

# PUBLIC SUBMISSION

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**Docket:** CMS-2009-0040

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

**Comment On:** CMS-2009-0040-0048

Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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## Submitter Information

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## General Comment

See attached file(s)

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## Attachments

**CMS-2009-0040-DRAFT-0061.1:** CA

## **Comment on the Interim Final Regulations for Federal Parity**

Comprehensive Behavioral Health Management is a regional MBHO located in Southern California. Currently we provide behavioral health management for over 1.5 million members being seen by a network of over 3,000 behavioral health clinicians.

We have been accredited by URAC since 2003 for Health Utilization Management.

### **Impact of Non-Quantitative Limitations**

While the federal legislation and Interim Final Regulations (IFR) support continued medical management for mental health and substance use disorders (MHSUD), the inclusion of non-quantitative limitations for establishing parity clearly diminishes the public's acceptance of medical management for MHSUD.

On page 5425 of the IFR it states: "Similarly, the Departments expect medical management and managed care techniques will help control any major cost impact resulting from MHPAEA and these regulations. As discussed earlier in this preamble, these regulations provide that medical management can be applied to mental health and substance use disorder benefits by plans as long as any processes, strategies, evidentiary standards, or other factors used in applying medical management are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying medical management to medical/surgical benefits."

MHSUD services are not directly comparable to medical services. Consumers and providers will legally challenge the "no more stringent" language. They will advocate for a direct comparison between medical/surgical services that typically do not include medical management (e.g., primary care visits) and an episode of care for a mental health diagnosis. We would like to request that the regulations provide further clarification that supports medical management as a process within a classification of care (e.g., outpatient or inpatient) rather than a distinct event for every "service of care".

With regards to "Standards for Provider Admission to Network, Including Reimbursement Rate", a single MBHO may contract with multiple health plans. Typically the MBHO will establish a fee structure for its network based upon licensure and region. Regardless of the health plan, the MBHO network provider rate schedule will be the same across license types and regions.

There is a substantial administrative and financial burden imposed by the IFR when requiring that the MHSUD provider rate schedules are comparable in design to the medical providers. In order to be compliant, the MBHO would have to align their credentialing and reimbursement designs with the "least restrictive" design established by the health plans. It could be argued that including this provision under non-quantitative limitations effectively eliminates the ability to develop a separate MBHO network, which is a key cost-savings strategy for MBHOs. The purpose of separate MBHO networks is not to limit access, but rather to reinforce quality behavioral health standards.

MHSUD medical management has protected patient rights by advocating for treatment to be provided "at the least restrictive level". This is to prevent patients, especially children and adolescents, by being traumatized by an unnecessary inpatient admission. The IFR specifically prohibits "step therapy protocols." The concern is that consumers and providers will interpret this as not allowing medical management to the least restrictive level and will advocate for inpatient or residential care even when evidence does not support this treatment as being more effective.

MHSUD levels of care do not fall into the distinct categories of Outpatient, Inpatient, Emergency Room, and Prescription Coverage. Most MHSUD programs also include Intensive Outpatient, Day Treatment, and Residential Treatment Coverage. We advocate that the MBHO's be allowed to define the category

where these additional levels of care are classified and that the regulations not be broadened to include coverage for any level of care under "scope of services."

We have concerns that the inclusion of "non-quantitative limitations" in the regulations will contribute to increase cost of care, as legal challenges will

- Seek to avoid the "no more stringent language" by applying the "substantially all" and "predominant language" to non-quantitative limitations in order to eliminate any medical management
- Advocate payment to "any willing provider" regardless of license, credentialing, and/or rate
- Focus on the "step-therapy" exclusion and eliminate the ability to provide appropriate care at the least restrictive level of care
- Create consumer expectations of "unlimited" and "unmanaged" MHSUD care at any level of care, which is not the intent of the original legislation.

### **Impact of Quantitative Limitations**

The quantitative limitation requiring a single group health plan impacts carve-out independent managed behavioral health organizations. As noted in the IFR MBHO's have established expertise in MHSUD and this expertise has resulted in cost savings.

Large employer groups have accessed this expertise by offering a mental health benefit separate from the medical benefit. The burden for employers to determine "substantially all" and "predominant" for a "single group plan" may result in elimination of the carve-out MBHO. Rather than offering a MHSUD benefit with proven medical management, an employer may eliminate MHSUD benefits altogether as there is no guarantee costs can be contained under the current Federal Parity Regulations.

Another cost driver is the single deductible requirement. MBHOs using good faith judgment interpreted the initial legislation as allowing separate but equal deductibles. As a result, they did not address the cost implications of a single deductible during the initial comment period. The costs related to transition to a single deductible are significantly underestimated in the IFR. Even if the cost of \$.60 per member were correct, for a small MBHO with 100,000 members, the cost is \$60,000, the equivalent to one FTE. Additionally MBHOs typically work with multiple health plans, each plan offering multiple benefit types and in some cases, multiple claims adjudication systems. Establishing the technology for efficient data exchanges will require time and resources. The July 1, 2010 compliance date is not realistic and consideration should be given to waiving requirement until final regulations are published.

### **Recommendations**

Our recommendation is that the deadline for compliance with the IFR be postponed until either Final Regulations are published and/or an additional time period be given for further comment. MBHOs must be given the opportunity to demonstrate not only the financial cost imposed by the IFR but also the harm caused to the MBHO industry, which as noted in the IFR has been influential on quality outcomes and cost containment.

We strongly support parity for MHSUD disorders with regards to quantitative limitations; however, we do not believe the IFR supports the original intent of the legislation, which was to provide parity while allowing medical management. The inherent differences between behavioral health care and medical care must be recognized. We encourage the regulators to either:

1. Eliminate the non-quantitative limitations from the regulations; or
2. Clarify within the regulations that the expectation for parity of non-quantitative limits is that the strategies and processes for all non-quantitative limits are "no more stringent than" and

behavioral health plans are not expected to match service-to-service when defining strategies and processes.

In the absence of the above recommendations, our belief is that the unintended consequences of these regulations will be the end of a valuable industry and ultimately the elimination of MHSUD benefits in an effort to avoid premium increases.