May 28, 2009

Attn: MHPAEA Comments
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, DC 20210

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

CC:PA:LPD:PR (REG-120692-090)
Room 5205
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted via the Federal eRulemaking Portal: www.regulations.gov

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

Dear Sir/Madam:

Molina Healthcare, Inc. is writing to comment and offer recommendations regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. Law 110-343, the "MHPAEA"). We are responding to a Request for Information (RFI) published in the *Federal Register* on April 28, 2009 (74 Fed. Reg. 19155).

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals. Molina Healthcare's ten licensed health plan subsidiaries in California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah and Washington currently serve approximately 1.3 million members.

We understand that Medicaid managed care plans that offer mental health or substance use disorder benefits are required to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage. We, therefore, appreciate this opportunity to provide comments on the implementation of the MHPAEA.

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

Currently, all states provide behavioral health services for Medicaid beneficiaries and most provide coverage for some substance use disorder benefits. As a result, each state has in place specific policies and procedures to correspond with its covered benefits. If states are now required to broaden the offered mental health benefits to match medical care benefits and that responsibility is, in turn, passed on to managed care companies, then policies and procedures would need to be adjusted and/or added accordingly regarding utilization management and prior authorization requirements and review timelines. The current process in place will largely remain the same, but will be on a much broader scale to incorporate additional benefits. Such addition of benefits may lead to enhanced burden of oversight, administration, and claims adjudication commensurate with the increase in benefits and utilization.

Additional clinical reviews will also be necessary for ongoing outpatient or inpatient care, likely resulting in the need for added clinical review staffing. This impact may be minimal, however, with regard to adult outpatient services. While parity will end the setting of arbitrary limits, this may not yield significant increased utilization among adults. However, we anticipate that children may use extended benefits to a greater degree as they have adult advocates ensuring their continued treatment engagement.

B. Comments Regarding Regulatory Guidance

Coverage levels for behavioral health and substance abuse vary but are dictated by the state. Under the MHPAEA, states may no longer be able to set budget driven limits on care, such as 12 outpatient visits. Particularly in this current economic downturn, states may find this an excessive burden. As a result, the central issue may become determining which Medicaid members qualify for these benefits and which ones will be diverted to community mental health services funded through blended dollars.

We are also unsure of how states will choose to care for Medicaid members who fall between current benefit limits for the sub-chronic or sub-acute populations versus those who fall into comprehensive services for Severe and Persistent Mental Illness. Furthermore, inpatient management is variable by state, as some states manage this benefit directly, and others contract with managed care organizations (MCOs) for prior authorization and concurrent review. Typically a member's inpatient care does not reach a technical benefit limit, but his or her hospital stay may be closely monitored for when and how to transition him or her into long-term placement such as

state hospital care. Consequently, the greatest impact of the MHPAEA may be on outpatient utilization dollars rather than inpatient.

Substance abuse treatment coverage also comes in all shapes and sizes. For example, MCOs often carry responsibility for medical detoxification as a medical benefit, although in some instances it remains a substance abuse cost carve-out to the state unless medical complications of the detox convert it to medical coverage (e.g., seizures). Subsequent residential or outpatient substance abuse care can be divided along the continuum between what the MCO is contracted to cover (and with what limits) versus what is covered by the state's substance abuse funding allocation and delivery system. The shift to state substance abuse services often involves a wait-list, so again, there will be additional burden placed on the state budgets in bridging the gap.

Furthermore, we believe that Medicaid MCOs should be given the flexibility to structure their provision of mental health and substance use disorder benefits such that the determination of any treatment limits may take into account whether any additional services are available through the Medicaid program once such limits are reached. Guidance should be issued to clarify that when determining parity, Medicaid MCOs may consider whether additional services are available to the beneficiary through the state with respect to treatment limits applicable to mental health or substance abuse disorder services.

In addition, necessary changes to the regulatory structure in the Medicaid program to facilitate compliance will lie primarily with the state's structure of the benefit coverage mandate. The amount of responsibility given to MCOs from the state as opposed to the benefits the states will continue to manage themselves or through community mental health organizations will determine the amount of regulatory guidance needed. It is important to note that there is significant opportunity for improved quality and coordination of care when one entity manages the entire spectrum of behavioral health and works as a team to maximize health, functional level and cost.

With respect to the criteria for medical necessity determinations made under the plan (or coverage), we believe there are existing best practice guidelines and clear standards for medical necessity of mental health benefits. These are available as they are for any medical care need. In addition, denial procedures remain the same for behavioral health/substance abuse services as with any medical care need. Denial information is sent to the member and provider and the appeals process is the same for both.

In your *Request For Information*, you asked whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. For most health insurance plans, out-of-network coverage is allowed when necessary. This provision is the same for behavioral health/substance abuse needs and medical care needs.

Finally, comments were solicited about which aspects of the increased cost exemption, if any, require additional guidance. Cost exemption is an essential safety clause. In the case of Medicaid, it will be essential to the states to be able to determine whether costs exceed the 2% of total medical and behavioral health/substance abuse costs. Any added coverage mandate may result in additional burden to already stressed budgets. The states will rely upon MCOs to demonstrate the costs incurred to see if they meet exemption status.

C. Additional Comments

While the implementation of parity does not necessarily imply development of integrated care models and the coordination of care, it certainly creates the opportunity for this. Over time, the integration of care, which may result from the decoupling of behavioral health care from stringent utilization limits, could lead to clearly superior results in physical health and behavioral health. The impact of care coordination on outcomes is most positive in the context of an integrated care model.

There currently exists significant tension between behavioral health and physical health providers in determining responsibility for cases that are not clearly one or the other (e.g., a suicide attempt with sublethal amounts of medication or trauma). In a unified model without treatment limits, the best, most cost-effective care setting and discharge arrangements become available.

Thank you for the opportunity to comment on these important issues.

Sincerely,

Joseph M Molina MD

Joseph M. Molina, MD
CEO and Chairman
Molina Healthcare, Inc.