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General Comment

May 27, 2009

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

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

Thank you for the opportunity to comment on the regulatory guidance concerning the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction

Equity Act of 2008. The National Disability Rights Network (NDRN) is the nonprofit membership organization for the federally mandated CAP and P&A programs for individuals with disabilities. Through training and technical assistance, legal support, and legislative advocacy, NDRN works to create a society in which children and adults with all types of disabilities and their families are afforded equality of opportunity. NDRN believes that the MHPAEA is a vital step toward equality of health care coverage for millions of Americans with mental health needs.

Economic Analysis, Paperwork Reduction Act and Regulatory Flexibility Act

NDRN recommends that the law should not permit any special considerations for smaller entities or plans that are subject to MHPAEA. These smaller plans should be required to comply in the same manner as other plans subject to MHPAEA.

Financial Requirements and Treatment Limitations on Benefits

NDRN recommends that the regulations make clear that the current definition of “financial requirements” and “treatment limitations” in the MHPAEA are not to be considered all inclusive.

Insurance companies have a myriad of ways to limit and discourage receipt of mental health services, not all of which are included in the current statutory definition. The regulations must make clear that utilization management techniques qualify as treatment limitations and as such may not be applied to mental health and substance use benefits in a discriminatory and more restrictive fashion. Some examples of utilization control techniques that should be clearly prohibited include:

• treatment limitations that plans disproportionately use to limit the "scope or duration of treatment" for mental health or substance use conditions include the following:
• Prior authorization that are applied more frequently and with higher standards for approval;
• More restrictive medical necessity and appropriateness criteria;
• "Fail first" policies that require consumers to suffer adverse outcomes from a preferred treatment or medication before the treatment or medication recommended by their providers will be covered;
• Step therapy requirements that force consumers to try a series of preferred medications or treatments prior to accessing the recommended treatment;
• Exclusion of certain specialized services like collaborative care, assertive community treatment, residential treatment, and partial hospitalization;
• Higher evidence-based standards;
• More frequent restrictions on treatments due to experimental status;
• Stricter cost effectiveness requirements;
• Lower provider fees;
• Limitations on covering specific types of providers;
• More restrictive provider licensure requirements;

• More limited preferred provider networks or phantom networks with invalid phone numbers and names of providers no longer practicing or accepting new patients;
• Requirement to prove current threat of harm to self or others as the justification for inpatient care; and
• Separate deductibles or lifetime limits.

NDRN recommends that the regulations make clear that the NMPAPA does not supplant state parity laws which provide more or greater protections of mental health and substance use benefits.
Clarification is necessary to illustrate how broader mandates that remain in effect in States interact with the new federal law. For example, any mandate to cover mental health services (whether only for people with certain serious mental disorders or only for a certain number of days) should remain in force. The federal law would then preempt any inappropriate limits on those services, and thus a mandate for 30 days of inpatient care would become a mandate for coverage of inpatient mental health care at parity with other inpatient health services. Additionally, statements that explain how a mandated minimum benefit becomes a parity benefit and how mandated coverage of serious mental illness remains in effect and becomes mandate for parity for serious mental illness are necessary.

NDRN recommends that the regulations make clear that the MHPAEA provisions apply to Medicaid managed care plans.

Criteria for Medical Necessity Determinations and Appeals
NDRN recommends that the regulations include standards for medical necessity definitions and for medical necessity appeal and enforcement mechanisms, including:
a) Services must be available to maintain or restore function and to prevent or ameliorate medical conditions in addition to treating injuries or illnesses; and
b) cost effectiveness does not necessarily mean lowest cost.
The regulations should require plans to do the following:
• Set timeframes for disclosure of medical necessity criteria;
• Detail appeal and enforcement mechanisms

NDRN Recommends model notices to assist with disclosure to participants and beneficiaries regarding a plan’s or issuer’s election to implement the cost exemption.