

# 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

**Document:** CMS-2009-0040-DRAFT-0108

DC

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## Submitter Information

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**Organization:** American Academy of Child & Adolescent Psychiatry

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## General Comment

The American Academy of Child and Adolescent Psychiatry (AACAP) is pleased to provide comments on the Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity of 2008 (“Interim Final Rules”[IFR] or “regulations”).

AACAP appreciates the significant work the Departments have put into the regulations to ensure the Act is implemented in a manner that was intended by Congress. The Institute of Medicine in their 2009 report, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, recommended the federal government make preventing mental, emotional and behavioral disorders and promoting mental health in young people a national priority. While it is understood that insurers have a fiscal responsibility to manage care, a concern exists that in anticipation of facing higher expenditures for reimbursement, insurers and managed care organizations will look to use utilization review or care management techniques to limit care or prevent care from being given, outside of the intent of the Act. On May 28, 2009, AACAP submitted comments on our organization’s view of the intent of the law. AACAP has reviewed the interim final rules and is pleased that the IFR holds the intent of the law and that our suggestions for clarification were included. Below are AACAP’s responses and recommendations to your questions in the IFR.

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## Attachments

**CMS-2009-0040-DRAFT-0108.1:** DC

# AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

May 5, 2010

Office of Health Plan Standards and Compliance Assistance  
Employee Benefits Security Administration, Room N-5653  
U.S. Department of Labor  
Attention: RIN 1210-AB30  
200 Constitution Avenue, NW.  
Washington, DC 20210

Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-4140-IFC  
P.O. Box 8016  
Baltimore, MD 21244-1850

CC:PA:LPD:PR (REG-120692-09), Room 5205  
Internal Revenue Service  
P.O. Box 7604  
Ben Franklin Station  
Washington, DC 20044

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

Dear Secretary Solis, Secretary Sebelius, and Commissioner Shulman:

The American Academy of Child and Adolescent Psychiatry (AACAP) is pleased to provide comments on the Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“Interim Final Rules” [IFR] or “regulations”).

The AACAP is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 8,000 members strong, the AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP’s members actively research, evaluate, diagnose, and treat psychiatric disorders and pride themselves on giving direction to and responding quickly to new developments in addressing the health care needs of children and their families.

AACAP appreciates the significant work the Departments have put into the regulations to ensure the Act is implemented in a manner that was intended by Congress. The Institute of Medicine in their 2009 report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, recommended the federal government make preventing

mental, emotional and behavioral disorders and promoting mental health in young people a national priority. While it is understood that insurers have a fiscal responsibility to manage care, a concern exists that in anticipation of facing higher expenditures for reimbursement, insurers and managed care organizations will look to use utilization review or care management techniques to limit care or prevent care from being given, outside of the intent of the Act. On May 28, 2009, AACAP submitted comments on our organization's view of the intent of the law. AACAP has reviewed the interim final rules and is pleased that the IFR holds the intent of the law and that our suggestions for clarification were included. Below are AACAP's responses and recommendations to your questions in the IFR.

**AACAP fully supports the Departments' determination that the Act prohibits health plans from applying separate deductibles, out-of-pocket maximums or other cumulative financial requirements on mental health/substance use disorder benefits.** We are pleased that the Departments have determined that separate but equal out-of-pocket maximums would not have been the intent of the law. There are many families who face both physical and mental health issues and the financial strain on them is extraordinary. Separate deductibles and out-of-pocket maximums have often been a barrier to care where individuals have had to forego care when they could not meet the separate requirements. Prohibiting separate cumulative financial requirements will dramatically improve access to mental health and substance use disorder services for individuals and their families who need and use these services. AACAP strongly encourages the Department to include a combined deductible in the Final Rule.

**Clarification that Any Exceptions to the Comparable and No More Stringently Standards Must Be Based on Independent and Objective Clinical Policies and Standards.** The regulations state that non-quantitative treatment limits must be comparable and applied no more stringently to mental health and substance use disorder benefits than to medical/surgical benefits. However, the regulations permit an exception "to the extent that recognized clinically appropriate standards of care may

# AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

permit a difference.” AACAP is most concerned that a plan’s internal review alone could weaken the intent of the law by defining its own clinically appropriate standards. To ensure the strong parity protections envisioned by Congress, the Departments should adopt a definition of “recognized clinically appropriate standards of care” that is based on independent and objective clinical policies and standards. This definition should state clearly that any “recognized” standard of care for purposes of the NQTL exceptions process must be: (1) an independent standard that is not developed solely by a single health plan or plans; (2) based on input from multiple stakeholders and experts, such as academic researchers, senior practicing clinicians, and consumer and advocacy leaders with subject matter expertise, in addition to a health plan or its advisory panels; (3) recognized or accepted by nationally recognized provider organizations and/or nationally recognized accrediting organizations that are responsible for developing quality standards; and (4) based on objective scientific evidence, such as peer-reviewed publications of control group research trials or expert consensus panels. When a non-quantitative exception is applied for by a plan, the plan should clearly identify this limitation as an exception and state in writing their rationale for permitting the exception to both the patient and the provider.

**Additional Illustrations of Non-Quantitative Treatment Limits and More Detailed Discussion of Selected Non-Quantitative Treatment Limits of Significance.** AACAP is increasingly concerned when specific non-quantitative treatment limits are being used to deny care. We understand non-quantitative treatment limits are used to manage benefits; however, when used inappropriately they have a negative effect on patient access to care. For example, non-quantitative treatment limits such as requirements to use lower cost therapies before the plan will cover more expensive therapies or medications (fail-first policies) can be life threatening to a patient. Because of the widespread use and potential for abuse related to non-quantitative treatment limits, the Departments should provide additional illustrations of non-quantitative treatment limits and highlight selected non-quantitative treatment limits of significance. The Final Rule should include additional illustrations of common non-quantitative treatment limits, including, but not limited to, the following:

- Prior authorization and concurrent review requirements for outpatient services, in and out-of-network;
- Prior authorization and concurrent review requirements for inpatient services, in and out-of-network;
- Reimbursement rate issues for in and out-of-network;
- Formulary design;
- Service coding;
- Provider network criteria;
- Policy coverage conditions and exclusions; and
- Geographic limitations, in and out-of-network.

**Medical Necessity Criteria.** AACAP recommends an external group or body to standardize the definition of medical necessity for mental health and substance use disorders. Health plans must,

at a minimum, follow professional organization guidelines. All medical necessity information should be published in such a way that it is available to providers or consumers, and all appeals procedures should be transparent and written at an 8<sup>th</sup> grade level. In medical necessity determinations, physician reviewers must be a licensed physician of the same specialty, working within the same state, and familiar with the resources available in the community. When the health plan is unable to secure access to the appropriate level of care, it must authorize either a higher level of care or services with an out of network provider. Network limitations, such as day treatment programs or residential treatment centers that are too far away from the home create insurmountable barriers for families. When reimbursement or care is denied on the basis of medical necessity, the rationale for this denial must be stated in writing accompanied by a written explanation of the procedures for appeals of this finding.

Regarding the disclosure requirement, because all denials of mental health and substance use disorder treatments can only be judged as compliant or noncompliant with the Act when compared with the same policies and/or criteria used for medical/surgical treatments, a plan should also be required to make available the corresponding medical coverage criteria or policy that is used for substantially all medical/surgical benefits. For example, if a mental health or substance use disorder treatment is considered experimental, the scientific criteria applied to the mental health/substance use disorder treatment should be disclosed as well as the scientific criteria used for substantially all medical/surgical treatments.

**Scope of Service and Continuum of Care.** The Department should clarify that if a level of care or prescribed treatment modality exists and is reimbursed for a physical illness, then the analogous level of care or treatment modality utilized for the treatment of mental illnesses must be provided as a covered benefit at the same level of reimbursement. AACAP's predominant concern is coverage of specific levels of care that may currently be provided under a plan will no longer be provided due to the plans determination that there is no equal level of care. It is important for the Departments to also clarify that when the health plan is unable to secure access to the appropriate level of care, it must authorize either a higher level of care or services with an out of network provider, as they would do for a medical/surgical treatment. Network limitations, such as day treatment programs or residential treatment centers that are too far away from the family home create insurmountable barriers for the families. In addition, some mental health carve-outs have limited networks and apply stricter limits on providing care, and these carve-outs should be required to adhere to any parity requirement to which the parent plan is mandated.

**Disclosure Requirements for Denial of Claims.** The statute clearly requires that a plan disclose the reason for any denial of reimbursement or payment for services with respect to mental health/substance use disorder benefits. However, patients have faced significant delays in receiving the required disclosure. AACAP requests that the Departments set a timeframe for plans to provide the reason for the denial. Specifically, when the denial is based on a medical necessity determination, plans should be required to provide the plan's medical necessity criteria within three business days. Without disclosure of such criteria, the patient has little information to understand any potential exposure to financial risk in undertaking a specific treatment. Summary plan documents are often inadequate. In practice, many patients appeal a denial of care. Without the medical necessity criteria on which the plan based its decision, the patient has little basis for responding to the plan's denial.

**Medical Necessity Reviews.** Often, after attempts to contact the treating physician, the reviewer declines the request due to lack of information. Many mental health/substance use providers do not have receptionists or other administrative office staff to answer phones. Many child and adolescent psychiatrists see patients throughout the day and are not able to return calls during normal business hours to talk with a reviewer. Reviewers must be required to contact the physician (via phone) to discuss the review with the treating physician; if the reviewer can not reach the physician they should be required to provide times the physician can call them back and discuss the treatment plan. We also recommend that in any instance where a denial is given, the name, discipline and phone number for the reviewer must be noted on the denial. Providing physicians subject to unprofessional treatment by physician reviewers should be able to report this behavior to state licensing agencies.

**Pharmacy Benefit Management.** AACAP is also concerned that pharmacy benefit management will be an avenue for denying appropriate care. In order to treat children with severe mental illnesses, child and adolescent psychiatrists sometimes prescribe medications that are not FDA-approved for the age, diagnosis or indication they are intended. An FDA indication alone as a standard for meeting the parity requirement is inadequate and that such standards must reference both "community standards of care" and expert consensus guidelines. Co-pays for medications should be the same as medical or other health problems. Any requirement for documentation for off-label use and fail-first policies can be applied only if they are also required in medical/surgical treatment. We recommend the Departments make a specific statement addressing that parity must be applied to medication as well as physician visits.

**Cost exemption.** The Act permits an exception to the mental health parity requirements for plans that experience a cost increase of over one percent in the total cost of coverage. The Act is clear that actual costs incurred, not actuarial cost projections, must form the basis of a cost exemption application. AACAP is concerned that some plans may intentionally run up their costs for providing mental health services. We request that the Departments address this in the final regulations.

These recommendations are intended to preserve the spirit and intent of the new legislation with full consideration of the necessity to manage the costs of both medical and mental health care. Mental health is essential to the health and well being of *all* children and adolescents, and the integration of mental health and physical health services is vital to improve the lives of millions of Americans. We thank the Departments for releasing these interim regulations and encourage you to expedite the release of the final rule.

Sincerely,



Laurence L. Greenhill, M.D.  
President