

April 27, 2010

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

Re: CMS-4140-IFC

Dear Gentlemen:

The National Association for Children's Behavioral Health (NACBH) appreciates the opportunity to comment on the interim final rules implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. As an organization representing multi-service treatment agencies for children and youth with emotional disturbances and their families, our members, and the children and families they serve, have a keen understanding of the full array of services children need during the course of treatment and the services that for too long have been denied. The implementation of parity for mental health and substance use disorders will begin a process to provide services based on need and clinical appropriateness rather than on arbitrary, capricious or fiscal determinations. Given the complexity of the regulations we would like to concentrate our comments on the several areas that most affect children and family services and respond to the Departments' request for additional examples of nonquantitative treatment limitations (NQTL) within medical management or general plan design.

#### Classification of Benefits:

The regulation establishes six classifications of benefits in which parity must be applied, inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency services and prescription drug coverage. We commend the Departments for recognizing Congress' intent to assure that benefits be provided without consideration to treatment setting, but rather by benefit and service.

It has long been recognized that children require an array of services based on individual needs and levels of service intensity. Optimally, services are organized based on levels of intensity which combine a number of variables including clinical services, support services, crisis stabilization, and supervision. The implementation of parity for mental health and substance use disorders based on broad classifications of services will allow services to be determined based on clinically accepted and appropriate levels of care. Furthermore, this will lead to the appropriate use of resources, both fiscal and clinical, ultimately assuring that care is clinically not cost driven. Therefore, we commend the Departments for recognizing and conferring a scope of service for mental health and substance use benefits comparable to and no more restrictive than medical surgical benefits, requiring that parity requirements for financial and treatment limitations be applied on a classification by classification basis. Again, these provisions will support access to a more comprehensive array of services essential to meeting the individual treatment goals of the child.

The law and regulations also require that when a plan provides mental health or substance use benefits in any classification of benefits, it must provide them in all classifications of benefits in which medical/surgical benefits are provided. Furthermore, quantitative and nonquantitative treatment limitations cannot be applied more restrictively or stringently for mental health and substance use benefits than with respect to the medical/surgical benefits provided. Individual plans will have the responsibility of defining and designing types of services, financial requirements and treatment limitations for each classification. While this may prove cumbersome and complicated, the requirements that the benefits be defined under the terms of the plan, in accordance with applicable Federal and state law and be consistent with generally recognized independent standards of medical care, requires the full input and consultation with the array of appropriate clinicians and specialists needed to assure comparability in mental health benefits with those of medical/surgical benefits. While the regulation does not define “clinically appropriate standards of care” there exists sufficient guidance and practice in the development of Federal, state and private health benefits to assure that the “processes for developing evidentiary standards” are comparable and applied no more stringently to mental health and substance use benefits than to medical/surgical benefits.

Nonquantitative treatment limitations:

Recognizing that health insurance plans impose a variety of limits on the scope and duration of services we are most appreciative that these regulations prohibit the imposition of any nonquantitative treatment limitations to mental health and substance use disorder benefits which are determined by any methods or means not similarly used to determine limitations on medical/surgical benefits. This will require that health plans maintain sufficient panels of mental health providers for all authorizations of care, medical necessity determinations, concurrent and retroactive reviews. Where services for children are concerned it is especially critical that plans identify appropriate providers that are trained and licensed to treat children and adolescents.

Similarly the range of mental health and substance use treatment providers must be adequate to meet the needs of the covered population, and should not be more restrictive than the range of medical/surgical health providers. For example, if physical health professionals are admitted to provider networks (or eligible for reimbursement under a plan that does not have a network) based upon state licensure in a field qualified to serve covered conditions, the requirements should be the same for mental health and substance abuse treatment providers. Any exclusion of entire licensing or practice categories on the mental health/substance abuse side should be made only if similarly determined exclusions are made on the physical health side.

The range of mental health and substance abuse treatment settings must not be more limited, or limited based upon different criteria or methodology, than are medical/surgical treatment settings. Within a given classification, if medical/surgical patients are admitted to the most appropriate treatment setting or level of care based on medical necessity and generally recognized independent standards of practice for their condition, the same must be true for covered mental health and substance abuse disorders.

The number of mental health and substance abuse treatment professionals and agencies currently accepting new patients from the plan should be sufficient to serve the beneficiary pool as promptly as medical/surgical services are delivered.

Centers for Medicaid and Medicaid Services  
April 27, 2010  
CMS-4140-IFC  
page three

We appreciate that the list of the nonquantitative treatment limitations articulated in the regulations, while including many of the most inequitable limitations and restrictions on mental health and substance use disorders, is non-exhaustive. This encourages a full examination of “any processes, strategies, evidentiary standards, or other factors used in applying a NQTL to mental health or substance use disorder” that is not applied to a medical/surgical benefit.

In closing we want to emphasize our support of the statutory language which defines parity as the “quality or state of being equal or equivalent.” While we understand that some ambiguities will arise as implementation proceeds, we believe Congressional intent was clear in its desire to end the long-standing discrimination between benefits for mental health and substance use disorders and medical/surgical benefits.

Thank you.

Sincerely,

A handwritten signature in cursive script, appearing to read "Joy Midman".

Joy Midman  
Executive Director