National Association of Psychiatric Health Systems

900 17th Street, NW, Suite 420
Washington, DC 20006-2507
Phone: 202-393-6700
Fax: 202-783-6041
naphs@naphs.org
www.naphs.org

SUBMITTED ELECTRONICALLY: www.regulations.gov

April 30, 2010

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

RE: CMS-4140-IFC: Interim Final Rules Under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*

Also:

- Department of Labor/Employee Benefits Security Administration [RIN 1210-AB30]
- Department of the Treasury/Internal Revenue Service [TD 9479; RIN 1545-BJ05; REG—120692-09]

Dear Acting Administrator Tavenner,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on the "Interim Final Rules Under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*" [CMS-4140-IFC] as published in the February 2, 2010, *Federal Register*.

We understand that you will share these comments with the Departments of Treasury and Labor.

ABOUT NAPHS

Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 600 psychiatric hospitals, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care. Our members deliver all levels of care,

-continued-

including inpatient care, residential treatment, partial hospitalization services, and outpatient services.

NAPHS has been a longstanding and major proponent and supporter of federal parity legislation. NAPHS was, for example, a founding member of the Coalition for Fairness in Mental Illness Coverage (which also includes the American Hospital Association, American Medical Association, American Psychiatric Association, American Psychological Association, Association for Behavioral Health and Wellness, Federation of American Hospitals, Mental Health America, and National Alliance on Mental Illness).

We are currently a member of the Steering Committee of the Parity Implementation Coalition. The coalition includes the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine, Bazelon Center for Mental Health Law, Betty Ford Center, Faces and Voices of Recovery, Hazelden Foundation, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, and National Council for Community Behavioral Healthcare.

We applaud the extensive and thoughtful work the Centers for Medicare and Medicaid Services, the Department of Labor, and the Internal Revenue Service have done to create the clarifications and examples provided in the interim final rule. We strongly support the interim final regulations, and we believe they provide critical guidance to help carry out the intent of Congress. We appreciate the opportunity to expand on our original comment letter submitted May 28, 2009. In addition to that initial comment letter and our current comments below, NAPHS has also signed an additional 2010 comment letter being submitted (under separate cover) by the Parity Implementation Coalition, which we would urge you to review and consider.

Feedback from our members as well as our association's specific comments on questions raised in the interim final rule follow below.

NAPHS-MEMBER SURVEY: WHAT HAS CHANGED SINCE THE LAW WAS IMPLEMENTED

To inform our comments and to get some perspective on how the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (MHPAEA or "the Act") has been implemented since the law became effective (which was for health plan years beginning on or after October 3, 2009), we conducted a brief survey of our member organizations in April 2010. We gathered feedback from the CEOs of our member behavioral healthcare systems. The respondents, who provided feedback through an online survey as well as phone interviews, oversee more than 150 inpatient provider organizations throughout the United States. As inpatient providers, these members serve children, adolescents, adults, and older adults with some of the most severe and complex mental and substance use disorders. As such, their organizations work day in and day out to help patients use health plan benefits of many types (including private insurance, Medicare, Medicaid, and state health programs).

We asked our members what changes if any they have seen regarding treatment limits (including both quantitative and non-quantitative), financial requirements, and scope of coverage.

In general, the survey respondents said they have seen few, if any, changes in treatment limits (both quantitative and non-quantitative), financial requirements, and scope of coverage.

The one area where it seems some positive change has occurred is in the quantitative limits (such as limits on inpatient days of care or outpatient visits). A third of the respondents said they have seen significant improvements in limits of days of care. However, 44% of the respondents have seen no changes in limits on days of care. Regarding financial requirements (such as copayments, deductibles, or coinsurance), the majority of respondents (more than 60%) said they have seen no changes in how copayments, deductibles, or coinsurance are applied to mental health and addiction treatment services.

Regarding non-quantitative treatment limits (such as preauthorization, concurrent review, retrospective review, and case management), many respondents said they have seen no changes. And some said that admission criteria, precertification, and concurrent review have become tighter in many health plans.

One commenter said that since mental health parity became effective, "we have seen a progressive tightening in the utilization of inpatient days, as well as a decline in days recovered after denial." Another commenter said "we are noting much more aggressive management of patient days and visits and increased numbers of required doctor-to-doctor reviews." Several respondents said that their doctors are spending significantly more time fighting for each day of care, and often not getting them, even though medical necessity criteria are clearly present. Respondents also said that these doctor-to-doctor reviews are very costly for providers and take valuable physician time away from patient care. In addition, many respondents said that not only are there more doctor-to-doctor reviews, but also many health plans now are only authorizing one day of inpatient care and then requiring a doctor-to-doctor review on the second day and each day thereafter.

In regard to scope of coverage, most survey respondents said that the following service lines are either excluded by some health plans or excluded by most policies: residential treatment for adults, residential treatment for children and adolescents, residential treatment for substance use disorders, substance use disorder detoxification, partial hospitalization, intensive outpatient, and ECT. Sixty percent (60%) of the respondents said that residential treatment for children and adolescents is excluded from some policies, and 42% of respondents said that residential treatment for children and adolescents is excluded by most policies. Forty percent (40%) of the respondents said that residential treatment for substance use disorders is excluded from most policies.

We also asked whether health plans have added any service lines since the effective date of the mental health parity law. A couple of respondents said that they have seen residential treatment for children and adolescents added to some policies as well as residential treatment for substance use disorders. This was clearly the minority viewpoint.

Most respondents said that there has been no change in the service lines covered since the effective date of the parity law.

Although this survey was voluntary and non-generalizable, its purpose was to provide some insight from the perspective of behavioral healthcare providers (who are NAPHS members) that are serving patients each and every day in communities across the country. We wanted to know from them what they are seeing at the local level regarding how health plans are addressing the new mental health parity requirements.

Based on this survey and much discussion with many of our members, it is clear that the issuance of the interim final regulations in February 2010 was critically important to begin to address this very wide interpretation of the mental health parity law by health plans and businesses.

We strongly support the interim final regulations and specifically support such provisions as:

- the combined deductible,
- the parity requirement regarding treatment limits, including quantitative and non-quantitative, financial requirements,
- the *substantially all* (two-thirds) test and the *predominant* (50%) test, and
- the scope of coverage requirements.

We also appreciate the clear guidance you have given on how to submit complaints should consumers find plans are not in compliance. This type of accountability is essential to ensure that your regulations are enforced.

In our comments we will address further ways that the final regulations could be clarified to make sure that the mental health parity act meets its true intent: to ensure equal access to mental health and substance use disorders services compared to medical/surgical services.

NAPHS COMMENTS

The regulations confer a scope of service that should be enforced and expanded.

The regulations' rules related to classification, NQTLs, and QTLs confer a scope of service. Many sections of the regulation operate to confer a scope of service parity requirement both across each of the required six classifications for applying the rule, and within each of the classifications. In addition, the underlying Act is clear that limits on the scope and duration of treatment must be applied no more restrictively in the mental health/substance use disorder (MH/SUD) benefit than in the medical/surgical benefit. **This should be retained and further clarified in the final rule.**

We suggest the following concepts (which are further detailed in the Parity Implementation Coalition comment letter being submitted under separate cover) **be clarified in the final rule**:

A plan that covers few MH/SUD treatment services, while providing many medical/surgical services, violates the Act if it has applied a treatment limitation more restrictively.

- A plan that offers only one type of MH/SUD treatment service in any of the six required classifications, while at the same time offering many medical/surgical services within the relevant classification is not compliant with the parity regulations if the comparatively low level of MH/SUD services is a result of the application of a treatment limitation to MH/SUD benefits that is more restrictive than the predominant treatment limitation of that type that applies to substantially all medical/surgical benefits in the classification. For example, if a health plan covers several levels of inpatient care within the inpatient classification for medical/surgical services (such as hospital, rehab hospital, and skilled nursing/SNF), then a health plan would also have to cover comparable levels of care within the inpatient classification for mental health/substance use disorders (such as hospital and residential treatment).

A plan that refuses to cover a MH/SUD service because there is no medical/surgical analog will violate the Act if it does not refuse to cover medical/surgical benefits that have no MH/SUD analog.

- A plan that refuses to cover a MH/SUD service because there is no medical/surgical analog violates both the regulations and MHPAEA if the plan does not likewise refuse to cover medical/surgical benefits that have no MH/SUD analog. In addition, practical and policy concerns weigh against allowing plans to refuse to cover MH/SUD benefits without medical/surgical analogs.

Non-quantitative treatment limit (NQTL) requirements in the regulations need to be enforced. Clarification is also needed to ensure that NQTLs cannot be used to create inappropriate barriers to essential behavioral health services.

The regulations state clearly that any "processes, strategies, evidentiary standards, or other factors" used in applying a NQTL to MH/SUD benefits in a classification must be "comparable to" and be applied "no more stringently" than the processes, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in a classification. For example, with respect to the requirement that an NQTL must be "comparable" between medical/surgical and behavioral health, it should be clarified that if a health plan does not have concurrent review for inpatient stays for medical/surgical services, the plan would not be allowed to have concurrent review for inpatient mental health/substance use disorder services because it would not be "comparable." The sole exception to this rule is in cases where "recognized clinically appropriate standards of care…permit a difference." Under the regulations, one of the two critical factors for determining plan compliance with these requirements is the manner in which the processes, strategies, evidentiary standards, and other factors are used in *applying* the NQTL. Plans can have the same NQTL in both MH/SUD and medical/surgical and still violate the parity requirements by applying these NQTLs differently. The second critical prohibition prevents a plan from instituting a NQTL in MH/SUD that is not comparable to an NQTL in the medical/surgical benefit. In such a situation, the question is not whether the same NQTL is applied differently across MH/SUD and medical/surgical, but rather whether a NQTL is being applied in MH/SUD that does not exist in medical/surgical.

There are two standards to which plans must adhere related to NQTLs. A plan may violate this section by utilizing processes, strategies, evidentiary standards, or other factors in the context of MH/SUD benefits that are either: (1) not comparable to *or* (2) applied more stringently, than those utilized in the context of medical/surgical benefits. Thus, a plan may violate this section by utilizing processes, strategies, evidentiary standards, or other factors in the context of MH/SUD benefits that are either not comparable to or applied more stringently than those utilized in the context of medical/surgical benefits.
The MHPAEA unequivocally applies the "predominant and substantially all" standard to all treatment limitations. Although there is ambiguity in the regulations regarding whether the "predominant/substantially all" and the "comparable/no more stringently" tests are separate or additive, **to remain consistent with the language and intent of the MHPAEA, the regulations should be interpreted to apply both standards to NQTLs.** The reason this is critical is that – without this requirement – a health plan, for example, could have precertification for only one benefit service (such as orthopedic procedures), but would be able to apply precertification to all inpatient psychiatric care if they did not have to meet the "substantially all/predominant" test. The Act sets forth three inquiries to determine plan compliance with the treatment limitation requirements: (1) Is the limitation applied to substantially all medical/surgical benefits; (2) Is it the predominant treatment limitation; and (3) Is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit? The statute applies the three-part test to *all* treatment limitations. Because of the difference between QTLs and NQTLs, and the practical difficulties of applying the "no more restrictive" test in the context of NQTLs, the regulations establish a second standard to operationalize the "no more restrictive" statutory test. This second standard is the comparable and no more stringently standard, and it is additive to the predominant and substantially all standard. **We would recommend that the *substantially all* and *predominant* test be specifically referenced in the final rule with respect to NQTLs.**

Medicaid managed care organizations are subject to the February 2, 2010, regulations; guidance should be issued.

The MHPAEA requires that Medicaid managed care plans comply with the parity provisions of the Act. Since the regulations implement the Act and do not contain an exemption for Medicaid managed care plans, Medicaid managed care organizations (MCOs) must comply with the parity requirements as spelled out in the regulations. This conclusion is supported by both the Act and the regulatory history of previous mental health parity laws. **We would strongly recommend that the agencies issue any additional guidance or regulations pertaining to the Medicaid managed care organizations, so that Medicaid enrollees can be afforded the mental health parity protections**.

Parity Implementation Coalition analysis needs to be considered.

As a member of the Steering Committee of the Parity Implementation Coalition, NAPHS has also signed a comment letter being submitted (under separate cover) by the Parity Implementation Coalition. That comment letter goes into more detail on the issues discussed in this letter as well as some important additional issues. We urge you to review each and all of the comments in that coalition letter.

NAPHS RECOMMENDATION

Parity means "quality or state of being equal or equivalent." To stay true to the fundamental purpose of parity, therefore, we would suggest that the parity law should be implemented in a way that meets the clear goal of Congress – to eliminate insurance practices that have been discriminatory to people who have mental or substance use disorders. The interim final regulations do an excellent job of clarifying that Congress intended to include all aspects of coverage—including treatment limitations, financial requirements, scope of services, medical necessity criteria, and utilization management—in the parity standard. The final rules should maintain this clear message and continue to offer examples to ensure that the intent of Congress is not subverted.

The final rule should be written to prevent overly restrictive utilization management/medical necessity criteria or substantial limitations on the scope of service for mental health or substance use services compared to the management and scope of medical/surgical services.

CONCLUSION

Thank you for your consideration of our comments. We look forward to working with CMS and the Department of Health and Human Services – as well as the Departments of Labor and Treasury – to ensure that implementation of the law fulfills the objectives set forth by Congress. By having clear and actionable regulations, we believe that this landmark legislation will have an extraordinary and positive impact on the lives of the millions of Americans who are living with psychiatric and addictive disorders.

Sincerely,

Mark Covall
President/ CEO