CALIFORNIA HOSPITAL ASSOCIATION

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May 28, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-4140-NC, Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Request for Information (Vol. 74, No. 80), April 28, 2009

Dear Ms. Frizzera:

On behalf of the California Hospital Association (CHA) and our nearly 450 hospital and health system members, we appreciate the opportunity to provide information to Centers for Medicare & Medicaid Services (CMS), Employee Benefits Security Administration and Internal Revenue Service regarding the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) published in 80 Fed. Reg. 19157 (April 28, 2009).

In 1999, California passed a mental health parity law (AB 88) requiring private health insurance plans to provide equal coverage for physical health and selected mental health conditions, including serious mental illnesses (SMI) in adults and serious emotional disturbances (SED) in children. The law requires health plans to eliminate the benefit limits and reduce the cost-sharing requirements that have traditionally made mental health benefits less comprehensive than physical health benefits. A decade after enactment, the private health plans have implemented the parity requirements quite well on paper. However, significant barriers to access have impeded the ability of enrollees to obtain the appropriate care in the appropriate environment.

By assuring that ERISA plan enrollees have equivalent access to care for necessary mental health and substance use disorder treatment as they do for non-mental health conditions, MHPAEA has substantial potential to positively affect the nation's public health. If implemented responsibly, MHPAEA will better ensure that ERISA plan enrollees (which include employees and their families at some of the nation's largest companies) will better be able to receive and afford quality mental health and substance use disorder treatment. CHA commends the Centers for Medicare & Medicaid Services and the Treasury Department agencies responsible for MHPAEA implementation for their thoughtful and deliberative approach to implementation of the mental

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health parity provisions of PL. 110–343, and hope that the following comments are helpful as CMS and Treasury consider how to frame the important upcoming regulatory cycle.

Question 1: *The statute provides that the term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit. The statute further provides that the term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage or other similar limit on the scope of duration of treatment. Do plans currently impose other types of financial requirements or treatment limitations to 1) medical and surgical benefits and 2) mental health and substance use disorder benefits? Are these requirements or limitations applied differently to both classes of benefits? Do plans currently vary coverage levels within each class of benefits?*

There are no national standards as to which mental health diagnoses are required to be covered at the same level as medical and surgical benefits. In California, nine "severe mental illnesses" are required to be covered. These illnesses include: Schizophrenia, Schizoaffective disorder, Bi-polar disorder, major depressive disorders, panic disorders, Obsessive-compulsive disorder, Pervasive developmental disorder or autism, Anorexia nervosa, and Bulimia nervosa. Any other mental illness or substance use disorder is not required to be covered by health plans. "Non-parity diagnoses" may still have restrictions on the number of visits, deductibles, lifetime limits, pre-existing condition restrictions, and gender-based rate setting.

CHA recommends that all Diagnostic and Statistical Manual of Mental Disorders* (DSM) *diagnoses be covered at the same level as medical and surgical benefits or regulators should develop a standard minimum benefit package.

Treatment limitations for mental illnesses and substance use disorders are difficult to determine. This is due to the fact that access to information regarding treatments covered by a given plan is limited. For mental health professionals to provide affordable and high quality care to their patients, they must have access to the plan's benefit package and "evidence of coverage" information. This information is often complex and difficult for enrollees to discern, especially enrollees with mental illnesses. Providers are frequently depended upon to assist enrollees with understanding a plan's benefits.

CHA recommends that regulations regarding prescriptive disclosure requirements should require current plans to make "evidence of coverage" available on request to potential and current enrollees as well as contracted medical providers.

Billing of treatment for mental illnesses and substance use disorders is extremely burdensome administratively. ***CHA recommends that agencies develop one standardized form (similar to the UB92) to streamline billing, lower administrative costs, and help providers run more efficiently.***

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

The term "psychiatric emergency condition" requires further clarification. CHA is currently working on a state bill to better define this term. The lack of a consistent definition causes confusion about which treatments require prior authorization and which do not.

Treatment authorization can be extremely complicated and time consuming, and frequently detracts from providers' ability to treat a psychiatric illness that may be considered an emergency. This additional time spent seeking authorization may pose a detriment to patients. Doctors and enrollees must frequently spend hours on the phone being sent back and forth from the department of the health plan which underwrites or administers the plan for physical health conditions and their contracted "carve out" mental health administrators. Sometimes, clinicians are required to call back at very specific times of day that (due to clinicians' high patient load) are inconvenient and may conflict with their patient care schedules. Frequently, the authorization ultimately is determined by a health plan employee who is not a mental health professional. CHA members especially report being sent back and forth from the physical health departments and the mental health departments of health plans when seeking authorization for imaging techniques, such as MRIs, to determine presence of brain injuries.

CHA recommends that regulatory agencies broadly define the term "psychiatric emergency condition" and clarify that prior authorization is not required, aligning this with current Emergency Medical Treatment and Labor Act (EMTALA) requirements.

Question 3: *What information, if any, regarding 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 it 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?*

In California, it is currently difficult for both providers and enrollees to determine coverage benefits and the definition of "medical necessity." Evidence of coverage information is considered proprietary by most plans. Although enrollees have depended on providers to explain benefit packages and advocate on their behalf, medical providers have limited access to benefit package information. The information that is often made available to providers is vague, lacks detail, and frequently differs from the information enrollees may access.

CHA recommends that regulators mandate that medical providers and enrollees have access to evidence of coverage information in order to better advocate on behalf of themselves or their patients.

Medical necessity varies by plan in California and is based on diagnoses. The term "medical necessity" is poorly defined and frequently causes confusion between medical providers and plans. No industry standard exists to classify treatments. The lack of a uniform care determination system can result in a wide variation in treatments. An evidence-based tool should be developed to standardized and evaluate treatment and level of care needs in order to determine best practices and medically necessary treatments. Currently, in order for enrollees to

receive coverage in California, medical providers must demonstrate necessity of treatment to individual plans with differing standards for medical necessity that can be at odds with each other.

CHA recommends that regulators develop or endorse the use of a uniform, evidence-based medical necessity clinical decision process in order to evaluate and standardize mental health and substance use disorder treatments and care.

Question 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?*

In California, plans may only deny coverage based on lack of medical necessity or a non-parity diagnosis. Due to the nature of mental illnesses, patients frequently depend on medical providers to advocate on their behalf and demonstrate medical necessity. Unfortunately, each plan is individualized and complex, making it difficult for consumers and providers alike to determine denial rationale.

The stigma surrounding mental illnesses and substance use disorder also impact the ability of plan enrollees to determine information regarding their plan coverage and reasons for denial. Most employees would be hesitant to ask employers about mental health benefits, making it difficult to gauge the quality of the ERISA plan. Appropriate appeals may not be made due to ignorance about plan details and fear of inquiring. A national entity that protects the anonymity of patients should be created to receive complaints about plans that enrollees may otherwise be afraid to make.

CHA recommends that regulators develop transparent and consistent medical necessity criteria. Further, insurers should be required to provide transparent and consistent criteria for denial, and that a uniform, meaningful, transparent, and expeditious process for contesting a denial be established.

Question 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 that out-of-network coverage provided for medical and surgical benefits?*

The use of out-of-network providers is commonplace in California for medical and surgical care. However, this practice is not allowed for mental health treatment.

CHA recommends that regulators mandate that mental health patients be permitted to use out-of-network providers when a plan network provider is inadequate to meet the needs of the patient and for emergency care.

Question 6: *Which aspects of the increased cost exemption, if any, require additional guidance? Would model notices be helpful to facilitate disclosure to federal agencies, state agencies, and participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption?*

Although plans that experience certain cost increases as a result of the mental health parity regulation may opt out of compliance with MHPAEA, plans that choose this cost exemption should be required to send paper notices to enrollees and contracted medical providers. Along with disclosure of the change to their benefits, plan enrollees should be provided with a transition advisor provided by the plan and mandated by the federal government. The transition advisor would help ensure that the enrollee does not experience disruption in care.

CHA recommends that regulators require plans to send a paper notification to plan enrollees and contracted medical providers should the plan opt out of compliance due to the cost exemption. Further, we recommend that, upon opting-out of parity, plans be required to provide the enrollee with a transition advisor to ensure continuity of mental health and substance use disorder care and coordination of care between physical and mental health providers.

Thank you for the opportunity to comment on these designated elements of the MHPAEA. CHA members are committed to ensuring access to care for all patients experiencing mental illness or substance use disorders, and commend CMS and the Department of the Treasury for laying the foundation for meaningful ERISA plan parity. If you have any questions about these comments, or if you wish to discuss these matters further, please contact Sheree Kruckenberg at 916-552-7576, or skruckenberg@calhospital.org.

Sincerely,

Sheree Kruckenberg
Vice President, Behavioral Health
Regulatory Affairs

John Rigg
Vice President, Federal

CHA Comments on CMS-4140-NC