorder services.

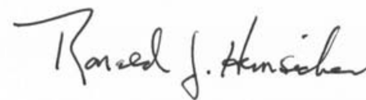
B. **Enforcement.** If the Report to the Secretary of Labor and the Government Accountability Office Study find that access to substance use disorder treatment decreases in a plan after it implements the MHPAEA, that should be interpreted as prima facie evidence of discrimination. The plan should face the burden of proof that it did not engage in discriminatory practices. The U.S. Department of Health and Human Services Office for Civil Rights should have the authority to conduct further investigations and impose penalties on such plans.

C. **Restrictions on Types of Professionals.** Many insurance plans severely restrict the types of services that state-licensed, certified or otherwise qualified providers can perform. This significantly reduces access to substance use disorder services and increases the expense for both beneficiaries and providers.

Once more, thank you for the opportunity to provide these comments on the MHPAEA. Please do not hesitate to contact us for additional information.

Sincerely,





Cynthia Moreno Tuohy, NCAC II, CCDC III
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NAATP National Association of Addiction Treatment Providers

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ATTACHMENT A

In order to provide the most current and accurate information possible, the National Association of Addiction Treatment Providers (NAATP) and NAADAC, the Association for Addiction Professionals offered its members the opportunity to share their experiences with the issues addressed in the Request for Information (RFI). A nine-question survey form based on the questions posed in the RFI was circulated to NAADAC and NAATP members.

Selected excerpts from the responses are included below in support of the comments that we have provided. It is our hope that these quotations provide a valuable real-world perspective on the challenges that the current insurance system poses to both beneficiaries and addiction treatment programs. NAADAC and NAATP members are uniquely situated to explain how health plans' benefits influence the way that addiction treatment is provided.

Some of the quotations have been edited slightly for clarity; none have been edited to change their content.

The full list of respondents can be found on page 8.

1. Financial Requirements, Treatment Limitations and Addiction Treatment

A. Residential Versus Inpatient Treatment:

> *Some insurance companies have a reputation for only authorizing intensive outpatient and rarely authorizing residential. When we call, we know it is very unlikely the client will get residential no matter what information we provide. If residential is authorized, it is extremely limited and we have to begin immediately planning for discharge.*
> *- Eleventh Hour Rehabilitation Programs, Fresno, Ca.*

> *Because most insurance companies are unwilling to contract for residential services, we do not have a negotiated rate-per-day for services. This leaves the client responsible to pay whatever charges remain after the insurance company pays what they determine they are responsible for. Most customer service reps state that they do not know what the daily rate is, so the client is stuck trying to decide what they can pay without knowing what the insurance company is agreeing to pay.*
> *-Johnson County Mental Health Center, Olathe, Kan.*

B. Limits on the Number or Types of Services per Day

If a client is seen by two clinicians on the same day at the same organization, one will be denied as a duplicate. For example, if a client meets with an M.D. for a psychiatric evaluation then meets with a clinician for outpatient bio-psycho-social evaluation.
-Chestnut Health Systems, Bloomington, Ill.

Some plans will ask for the name of the attending physician for the patient's care. They are given the name of the admitting physician. They will sometimes deny other practitioners' charges because all of the providers were not listed by name for every level of care.
-Fairbanks Hospital, Indianapolis, Ind.

C. Pre-Existing Condition Exclusions:

Some of our patients have participated in treatment prior to admission to our program and are considered as having a pre-existing condition. Some insurance companies refuse to cover services for this pre-existing condition. This makes it difficult to provide services for patients experiencing substance use disorders, which are often chronic, relapsing conditions.
-Connections Counseling, Madison, Wis.

The standard definition for "pre-existing condition" is "Any condition for which a person has sought medical treatment or advice within the past 12 months or any symptomology for which an ordinarily prudent person would have sought medical treatment or advice within the past six months." By definition, a substance abuse patient must have had a history of symptoms or they would not have been approved for treatment by anyone's standards. … In addition, there would always be a question of whether a substance dependent person could ever be defined as a person with "ordinary prudence."
-Fairbanks Hospital, Indianapolis, Ind.

D. Court-Ordered Treatment Exclusions:

Most policies will not cover court-ordered treatment even though [the patients] meet criteria for alcohol dependence as stated in the Diagnostic and Statistical Manual-IV-TR. Some will not cover even before [the patient] is convicted for anything. One company sent out a questionnaire asking me questions about [the patient's] Operating While Intoxicated history and any history resulted in denial.
-Parkview Counseling Associates, LLC, Greenfield, Wis.

[The court-ordered exclusion] clearly violates the intent and plain language of the federal parity statutes and should be expressly addressed. … The insurance industry would be hard-pressed to identify illnesses/medical treatment ordered by the courts other than treatment of mental health and substance use.
-Rosecrance, Inc., Rockford, Ill.

Most payors will not pay for court-ordered treatment for substance abuse. For medical conditions (since they are not generally judicially-related), many contracts will only state that there will not be coverage if the [injuries] are incurred as the result of committing a felony. In the environment of substance abuse, a patient will far more often be affiliated with the judicial system, but much court-ordered treatment is in lieu of pressing charges … This creates a clear parity problem for psychiatric conditions such as substance abuse versus medical conditions.
-Fairbanks Hospital, Indianapolis, Ind.

E. Alcohol and Drug Trauma Exclusions:

In September 2006, the American College of Surgeons adopted a formal statement calling for the repeal of this trauma exclusion. … These insurance exclusion laws certainly violate the spirit of the parity statute and serve as barriers for early screening and prevention of substance use, abuse and dependency. In 2007, Illinois, Indiana, Oregon and the District of Columbia all repealed that law.
- Rosecrance, Inc., Rockford, Ill.

F. Requirement to Complete Treatment:

Treatment will often not be covered … if the patient does not complete a portion or all of the treatment suggested in the final treatment plan, which includes aftercare.
-Fairbanks Hospital, Indianapolis, Ind.

-Insurance companies limit services through "clauses/exclusions," for example [that the patient] must complete the entire phase of treatment.
-Sundown M Ranch, Selah, Wa.

2. Terms and Definitions

N/A

3. Medical Necessity

Each company has its own language, and you have to say exactly what they want to hear or they will deny coverage.
- Heartview, Bismark, N.D.

The majority of managed care organizations do not want members to do higher levels of care if they have not failed at lower levels of care. For example, they may not authorize an intensive outpatient program if the member has not done outpatient treatment prior. They also may not authorize an intensive outpatient program and failed at that level. … If someone is ill enough to meet the criteria for a higher level of care, why do they need to go to a lower level of care first and fail? It not only prolongs treatment which is expensive, but the member can become more ill, become harmed, and have a much harder time with a full recovery.
-Ridgeview Institute, Smyrna, Ga.

They do not inform us of what the criteria are for medical necessity. They will sometimes request our records to determine if our services meet their definition of medical necessity, but they don't tell us their definition.
-Connections Counseling, Madison, Wis.

I had one plan make me call them one time per month to justify that my client still needed treatment. I would spend 45 minutes each time on the phone with the person who followed the case. I had to guess which symptoms would help to qualify him for continuing care. They insisted that if his wife did not attend Al-Anon [family support meetings] they would not pay for his treatment.
- ChangePoint, Inc. – Vancouver Office, Vancouver, Wa.

In the past, when consumers have been denied additional treatment "based on medical necessity," I have been told I can refer back to the contract [online] for that information. In doing so, I have always been able to confirm that the consumer does *meet the criteria, but this usually ends in an argument where the care manager of the insurance company wins!*
-Stepping Stones to Recovery, LLC, Augusta, Ga.

Those individuals who present for treatment with cocaine dependence or amphetamine dependence are often kept out of inpatient detoxification services due to the fact that withdrawal from these drugs does not pose the physical risk associated with other drugs, including alcohol and opioids. However, recovery from cocaine or amphetamine dependence often requires the client to be removed from environments that may trigger overwhelming compulsions to use despite catastrophic consequences (as with other drugs).
-Firebird Counseling, LLC, Akron, Ohio

We see this scenario most often where the managed care organization makes a determination based on no formal participation in less intensive levels of care, even with evidence reflecting little or no stability in their environment, making it impossible to succeed. This has little or no impact on the plans' decision making.
- Sundown M Ranch, Selah, Wa.

Halfway houses, intervention services and educational programs are typically not covered by insurance plans. Insurance companies do not explain why certain services are not covered.
-Gateway Rehabilitation Services, Moon Township, Pa.

Some managed care companies do not cover someone if they have "opiate dependence." This is extremely challenging, considering that this is a very serious addiction that appears to be on the rise. [Others] do not cover inpatient treatment for cocaine or marijuana.
-Ridgeview Institute, Smyrna, Ga.

4. Reasons for Denial

There are so many reasons for not reimbursing, it's mind-boggling. [An insurance plan] has denied reimbursement because they couldn't read the clinician's signature. They are made available to the agency after the fact. Then the agency has to "pay back."
-Ms. Neil A. Raffen, MEd, CAC II, CCS, Covington, Ga.

Addiction patients may be denied because they have *a support system,* are *motivated for treatment,* are *participating in [support] groups, attending [support group] meetings, etc.— the managed care company may say the patient can be treated at a lower level of care. Addiction patients may also be denied if they are* not *motivated for treatment, are* not *participating in group, are* not *attending meetings regularly,* don't *have a sponsor yet, etc.— the managed care company may say that the member is not motivated enough for treatment and they are not going to continue authorizing treatment.*
-Ridgeview Institute, Smyrna, Ga.

This information is not made available to us as treatment providers, and from what my clients tell me the reasons that they are given are arbitrary and confusing.
- ChangePoint, Inc. – Vancouver Office, Vancouver, Wa.

They usually offer a myriad of reasons which do not even apply. When one unreasonable excuse is confronted and handled, they come up with ten others, trying to wear you down … . Often the patient becomes fearful of having to pay for the expenses out of pocket after seeing denial after denial and drops out of treatment prematurely.

- Summerhill Counseling Center, Texarkana, Texas

Most of the time, the insurance companies only authorize a certain number of days at a time. They tell us when to call back for authorization for additional days. Often they do not give us a response until late in the day of the last day authorized. If additional days are not authorized it causes a real hardship for the client and the program. Late in the day, the client has to try to make arrangements to leave. If the client doesn't leave until the next day, the client has to pay for the previous day or the program doesn't get paid for that day.
-Eleventh Hour Rehabilitation Programs, Fresno, Ca.

During the managed care process, the insurance company staff will say patients no longer meet their medical necessity criteria and/or that patients should be discharged to a lesser level of care. The medical necessity criteria are generally not [well] explained in a person's insurance benefit coverage information book.
-Hanley Center, West Palm Beach, Fl.

5. Out-of-Network Coverage

Approximately half of the time, our facility is included in plans' out-of-network coverage. If we are not in the coverage, we will attempt to negotiate a "single-case agreement," but this is usually not successful. The coverage difference between in-network and out-of-network is typically a significant amount of out-of-pocket expenses to the patient (i.e. 10 percent co-pay for in-network versus 50 percent co-pay for out-of-network.
-Gateway Rehabilitation Center, Moon Township, Pa.

In some cases, out-of-network has no benefits. In others, it doesn't make sense for the insured [to receive out-of-network services]. In one recent case, I was filing claims to collect $5 for a session.
-A New Direction Counseling & Training, Corpus Christi, Texas

I had one insurance company refuse to put me on their panel because they already have six [providers] listed, however those six are not in the county or actively practicing therapy. When I explained this, they said they had providers in surrounding counties and consumers could travel there. When I explained traveling in the mountains and transportation were issues, they said they would make arrangements for the consumers to travel to providers in other counties.
-Mid-Day Counseling, Sparta, N.C.

If we treat someone who is out-of-network, we are for the most part out of any contact with the plan. We give the client receipts to submit, they do so and are not sure what they will be reimbursed or when they will be reimbursed.
-ChangePoint, Inc. – Vancouver Office, Vancouver, Wa.

We are included in some plans' out-of-network coverage. The deductibles are usually much *higher and out of the patient's range to pay. Another problem we have recently encountered is that our program is the only intensive outpatient program in about a 150 mile radius. In this circumstance, under Texas law, the insurance companies are supposed to grant an "ad hoc" in-network status for the patients on a case-by-case basis. In the past they have done so. In the past two months, they are refusing to do so.*
-Summerhill Counseling Center, Texarkana, Texas

The out-of-network benefits offered through some insurance plans do cover our programs, however some do not. Ultimately, coverage is based on whether or not Sundown M Ranch

falls into what the plan defines as an "approved inpatient facility or hospital." These benefits are paid at a lesser rate than our daily rate. Most of the plans state that coinsurance is based on "reasonable and customary" charges. At the same time, they generally cannot provide what these reasonable and customary charges equate to.
-Sundown M Ranch, Selah, Wa.

Some companies will sign an ad hoc agreement and some will not. Some deny [out-of-network benefits] because we are not affiliated with a hospital, provide residential versus inpatient, or if there is another in-network facility in the area. We are in North Dakota, and "in the area" may mean over 100 miles away.
-Heartview, Bismark, N.D.

What we find to be most difficult is the limited nature of how many providers they will allow on a panel. It takes away choice from the client and we are often forced to refer them … to lower quality treatment programs.
-Valley Health Care System, Morgantown, W.V.

In one incident, the plan recommended inpatient substance abuse services, but the plan did not have an in-network provider of this service.
-Mr. David Edelman, LCSW, Fairfax County, Va.

6. Additional Comments

A. Reporting

N/A

B. Restrictions on Types of Providers:

Some policies restrict provider licenses. We see that most often with the Certified Alcohol and Drug Counselor (CADC) [4,000 hours of experience and certification], but occasionally a policy is written where the outpatient providers must be a physician, psychiatrist or PhD, which then makes it impossible for most chemical dependency programs to provide affordable services.
-Chestnut Health Systems, Bloomington, Ill.

In the State of New Jersey, insurance plans have refused to allow Licensed Clinical Alcohol and Drug Counselors (LCADC) to be recognized as providers. They refuse to allow LCADCs to enroll as approved in-network providers, and they also refuse to allow LCADCs to be recognized as approved out-of-network providers, even though the N.J. statute authorizing licensure specifically includes a provision authorizing LCADCs as qualified healthcare professionals to receive third-party payments for services to clients within their scope of practice.
-GoodPath, LLC, Hackettstown, N.J.

Wisconsin's version of a CADC III [requiring 7,000 hours of experience and certification] isn't covered. Some say "Ph.D. or M.D. only," some say "M.S.W. only." There does not seem to be a requirement that they have any substance abuse experience.
-Parkview Counseling Associates, LLC, Greenfield, Wis.

Some insurance companies require a mental health license for outpatient substance abuse treatment. Some deny residential coverage unless there is an attending physician and 24-hour nursing care on-site (which is more appropriately a requirements for acute care).
- Johnson County Mental Health Center, Olathe, Kan.

I dropped my Chemical Dependency license because most insurance plans will not pay unless the provider is a Licensed Professional Counselor, Licensed Master of Social Work or a psychologist.
-New Direction Counseling & Training, Corpus Christi, Texas

Once more, thank you for the opportunity to submit feedback in response to the MHPAEA RFI, and for the chance to share some input from providers and professionals in the field.

For more information, please do not hesitate to contact NAADAC and NAATP's Government Relations Department at 703.741.7686 x129.

List of respondents to NAADAC and NAATP's "Parity Request for Information (RFI) Response Form"

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Contact: Joseph J. Youngblood

A NEW DIRECTION Counseling & Training
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BAC
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Alamogordo, NM 88311
Contact: Timothy W. Basha, BS, LADAC

Carl D. Perkins Vocational Training Center,
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Contact: James F. Recktenwald, CADC, MSW

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Chestnut Health Systems
1003 Martin Luther King Dr.
Bloomington, IL 61701
Contact: Joan Hartman

Columbia River Mental Health/Northstar Clinic
6926 E. Fourth Plain Blvd
Vancouver, WA 98661
Contact: Patrick Dieter, CDP

Connections Counseling
1334 Applegate Rd, Ste. 101
Madison, WI 53713
Contact: Tami Bahr, LCSW, CSAC, ICS

Counseling Associates, LLC
115 5th Ave S., Ste. 301
Lacrosse, WI 54601
Contact: Mary Turner

Counseling Services of Southern Utah, LLC
561 E. Tabernacle
St. George, UT 84770
Contact: Leslie Talbot

Ms. Sharon Cunningham, LAC, NCAC II
Butte, MT 59701

Devereux Texas Treatment Network
1150 Devereux Dr.
League City, TX 77573
Contact: Robert L. Scott

David Edelman, LCSW
Falls Church, VA 22046

Eleventh Hour Rehabilitation Programs
5639 E. Park Circle Dr.
Fresno, CA 93727
Contact: Jessie Robb, LCSW, CADC I

Fairbanks Hospital, Inc.
8102 Clearvista Parkway
Indianapolis, IN 46256
Contact: Helene M. Cross

Firebird Counseling, LLC
2855 W. Market St, Ste. 2855
Akron, OH 44333
Contact: Valerie Kreider, PhD.

Franklin Family Services
332 Minnesota St., #E-1255
St. Paul, MN 55101
Contact: David Forsell

Frona P. Israel, MSW, BBA, Inc.
2225 N. University Dr.
Pembrose Pines, FL 33024
Contact: Frona Israel, LCSW

Gateway Rehabilitation Center
311 Rouser Rd.
Moon Township, PA 15108
Contact: Martha Baldassare, Manager of Admissions Services

GoodPath LLC
38 Kim Lane
Hackettstown, NJ 07840
Contact: Harry Zerler, MA, LCADC, MAC

Hanley Center
933 45th St.
West Palm Beach, FL 33407
Contact: Dr. Barbara Krantz, CEO

Heartview Foundation
101 E. Broadway Ave
Bismarck, ND 58501
Contact: Kurt Snyder, Executive Director

Mr. James Clarke, MA, LPC, MAC
604 N. Main St.
Adrian, MI 49221

Johnson County Mental Health Center
301 N. Monroe
Olathe, KS 66061
Contact: Barbara Burks

Keystone
1010 E. 2nd St
Caniton, SD 57012
Contact: Robert Bogue

La Hacienda Treatment Center
P.O. Box 1
145 La Hacienda Way
Hunt, TX 78024
Contact: Art VanDivier, MA

Lakeside-Milam Recovery Centers
10322 NE 132nd St.
Kirkland, WA 98034
Contact: Amy Luehrs

Linda B. Fuller, LCSW, P.A.
800 North Fern Creek Ave, Ste. 2
Orlando, FL 32802
Contact: Barbara B. Fuller

LUK, Inc.
545 Westminster St.
Fitchburg, MA 01420
Contact: Gerald J. Manney

Mid-day Counseling
P.O. Box 205
Sparta, NC 28675
Contact: Sherry Cahn

New Concepts & Associates
1707 NE 74th Ter.
Gladstone, MO 64118
Contact: Dan R. Gray

Oasis Behavioral Health Services LLC
689 Central Ave.
Barboursville, WV 25504
Contact: William B. Webb, PhD, LICSW

Olympic Pain & Addiction Services
1334 Lawrence St.
Port Townsend, WA 98368
Contact: James K. Rotchford, MD, MPH

Parkview Counseling Associates, LLC
9910 W. Layton Ave
Greenfield, WI, 53228
Contact: Nancy A. Shirk

Mr. Chet Phillipe, M.Div, CADCII Ret.
Visalia, CA 93277-1739

Ms. Neil A. Raffen, MEd, CAC II, CCS
Covington, GA 30014

Restoration Counseling
78-150 Calle Tampico, Ste. 207 A
La Quinta, CA 92253
Mail: P.O. Box 536, La Quinta, CA 92247
Contact: Patricia A. "Annie" McCoy, CADCA

Rideview Institute
3995 S. Cobb Dr.
Smyrna, GA 30080
Contact: Paul Hackman, President/CEO

Rosecrance, Inc.
1601 University Dr.
Rockford, IL 61107
Contact: Renee Popovits and Janis Waddell

Sacred Heart Medical Center
17940 Farmington Rd., Ste. 140
Livonia, MI 48152
Contact: Jeffrey Berger, M.D.

Solution Focused Treatment Services
2122 Rosefield Dr.
Houston, TX 77080
Contact: Michael Yeager

Stepping Stones to Recovery, LLC
2610 Commons Blvd.
Augusta, GA 30909
Contact: Jessica Epps, LMSW

Summerhill Counseling Center
4091 Summerhill Square
Texarkana, TX 75503
Contact: Jeanne Field Miller, MS, LPC, LMFT,
LCDC, NCC, SAP, DABFE

Sundown M Ranch
P.O. Box 217
Selah, WA 98942
Contact: Scott Munson

Therapeutic Alternatives, Inc.
4024 Barrett Dr., Ste. 101
Raleigh, NC 27609
Contact: Steven P. Rochkind, MSW, PLCSW

The Ringer Mental Health Center
213 E. Bessemer Ave.
Greensboro, NC 27401
Contact: Stephen W. Ringer

Valley HealthCare System
301 Scott Ave
Morgantown, WV 26508
Contact: Gerard J. Schmidt

Vet Center #710
2990 Richmond Ave, Ste. 325
Houston, TX 77006
Contact: Dr. Edgar A. Wallace, LCSW, MAC,
ICAADC