



MHSACM, Inc.

251 West Central Street, Suite 21, Natick, MA 01760 (508) 647-8385 / Fax (508) 647-8311 www.mhsacm.org

Vicker V. DiGravio III, *President / CEO*

Deborah Ekstrom, *Chair*

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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

Attention: MHPAEA Comments Regarding Federal Register Notice April 28, 2009

Mental Health and Substance Abuse Corporations of Massachusetts, Inc (MHSACM) is a statewide association representing ninety-one community-based mental health and substance abuse provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately 117,000 Massachusetts residents daily and employing 22,000 people. On behalf of MHSACM, thank you for the opportunity to comment on The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

By enacting the MHPAEA, Congress rectified an inherent unfairness in our healthcare system and sent a clear message that discrimination against individuals with mental illness and substance use disorders will not be tolerated in the public or private sectors. By adopting parity, we reject the discrimination that causes people with mental illness and substance abuse disorders to go without care because of the persistence of scientifically rejected notions about illness in our healthcare system. By amending the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code) to create new requirements and amend several of the existing group market mental health parity provisions, the MHPAEA will help end this outdated discrimination by ensuring that behavioral health disorders are treated like any other illness for insurance purposes.

MHPAEA will establish new coverage requirements for an estimated 113 million Americans in group health plans, including 82 million who are not protected by state mental health and substance abuse parity laws; it also will extend parity benefits to Medicaid managed care plans, greatly expanding coverage for poor and underserved children.ⁱ The following comments focus on the implications of the Parity law for access to care and how the regulatory process and implementation guidelines can ensure that risk and cost-sharing are not disproportionately shifted to the consumer when compared to other medical services.

In Network Access: Reducing Cost-Shifting to Consumers

Restrictive provider network designs often are used to help manage risk for adverse selection. However, they also increase consumer cost-sharing for out-of-network services. Given that the intent of MHPAEA is to protect consumers from unequal access, cost-sharing, and scope of treatment, the MHPAEA implementing regulations should include guidance to health plans on how to ensure in-network access to mental health and addiction services in addition to addressing other critical issues of out of network care and medical management of the benefit. We recommend that the regulations address the following:

- Require that applicable health plans enroll behavioral health providers who are trained and/or licensed to serve the needs of individuals with serious mental illness and addiction disorders in order to ensure access for high-risk or special needs clients. Adoption of this concept would ensure that behavioral health providers would be included in the network offered by a health plan.
- Provide guidance to plans on how to conduct ample outreach and education to consumers/patients and their families to educate them about the availability of mental health and addiction providers in the provider network. Individuals must have access to accurate provider network information in order to avoid additional out-of network cost-sharing that may occur because in-network providers are not accessible or available.
- Ensure that there are standards that require networks to have sufficient enrolled, participating providers to ensure access to services equal to other health services. Based on our experience, we are especially concerned that providers may be listed in a network, but in reality are not accepting new patients, an obvious contradiction. The standards should be the same standards as primary care in terms of wait time for appointments, travel distance or travel time. Access to specialized services should have at least the same geo-access standards as would be applied in the local service area to hospital/inpatient care for medical-surgical. Wait time for appointments should be specified in hours for emergency, crisis, or urgent care and days for routine outpatient.
- Provider competencies and scope of practice of enrolled providers and treatment programs should match the benefit design. Restrictions on the type of mental health and substance use disorder providers and services included in the network commonly limit access and increase consumer cost-sharing in a way that is unequal to other health services. To cover a type of treatment, but not enroll providers would be illogical and inconsistent with the purpose of the MHPAEA.

“Financial Requirement” and Treatment Limitations on Benefits

If a health plan covers mental health and addiction services, the MHPAEA law prohibits “limitations on the frequency of treatment, number of visits or days of coverage, or other similar limits on the duration or scope of treatment” under the plan that are more restrictive than the predominant limitations applied to substantially all the medical-surgical benefits. In addition, the Act stipulates that there must be “no separate treatment limitations that are applicable only with respect to mental health/substance use disorder benefits.” For example, if a plan offers a full continuum of benefits under medical/surgical benefits and only one or two services, such as detoxification and outpatient services, for alcohol and other drug treatment, under the mental health/substance use disorder benefit, the plan will likely not be in compliance with the parity

requirements in this Act. It is important for the regulations to emphasize that such limitations will be in violation of the Act.

Our members have identified a range of treatment limitations often used to deny or make care more difficult to access, including: limits on yearly sessions and/or requiring more paperwork after a certain number of sessions; requiring prior-authorizations for out of network services that are rarely, if ever approved; and medical necessity criteria that effectively restrict appropriate and timely care. In addition, the following are specific examples of practices that often result in limitations in behavioral health care:

- Annual and lifetime caps
- Deductibles
- Coinsurance
- Out-of-pocket expenses
- Limits on the frequency of treatment, number of visits, and days of coverage
- Coverage based on completing assessment/review with exceedingly short time frames (as little as an hour)
- Pre-authorization practices
- Medical necessity and appropriateness criteria, including ever-changing criteria lacking clear definitions for specific levels of care such as “inpatient,” “rehab” or “residential”
- Coverage requirements based on patient completing an entire course of treatment
- “Fail first” policies that require the patient has to fail one to two times at outpatient treatment within the last year to be eligible to use detoxification or residential benefits
- Utilization review being conducted by professionals with no training in mental health or addiction
- Exclusion of certain levels of care like residential treatment or partial hospitalization (in or out of network)
- Review of treatment as to whether or not services are cost effective
- Fee schedules that do not enlist an adequate supply of providers to assure access
- Prohibiting plan coverage for eating disorders

Scope of Treatment

While frequency, duration or number of visits or days of coverage can be objectively measured, what is meant by “scope of treatment” will require more definition in the regulations. The regulations should provide guidance and clarification on the types of covered treatment and how other services, whether new or long established, become accepted. It is the intent of the MHPAEA that the scope of services offered under the mental health and addiction benefit are consistent with the level applied to substantially all medical-surgical benefits. Although “services” are referenced throughout the statute, additional guidance is necessary to ensure that the covered treatment and services are of sufficient type, duration, frequency, and intensity to “correct or ameliorate”ⁱⁱ the episode of illness for the covered conditions.

The regulations should articulate that the covered services and level of care should be appropriate to the covered diagnoses. Services recognized as community standards or evidenced-based practices for a given condition should be covered. For example, for major depression, coverage of only medications prescribed through primary care would restrict access to psychotherapy in the benefit design, thus shifting the cost for this benefit to the patient. Similarly, for medication-based addiction treatment, coverage of only the medication would leave patients without access to critical psychosocial rehabilitation services, a community standard. Medication for the treatment of mental health and substance use disorders has been proven to be critical to the recovery of many individuals and should be part of the scope of treatment offered under the benefit, no less than for medication for other medical and surgical conditions. The point is not to establish artificial limitations or exclusions, which will be counter-therapeutic for the client and limit successful outcomes. More than four decades of research have demonstrated that appropriate use of medications, such as methadone and buprenorphine, to treat chronic opioid dependence/addiction in conjunction with comprehensive needs-based treatment services have proven to be extremely cost effective.

The regulations should recognize that the scope of treatment for mental illness and addiction disorders should be no more restrictive than what is available substantially for other chronic health conditions such as diabetes, epilepsy, heart disease, or respiratory conditions. Comprehensive disease management, chronic care, or packages of services with proven efficacy for treatment and rehabilitation services for people with serious mental illness, substance use disorders and emotional disturbance should be covered if similar approaches are covered for substantially all other chronic health conditions. Comprehensive approaches that organize and coordinate packages of care can structure copayments and other cost-sharing to provide an incentive to active engagement in treatment.

State Pre-emption Issues

As the regulations are drafted special attention must be given to ensure that federal parity regulations pre-empt weaker state laws, but do not supplant state laws that provide more protection to enrollees. Specific areas to consider include states with weaker substance abuse treatment requirements and state laws that limit parity to certain conditions versus MHPAEA that may apply parity to a broader list of disorders.

Medical Necessity

Medical necessity determinations are critical to equal access to appropriate care. Denials of care are denials of payment to the provider—directly shifting responsibility to the patient to either seek another plan of care or pay out of pocket for an otherwise covered benefit. The parity law regulations must provide guidance and predictability to health plans, consumers and providers regarding how medical necessity is defined and the criteria used to make utilization management decisions.

A current federal standard to consider while developing MHPAEA regulations exists under Medicare statute, which states “no payment may be made... for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” (42 U.S.C. 1395y (a) (1) (A)) There are specific areas that the regulations should address in order to ensure that this does not become a means to make other provisions of the law irrelevant. This includes the following:

- Clinical criteria for admission/authorization, continuing care and discharge should be used for utilization decisions and these criteria must be available to enrollees and their providers at the initiation of treatment.
- There must not be a “fail-first” policy. If a service is necessary and appropriate, failure in another service should not be required as a prerequisite to authorization.
- Health plans must make information available to providers on covered benefits, limitations, and authorization procedures so that they can verify before initiating a plan of care.
- Health plans must make mental health/substance use disorder medical necessity criteria available to current or potential beneficiaries and providers upon request.
- Health plans must make reasons for payment denials available to beneficiaries and their providers through a process specified in the regulations.
- No pre-emption of stronger state laws: Federal regulations regarding utilization review and definition of medical necessity should not pre-empt criteria defined in state statute that provides more benefit and consumer protections.
- Medical necessity should be based on local community standards and expert consensus opinion. Benefits and scope of services covered should be defined to include those necessary to improve or maintain functioning.

Appeals and Independent Review of Denial of Reimbursement or Payment for Services

Parity for mental health and addictions services represents a significant change that will present implementation challenges for health plans and providers. As with any regulatory change, problems must be anticipated and plans to assist and respond must be put in place. To be effective, information about how to access internal member services or ombudsman assistance, appeals procedures and independent review must be made readily available to enrollees and easy to access. The MHPAEA regulations must provide guidance and standards for appeals and independent review that provide no less consumer protections than those that would exist for other health services. We recommend that the regulations specify:

- Independent review must be available to re-consider utilization management decisions within a specified time period. The appeal or review process must be communicated to patients and the requesting provider. Summary results of review decisions must be available to plan members, network providers, state regulators, and the public.
- If state law requires medical necessity criteria for various services to be publicly available without request, the state law pre-empts the federal statute.
- Otherwise covered services/treatment should be covered while an appeal is pending.
- Health plans and providers must inform consumers through an “advanced beneficiary notice” that they may be liable for the cost of services when denied or limited by management decisions.
- Health plans should not be able to deny or limit an otherwise covered service without also recommending another allowable plan of care to the patient and/or provider.

- There should be a mechanism for expedited appeal for situations in which a crisis or urgency that cannot be delayed without putting the patient at risk. Coverage should not be denied in situations where an emergency or urgency made prior approval unfeasible.

We thank you for the opportunity to comment on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Sincerely,

A handwritten signature in black ink that reads "Vicker V. DiGravio III". The signature is written in a cursive style with a large initial "V" and "D".

Vicker V. DiGravio III
President and CEO

ⁱ After Parity—What’s Next, David L. Shern, Kirsten K. Beronio and Henry T. Harbin, *Health Affairs*, 28, no. 3 (2009): 660-662, doi: 10.1377/hlthaff.28.3.660.

ⁱⁱ For example, the Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit language offers that “States must provide other necessary health care, diagnosis services, treatment, and other measure described in section 1905(a) of the Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.” EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.