



701 13th Street, NW, Suite 950
Washington, DC 20005-3903
Phone: 202/393-6700
Fax: 202/783-6041
E-mail: naphs@naphs.org
Web: www.naphs.org

SUBMITTED ELECTRONICALLY: www.regulations.gov

May 28, 2009

Ms. Charlene Frizzera
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-NC: Request for Information Regarding the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*

Also:

- Department of Labor [ATTN: MHPAEA Comments]
- Internal Revenue Service [REG-120692-09]

Dear Acting Administrator Frizzera,

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 "Request for Information Regarding the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*" [CMS-4140-NC] as published in the April 28, 2009, *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, including partial hospitalization services, outpatient services, residential treatment, and inpatient care.

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).

Our comments follow below.

BACKGROUND

The *Mental Health Parity and Addiction Equity Act* was signed into law on October 3, 2008. The law aims to ensure parity between coverage for mental health and substance use disorders and medical/surgical benefits in insurance plans that offer coverage for both benefits. Enactment of this legislation came after a decade of congressional consideration of parity legislation. Although Congress worked very hard to be as clear as possible regarding the meaning of mental health and addiction parity, by definition this type of legislation will result in some ambiguities.

It is our view that the **implementation** of mental health and addiction parity **must ensure the basic principle/goal** of this law, which is **to eliminate the long-standing discrimination between benefits for mental health and substance use disorders and medical/surgical benefits**. In other words, mental health and substance use disorder coverage should be “no more restrictive” (this is a key phrase in the *Mental Health Parity and Addiction Equity Act*) than coverage of medical/surgical benefits.

REQUEST FOR INFORMATION QUESTIONS ON CURRENT HEALTH INSURANCE PRACTICES RELATED TO MENTAL HEALTH AND SUBSTANCE USE DISORDERS

The Request for Information asked the public to answer the following questions (among several others):

- 1) How do plans currently apply financial requirements or treatment limitations to a) medical and surgical benefits and b) mental health and substance use disorder benefits?
- 2) Are these requirements or limitations applied differently to both classes of benefits?
- 3) Do plans currently vary coverage levels within each class of benefits?

NAPHS SURVEY

We know based on current insurance practices that benefits, services, and medical necessity/utilization management are substantially different for mental and substance use disorders compared to other medical illnesses.

To document some of these differences and to prepare to answer some of the Request for Information questions, NAPHS in May 2009 conducted an on-line survey of its membership. We received responses from 33% of the CEOs of NAPHS behavioral healthcare systems. These respondents operate more than 250 hospitals and residential treatment centers nationwide.

NAPHS Survey Results

We asked our membership the following questions:

- 1) *Of health plans you deal with, what percent of private health insurance plans that have (either or both) a mental health/substance use benefit have NO coverage for the following:*
 - a. Acute psychiatric hospital or substance-use hospital
 - b. Psychiatric residential treatment facilities for children and adolescents
 - c. Residential treatment facility for substance use disorders
 - d. Office-based treatment services for mental health or substance use (including all forms of psychotherapy, behavioral therapy, group therapy, addiction counseling)
 - e. Intensive outpatient programs
 - f. Partial hospitalization programs
 - g. Other specified non-office based intensive outpatient programs [e.g., assertive community treatment, intensive case management, psychosocial rehabilitation, collaborative care programs, crisis intervention programs (both residential and non-residential)]
 - h. Any specific mental health or substance use medications
 - i. Any specific mental health or substance use medical devices for mental health or substance use disorders, e.g., transcranial magnetic stimulation (TMS)
 - j. Any specific mental health or substance use diagnostic tests (e.g. psychological testing)

The results showed that close to 75% of the respondents said that almost all (90%-100%) of the health plans they deal with did cover inpatient psychiatric care. However, only 10% of the respondents said that most of the health plans they deal with cover psychiatric residential treatment for children and adolescents. In fact, close to 40% of the respondents said that fewer than 25% of the health plans they deal with cover psychiatric residential treatment facilities for children and adolescents.

Regarding coverage for residential treatment for substance use disorders, 27% of the respondents said that almost all (90%-100%) of the plans they deal with had this type of coverage, but close to 25% of the respondents said that fewer than 25% of the plans they deal with have coverage of residential treatment for substance use disorders.

Respondents also noted that many other services, such as intensive outpatient and partial hospitalization, are not covered by all the plans they deal with.

Inpatient, residential, and intensive outpatient/partial hospitalization are all considered essential services in the continuum of care for persons with mental and substance use disorders, but these results suggest that coverage for these critical services falls substantially short of being universally covered by health plans.

2) *How often do private health insurance plans that have (either or both) mental health/substance use benefits take the following actions related to patients with either mental health or substance use disorders?*

- a) Deny patient's entire stay using medical necessity criteria
- b) Order a length of stay that is less than the physician recommended because of medical necessity criteria

The results show that close to 40% of the respondents said that an entire stay is "sometimes" denied and close to 20% said an entire stay was "often" denied. Close to 50% of the respondents said that health plans "often" shorten length of stay below what is recommended by the physician.

3) *Are you aware of behavioral health criteria that are more restrictive than medical/surgical criteria in any of the following areas?*

- a) Utilization management
- b) Medical necessity

The results show that 88% of the respondents said that they were aware of behavioral health utilization management criteria that are more restrictive than medical/surgical criteria.

And 71% of the respondents said that they were aware of medical necessity criteria that were more restrictive than medical/surgical criteria.

4) *Restrictions in Medicaid managed care plans*

It is our understanding that the statute also applies to Medicaid managed care plans. We repeated the questions above to get a sense of current practices within Medicaid managed care plans. Our survey found that our members reported similar restrictions to those in private health plans regarding scope of services, medical necessity, and utilization management practices.

REQUEST FOR INFORMATION QUESTION: HOW SHOULD MENTAL HEALTH AND ADDICTION PARITY BE IMPLEMENTED?

From the text and history of the statute, it is clear that congressional intent was that coverage for mental health/substance use must be "no more restrictive" than medical/surgical coverage. It is our view that Congress intended coverage to not be so narrowly defined that it would prevent parity from being achieved between mental health/substance use and medical/surgical services. It is our view that coverage includes treatment limitations, financial requirements, scope of services, medical necessity criteria, and utilization management. Regulations should clarify this point.

The *Mental Health Parity and Addiction Equity Act* should be implemented based on the core principle of parity. The definition of parity is "the quality or state of being equal or equivalent."

The key areas of benefit structure that need to be evaluated in the context of this definition are:

- benefit levels,
- scope of services, and
- medical necessity/utilization management.

Benefit Levels

The statute seems clear that benefit levels (defined as treatment limitations and financial requirements) can be no more restrictive for mental health and substance use disorders than they are for medical conditions. One of the key reasons for mental health parity legislation was the longstanding inequity in mental health and substance abuse coverage – specifically related to more restrictive treatment limits and financial requirements on mental health/substance use than on medical/surgical services.

Scope of Services / Medical Necessity / Utilization Management

In the areas of scope of services and medical necessity/utilization management, the statute is not as clear. The statute does say that utilization management is permitted, but it does not go further on the details of utilization management for mental health and substance use and medical/surgical care.

In the scope of service area, the statute does reference services in the mental health and substance use definition. Mental health benefits are defined in the act as “benefits with respect to services for mental health conditions.” Based on this definition, if health plans were allowed to qualify as providing “benefits” while not providing any services, it would severely undermine the statute.

Based on the text and history of the statute, the scope of services for mental health/substance use cannot be more restrictive than what is offered for medical/surgical conditions. For example, based on our survey of our membership, currently many health plans fail to offer children and adolescents with psychiatric disorders coverage for psychiatric residential treatment, while services for children for other medical conditions are generally fully covered. Similarly, many health plans exclude coverage for psychiatric partial hospitalization and intensive outpatient services – while no such restrictions may exist for medical/surgical conditions.

In reviewing the NAPHS survey, it is clear that **what most experts in the mental health and substance use field consider critical services are not universally covered under current health insurance plans.** It is our view that if a medical/surgical benefit generally does not limit the range of services for a particular condition or disorder, then the parity law should require that mental health and substance use services should not be arbitrarily limited as well.

NAPHS RECOMMENDATION

Let’s state it again: 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 not be so narrowly implemented that the clear goal of Congress – to eliminate insurance practices that have been discriminatory to people who have mental or substance use disorders – would be undermined.

The National Association of Psychiatric Health Systems recommends that the regulations clarify 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 regulations should clarify that the “no more restrictive” standard for financial requirements and treatment limitations not be subverted. Regulations 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

cc:

- Department of Labor [ATTN: MHPAEA Comments]
- Internal Revenue Service [REG-120692-09]