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ABH FOUNDATION

ASSOCIATION FOR BEHAVIORAL HEALTHCARE FOUNDATION

May 3, 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 Association for Behavioral Healthcare (ABH), formerly Mental Health and Substance Abuse Corporations of Massachusetts, 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 the membership of ABH, thank you for the opportunity to provide comments on the Interim Final Rules (IFR) under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity of 2008 (MHPAEA).[1]

ABH recognizes that a great deal of work and analysis has gone into the Interim Final Rules and commends the Departments for their efforts to ensure the Act is implemented in a manner that will convey strong parity protections consistent with the intent of Congress. The Interim Final Rule is consistent with the MHPAEA statute and Congress's goals of eliminating discrimination in group

[1] 75 Fed. Reg. 5410 (Feb. 2, 2010).

health plan coverage of mental health and substance use disorder and mental health treatment benefits and improving access to care.

**State Laws**

Many states, including Massachusetts, have implemented their own mental health parity laws. ABH strongly supports the IFR's interpretation that state parity laws with stronger protections than those contained in the MHPAEA will not ordinarily be preempted by the Act. State insurance commissioners need continued guidance from the Departments to ensure the greatest compliance with the MHPAEA. In particular, although the IFR preamble affirms that the MHPAEA does not preempt any state laws except those that would prevent the application of the MHPAEA, additional education and outreach is needed to ensure that managed care organizations continue to comply with state laws that provide greater protections than the MHPAEA.

The operative issue in determining whether a state parity law is preempted is not whether the law is weaker or stronger than MHPAEA, but rather whether the state law acts to "prevent the application" of MHPAEA."[2] The regulations state that MHPAEA requirements are not to be "construed to supersede any provision of state law…except to the extent that such standard or requirement prevents the application of a requirement of MHPAEA."[3] For example, a state law that mandates that an insurer offer a minimum dollar amount of mental health/substance use disorder benefits "does not prevent the application of MHPAEA." This is presumably because, even with the minimum dollar amount requirement, the plan could still provide (and would be required to provide) parity between mental health/substance use disorder and medical/surgical benefits. The regulations specify that state insurance laws that are stronger than the federal requirements are unlikely to prevent the application of MHPAEA and be preempted.[4] Accordingly, "States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law."[5] ABH strongly supports this interpretation of the Act, and requests that it be included in the Final Rules.

**Quantitative and Non-quantitative Treatment Limitations in the IFR**

The IFR's inclusion of both quantitative and non-quantitative treatment limitations in the MHPAEA parity analysis is fully within the scope of the MHPAEA and is consistent with the statute and its legislative history.

Limiting the scope of the MHPAEA analysis solely to day or visit limits or frequency of treatment limits would not achieve the legislation's intended result of ensuring that substance use disorders and mental health benefits are not provided in a more restrictive way than benefits for other medical and surgical procedures. In Massachusetts, state parity laws have been applied mainly with regard to prohibitions on benefit limits. However, medical management tools, identified in the IFR as non-quantitative treatment limitations (NQTLs), are a fundamental means through which plans limit treatment. In Massachusetts, plans are currently using NQTLs as a way to limit

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[2] 75 Fed. Reg. 5418.
[3] *Id.*
[4] 75 Fed. Reg. 5430.
[5] *Id.*

treatment. For example, plans use utilization management, medical necessity criteria, "fail first" requirements, and prior authorization requirements to limit access to certain behavioral health treatment. NQTLs were determined by both Congress and the regulators as a form of treatment limitation as defined under the law and hence subject to the purview of the statute and regulations.

**Application of the MHPAEA to Medicaid Managed Care Plans**

ABH strongly urges the Centers for Medicare and Medicaid Services (CMS) to issue guidance clarifying that the IFR applies to Medicaid managed care plans. There is no rationale for a separate, different parity standard for Medicaid managed care plans.

The MHPAEA statute and its legislative history do not include any distinction between how the law applies to group health plans and Medicaid managed care plans. The IFR implements the MHPAEA, and Medicaid managed plans must adhere to the MHPAEA. As such, Medicaid managed plans must comply with the IFR.

Until CMS affirms that the IFR applies to Medicaid managed care plans, there will likely be significant confusion as the MHPAEA is implemented for Medicaid managed care plans. In Massachusetts, Medicaid managed care plans are already stating that federal parity does not apply to these plans. The MHPAEA is in effect, and guidance is quickly needed to ensure the Medicaid managed care plans comply with the requirements of the current law.

**Recognized Standards of Care and Scope of Services**

The IFR includes a number of references to "generally recognized independent standards of current medical practice" and the need for managed care organizations to use these standards in making decisions about coverage for mental health and substance use disorders. The substance use disorder treatment field has a body of widely accepted standards of care and evidence-based practices for the treatment of substance use disorders. In providing additional guidance to plans on standards of care and the scope of services covered in substance use disorder treatment benefits, the Departments should adopt these recognized best practices and standards so that plan decisions best reflect recognized clinically appropriate standards of care for substance use disorder treatment.

Thank you for your consideration.

Sincerely,

Vicker V. DiGravio III
President/CEO