May 28, 2009

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor, 200 Constitution Avenue, NW
Washington, D.C. 20210
Attention: MHPAEA Comments Regarding Federal Register Notice April 28, 2009

Mercy Behavioral Health (MBH) appreciates the opportunity to offer our comments on the formulation of the MHPAEA regulations. As part of the Pittsburgh Mercy Health System (PMHS) which is a part of Catholic Health East, MBH provides a full continuum of recovery-oriented, community-based mental health, mental retardation, and drug/alcohol treatment and prevention services to 23,700 children, adolescents, adults and families annually throughout Allegheny County, Pennsylvania.

The passage of the MHPAEA is a remarkable step in this country's path towards the acknowledgement of the reality and prevalence of mental health and substance use disorders (MH/SU) as well as the long history of documented problems with MH/SU coverage affecting millions of individuals and families. Although a range of efficacious treatments is available to ameliorate symptoms of mental illnesses and substance use disorders, financial and access barriers in addition to limited treatment often stand in the way of receipt of effective treatment. It is hopeful these recommendations will be of use in the regulatory process.

In Network Access:

The MHPAEA regulations should include guidance to health plans on how to ensure in-network access to mental health & addiction services in addition to addressing other critical issues of out-of-network care and medical management of the benefit. Other issues include:

- Require that applicable health plans enroll (existing) community providers in their network in order to assure access for high-risk or special needs clients/patients. Many of the clients seen by community providers, including MBH, fall into this category. It would be a logical step to include community providers already providing this care to be included within the network.

- Ensure there are standards that require networks to have sufficient enrolled, participating providers to assure access to services equal to health services. The standards should be the same standards as primary care in terms of wait time for appointments, travel distance or travel time. Access to specialized services should have at least the same geo-access

standards as would be applied in the local service area to hospital/inpatient care for medical-surgical.

Financial Requirements & Treatment Limitations

The MHPAEA regulations should articulate that limitations of services have to meet the "requirements of the Act" i.e., should prohibit restrictive limitations on scope of treatment that has the effect of shifting risk to the consumer or to secondary coverage. As a member of the National Council for Community Based Healthcare (NCCBH), MBH has helped in identifying ranges 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 for coverage/reimbursement, forcing chronic patients to chose another provider which leads to lack of continuity of care; and medical necessity criteria that restricts appropriate and timely care. The following practices are also examples of treatment limitations:

- 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 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, partial hospitalization, assertive community treatment, crisis intervention & stabilization services, illness management & recovery programs, supported employment & vocational rehabilitation, (intensive) case management and peer support services
- Review of treatment services as to whether or not services are evidence-based, experimental & 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)l
- Prohibiting plan coverage for eating disorders and MH/SUD services required due to court order

Scope of treatment

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. 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. Services recognized as community standards or evidence-based practices for a given condition should be covered. For example, some people living with mental illness respond successfully to Assertive Community Treatment (ACT) which is an evidence-based model of care that provides wraparound, comprehensive treatment provided by a multi-disciplinary team of professionals.

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 severe mental illnesses, addictions and emotional disturbance should be covered if similar approaches are covered for substantially all other chronic health conditions.

We also urge that the regulations address "exclusion" provisions in health plan contracts. Common exclusions especially relevant to MH/SU include court-ordered treatment and experimental or investigative treatment that restrict the scope of treatment or services that would otherwise be appropriate to the patient's diagnosis and functional condition.

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. Pennsylvania's Adultbasic, the current state-sponsored health care program for low income residents, does not provide any MH/SU coverage. Even though new legislation has been introduced in the General Assembly to include MH/SU benefits, there has been no action towards enacting a state parity law. Without the Federal regulation that would ensure MH/SU parity to pre-empt the state law, states with healthcare programs alike to PA and without state parity laws could find loopholes to full parity inclusion.

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. 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. The National Council for Community Behavioral Healthcare's MHPAEA comments indicate several other specific areas that regulations should address in order to assure that this flexibility does not become a means to make other provisions of the law irrelevant.

Appeals & Independent Review of Denial of Reimbursement or Payment of Services

As with any regulatory change, problems getting it right can be anticipated and plans to assist and respond must be put in place. To be effective, 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. Regulations should be inclusive of but not limited to:

- Otherwise covered services/treatment should be covered while an appeal is pending.
- The appeal or review process must be communicated to patients and the requesting 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.

As the formulation of the MHPAEA regulations continues, we welcome the opportunity to provide future comments. Please consider our recommendations as outlined above. Thank you.

Sincerely,

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