GEORGETOWN UNIVERSITY

Health Policy Institute

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Alan D. Lebowitz
Deputy Assistant Secretary for Program Operations
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Ste. N-5653
Washington, DC 20210

Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Dear Mr. Lebowitz:

Thank you very much for the opportunity to provide information regarding the development of regulations for the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. This landmark legislation signed into law on October 3, 2008 seeks to protect the rights of individuals in need of treatment for mental health and/or substance use disorders. The drafting of the regulations will help to fully realize this promise. Currently I am the director of a 16 State Federal grant program. In that capacity I have worked with States throughout the country for four years to improve the treatment system for adolescents with substance use and/or mental health disorders. I have been privileged to talk with youth, family members, treatment providers and State officials from the child serving agencies in these States. My comments will reflect this experience. I would be pleased to provide additional information if that would be helpful to the committee.

Respectfully,
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Professor of Mental Health Policy
Director, National Adolescent Substance Abuse Treatment Coordination Program
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Comments regarding Regulatory Guidance

2. What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?

- **Managed Care Models.** The regulations should clarify which managed care models are covered under MHPAEA. As I am sure the reader knows, there are at least three common managed care designs that payers might use to provide health care. In the first design, the payer (employer, Medicaid, SCHIP) contracts with one firm that manages and delivers either directly or through contracts with treatment providers, medical/surgical and MH/SUD services. In the second managed care design, the payer contracts with a firm that manages and delivers medical/surgical care either directly or through contracts with treatment providers but subcontracts the management and provision of MH/SUD services to a managed behavioral health care organization (MBHO). This arrangement is often referred to as an internal carve-out of the behavioral health benefit. In the third design, the payer contracts with one or more firms to manage and deliver medical/surgical care and the payer directly contracts with one or more behavioral health care organizations to manage and deliver the MH/SUD benefit. This may be referred to as an external carve-out. There is a need to clarify whether the MBHOs are subject to the requirements of the MHPAEA. Not including MBHOs may have repercussions. First, MBHO arrangements are common. "The dominance of MBHO contracting in all types of managed care products underlines that the existence of a separate organization for specialty behavioral health care is the typical scenario to envision when considering behavioral health policy and practice relating to private health plans"(Horgan et al, 2009, p.23). MBHOs are also commonly used in Medicaid managed care. Oss, et al. found that in mental health, specialty managed behavioral health carve-out firms have emerged as a dominant approach to managing care with the carve-out industry growing to 164 million individuals covered in 2002 compared to 70 million in 1993 (2003).

  Research shows that carve-out arrangements might increase under MHPAEA. In a study of the effects of mental health and substance abuse parity for Federal employees (Barry and Ridgely, 2008) the authors compared 213 Federal employee health plans subject to parity to 35 health plans not subject to parity from the Medstat MarketScan Benefit Plan Design database. The authors found that "… while 47 percent of Federal Employee Health Benefit (FEHB) plans carved out management of mental health and substance abuse benefits in 2000 before parity, 69 percent carved-out after parity implementation in 2001" (Barry and Ridgely, 2008, p. 162). There was a statistically significant difference in the increase in carving-out after parity among the FEHB plans compared to the Medstat plans. Thus it seems that managed behavioral health care carve-outs are important now and may increase post the implementation of the MHPAEA.

- **Predominant/substantially all**. The terms "…no more restrictive than the predominant financial requirements applied to substantially all medical or surgical benefits covered by the plan(or coverage)…" and "…no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage)…" need further clarification.

- **Financial arrangements.** In the case of a payer that offers an external MBHO it is not clear in the legislation if the MBHO must meet the predominant financial arrangements across all of the medical/surgical plans offered by the payer or just the predominant financial arrangements of the medical plan an individual consumer has selected.

- **Deductibles and out-of-pocket maximums**. There is significant discussion in the field about whether the MHPAEA would allow insurers to have separate but equal deductibles and out-of-pocket maximums, one for medical/surgical care and one for mental health and substance use disorder treatment. For the treatment of substance use disorders,

there are a number of examples which support having one deductible and out-of-pocket maximum across all types of treatment, including laboratory services and medical and specialty treatment. For example, detoxification performed in a medical facility is currently billed within the medical benefit while substance abuse treatment following detox is most often covered through the substance use disorders benefit. Likewise medication assisted treatment for addiction is often administered in primary care through the medical benefit, while specialty counseling and psychotherapy is covered through the substance use disorders benefit. In both cases, the consumer would do better having one understandable deductible and one out-of-pocket maximum which would include both general and specialty components of addiction treatment.

- **Co-pays**. Currently for medical/surgical conditions co-pays may vary by primary vs. specialty care. How will this translate to treatment for mental health/substance use disorders?

- **Cost sharing.** There should be no separate cost sharing arrangements for MH/SUD residential treatment that differ from cost sharing arrangements for medical/surgical residential rehabilitation.

- **Services**. The regulations should clarify that it was the intent of Congress to include services within the definition of MH/SUD benefit.

- **Service settings**. MH/SUD service types may be delivered in a number of different settings. For example, medically necessary MH/SUD treatment services for youth should be allowed to be provided by specialized clinicians in settings including but not limited to in the home or at school-based clinics.

- **In-network benefit**. The health plan should be required to cover all medically necessary MH/SUD service types under the in-network benefit. Plans should not be permitted to offer more costly intensive services as out-of-network services only as this may disadvantage consumers financially.

- **Continuity**. Health plans/MBHOs should be required to continue all treatment service types for mental health conditions and substance use disorders that were provided by health plans prior to the passage of MHPAEA after the implementation of MHPAEA as well.

- **Medications**. The regulations should clarify that plans that provide both medical and surgical and MH/SUD benefits are required to cover medications that treat MH/SUD conditions in a manner that is no more restrictive than the coverage for medications for medical/surgical conditions.

- **Coverage of provider types**. The regulations should clarify that health plans should cover all MH/SUD professionals licensed by the State who are practicing within the scope of the license.

- **Fee Schedules**. The regulations should clarify that permitting fee schedules so low that access is reduced is against the intent of the law.

- **Continuum of services**. Currently plans may offer a full array of medical/surgical service types but may only cover a few MH/SUD service types (ex. detox and outpatient treatment). It would seem that this would violate the provision of the law that prohibits imposing limitations on the scope or duration of treatment. This should be clarified in the regulations.

- **Network adequacy**. Health plans/MBHOs should at a minimum meet the National Committee for Quality Assurance (NCQA) standards for availability of practitioners and providers, accessibility of services and member satisfaction[1].

- **Medicaid**. The regulations should specifically state that MHPAEA applies to Medicaid (and SCHIP Medicaid expansion) managed care.

- **Medicaid requirements**. The regulations should clarify that nothing in the MHPAEA dilutes Medicaid's (or any SCHIP Medicaid expansion's) responsibility to cover treatment for both mental health and substance use disorders. The regulations should reaffirm that for Medicaid and SCHIP Medicaid expansions the requirement as codified in 42 U.S.C. §1396d[2] still applies.

- **Existing State laws**. The regulations should clarify the relationship of the MHPAEA to existing State parity/State benefits laws. It is particularly important to provide examples that illustrate how broader State mandates are to be protected from being preempted by the Federal law. The MHPAEA should adopt criteria similar to the HIPAA privacy regulations in 45 CFR 160.201 through 160.205.

- **Alcohol and Drug Trauma Exclusion**. This is based on a model law, the Uniform Accident and Sickness Policy Provision Law (UPPL). Trauma/alcohol exclusion laws still in effect in many States allow insurance companies to deny reimbursement to hospitals and health care providers that treat individuals who are impaired by alcohol or drugs at the time of the injury. The regulations should address the effect of MHPAEA on these State laws.

- **Court ordered treatment**. The regulations should clarify the responsibility of health plans to pay for medically necessary mental health and/or substance abuse treatment when it is ordered by the court.

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.** Medical necessity criteria should employ accepted research-based industry standards for level of care decisions such as the patient placement criteria developed by the American Society of Addiction Medicine "Patient Placement Criteria for the Treatment of Substance-Related Disorders (Second Edition – Revised or ASAM PPC-2R)". The regulations should specify timeframes for responding to a consumer's request for medical necessity criteria and should specify enforcement procedures for failure to comply. If the plan modifies its medical necessity criteria, it should notify all plan participants and providers of the change at least three months prior to the change taking effect.

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[1] For more information on health plans from the NCQA, please see: http://www.ncqa.org/tabid/850/Default.aspx and for more information on MBHOs, please see http://www.ncqa.org/tabid/711/Default.aspx

[2] Codified at 42 U.S.C. §1396d "No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency".

- **Medical management**. While the MHPAEA allows for the use of medical management the regulations should clarify that medical management criteria for MH/SUD benefits may not be more stringent than for medical/surgical benefits.

- **Mental health or substance use disorder benefits.** The MHPAEA allows for a health plan to cover either mental health or substance use disorder benefits. At least in the case of adolescents and young adults choosing to offer services for only one condition may present challenges. The National Survey on Drug Use and Health (NSDUH) estimates that over 1.9 million (7.7 percent) adolescents aged 12 through 17 had past year illicit drug or alcohol dependence or abuse. According to the 2007 NSDUH, 20.7 percent of individuals aged 18 through 25 met criteria for past year illicit drug or alcohol dependence or abuse (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008).

  Twenty percent of children and adolescents have a diagnosable mental disorder according to the Center for Mental Health Services (CMHS) (CMHS, 1998). The United States Surgeon General estimates that between nine and thirteen percent of children and adolescents meet the criteria for a serious emotional disturbance (United States Department of Health and Human Services (USDHHS, 1999).

  The challenge however is that co-occurring substance use and mental health disorders are common among adolescents diagnosed with either a substance use or mental health disorder. In a study of Center for Substance Abuse Treatment (CSAT) funded adolescent programs from 1998 to 2004, seventy-four percent of youth diagnosed with a substance use disorder also had a co-occurring mental health disorder (Turner, et al., 2004). Among adolescents receiving inpatient substance abuse treatment, seventy-five to eighty percent were diagnosed with a co-occurring mental health disorder (Gee et al., 2006; Greenbaum, et al., 1996). Among youth receiving mental health services, almost fifty percent were diagnosed with a co-occurring substance use disorder (Gee, et al., 2006; USDHHS, 2002). Failure to treat one disorder generally leads to both disorders becoming more severe (Gee, et al., 2006; New Freedom Commission on Mental Health, 2003). This has led researchers to conclude that co-occurring substance use and mental health disorders require attention (Gee, et al., 2006) and that co-occurring disorders should be considered the rule, rather than the exception, among adolescents in substance use disorder treatment (Whitmore & Riggs, 2006). Thus if a health plan chooses to offer services for only one condition this could put treatment professionals in an ethical dilemma confronting how to treat the co-occurring disorders within the limits of the covered benefit.

- **Chronic disease management model.** Research suggests that the acute care model of clinical intervention may not be sufficient to allow youth with substance use or co-occurring mental health disorders to achieve treatment gains and sustain long-term recovery. Adolescent first-year post-treatment relapse rates, defined as at least one episode of alcohol or other drug use, range from sixty to seventy percent (Brown, et al., 1989; Godley, et al., 2002; White, 2008). Within thirty days of discharge, one-third of adolescents will relapse and the relapse rate rises as the adolescent becomes further removed from treatment (Brown & Ramo, 2006; White, 2008). Over ninety percent of adolescents will use alcohol or drugs within five years of treatment (Chung, et al., 2003; Godley, et al., 1999; White, 2008).

  To address the high levels of relapse among adolescents, continuing care has been suggested as a critical mechanism to maintain treatment gains for adolescents and adults (Belenko & Logan, 2003; Brown, et al., 1994; Catalano, et al., 1989; Dasinger, et al., 2004; Donovan, 1998; Godley, et al., 2006; Jainchill, et al., 2000; Kaminer, 2001; McKay, 1999). Continuity of care is a significant predictor of three-month recovery status (Garner,

et al., in press). Adolescents receiving continuing care services within 14 days of discharge from residential treatment were found to be 92 percent more likely to be in recovery three-month post discharge than adolescents not receiving continuing care services (Garner, et al., in press). Adolescents in recovery at three months had four times higher odds of being in recovery at twelve months than adolescents not in recovery at three months (Garner, et al., in press). Receiving assertive continuing care significantly predicted the likelihood of twelve-month recovery status among adolescents (Garner, et al., in press). The regulations or accompanying narrative should provide guidance to the field on the advisability of supporting chronic disease management/ continuing care models.

- **Provider network**. The regulations should address the issue of services provided out-of-State. If medical/surgical care may be delivered out-of-State, then health plan provider networks should include specialized MH/SUD programs (which may be located out-of-State) for the treatment of complex or low incidence mental health and/or substance abuse disorders.

- **Date of service**. The regulations should clarify that MH/SUD benefits may apply to both medical and specialty services provided on the same day, e.g., screening and brief intervention or medication management on the medical side and assessment or treatment for MH/SUD on the behavioral health side. The regulations should also clarify that more than one behavioral health service may be received on the same day, e.g., individual psychotherapy and group counseling.

4. What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services 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?

- **Utilization review and denial standards**. All behavioral health plans should at a minimum meet the industry standards as set out in the National Committee for Quality Assurance utilization review and denial standards for health plans/MBHOs.[3] Emphasis should be placed on the timeliness of utilization review and denial decisions, appeals processes and appropriate notification of the consumer/family. All communication with health plan members should be in consumer friendly and culturally appropriate language. In the case of a youth in the custody of a State child welfare or juvenile justice agency, the health plan should be required to notify the appropriate State agency and follow the same procedures for information sharing and notification as used for health plan members. Dispute resolution processes and mechanisms should be clearly described and followed. These requirements should be enforced by an appropriately resourced division of the United States Department of Justice.

[3] For more information on health plans from the NCQA, please see: http://www.ncqa.org/tabid/850/Default.aspx and for more information on MBHOs please see http://www.ncqa.org/tabid/711/Default.aspx

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?

- **Out-of-network providers**. MHPAEA requires that if a plan provides out-of-network medical/surgical benefits the out-of-network requirements for MH/SUD can be no more restrictive than the out-of-network requirements for medical/surgical care. The regulations should assure that the most intensive and expensive MH/SUD treatment is not limited to out-of-network providers only.

7. Other Issues

- **Studies**. The application of this law may differentially affect sub-populations. It will be critically important to collect data by age group in order to analyze the effects of the law on children/adolescents and young adults. Too often government studies aggregate data, making it impossible to conduct any meaningful analyses on the effects of change on youth. The required Secretary's study and the GAO report have an opportunity to address this proactively. The regulations should require that the studies use common age groupings either used for analysis of Medicaid data or from national health surveys such as the National Survey on Drug Use and Health.

- **Notice and Assistance**. Reports on the implementation of State parity laws in California (Lake et al., 2002) and Vermont (Rosenbach et al., 2003) have highlighted the importance of education and communication outreach efforts to patients, families, providers and health plans. Information on financial arrangements, benefits and delivery system changes is essential. In the first years post implementation of MHPAEA it will be important to reach out to consumers to the maximum extent possible, with planned follow up annually. Outreach must be culturally competent and respectful of privacy concerns and rights.

- **Establishment of a Consumer Advocate Office**. A consumer advocate office should be established at the Federal level to assist consumers with questions concerning their new rights and benefits under the law and to receive real time information on denials and other MHPAEA implementation barriers. Communication processes should be put in place which will protect consumer privacy rights.

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