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The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Document: CMS-2009-0040-DRAFT-0060

MD

Submitter Information

Name: Marcie Granahan

Address:

Linthicum, MD, 21090

Organization: US Psychiatric Rehabilitation Association

General Comment

Attached are USPRA's comments. Thank you for the opportunity.

Attachments

CMS-2009-0040-DRAFT-0060.1: MD

April 5, 2010

Centers for Medicare and Medicaid Service
U.S. Department of Health and Human Services
Attention: CMS-4140-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

To Whom It May Concern:

On behalf of its 1,400 psychiatric rehabilitation agencies, practitioners, and interested organizations and individuals who are dedicated to promoting and strengthening community-oriented rehabilitation services that support recovery from the disabling effects of serious mental illness, the United States Psychiatric Rehabilitation Association (USPRA) applauds the efforts of the Department to level the playing field between mental health treatment and medical health treatment. This is a welcome change for those individuals who have experienced difficulties obtaining needed behavioral health care and services. USPRA has long advocated for equality in treatment and opportunities for persons with mental illness to recover and lead meaningful and purposeful lives, regardless of financial status or other complicating factors. We thank you for this opportunity to comment on the provisions of the interim final rule for the MHPAEA of 2008.

The language chosen to describe the scope of services causes us some concern. The rule uses the term “generally accepted medical standards” and other ambiguous terminology. There are many conditions and services that do not fit appropriately under the category of “medical standards”. Indeed, USPRA has long argued that medical definitions do not fully capture the essence of “recovery”, as recovery incorporates elements of well being and satisfaction that cannot be measured simply by a reduction in symptoms. Psychiatric rehabilitation uses a person-centered approach that promotes flexibility in assessing, planning and measuring services and outcomes. We urge the Department to expand this language to include other standards of care that are not solely based on medical definitions, interventions or outcomes. Psychiatric rehabilitation and recovery practitioners/researchers have defined several Evidenced Based Practices and emerging practices, and we urge the Department to include these and other promising practices within the scope of services and to require plans and States to learn how these practices are designed, administered, delivered, funded and measured.

The required six broad categories of benefits – inpatient in-network, in patient out-of-network, outpatient in network, outpatient out-of network, emergency care and prescription drugs are all mandated. States or health plans offering MH/SUD benefits must offer benefits in each classification for which any medical benefits are provided. Unfortunately, the scope of services

for substance abuse (SUD) or mental health (MH) benefits are not specified and, therefore, permits States and group health plans to define the services covered in the benefit packages. Ancillary services considered essential to the recovery of persons in services, such as rehabilitation-related services, are not specifically referenced in the rules. For example, respite care, overnight hold beds, crisis diversion facilities, and residential support services are not addressed in the current rules. If the scope of services is left to States and health plans, we have serious concerns that such services will not be included and individuals will experience gaps in support, ultimately compromising their overall health.

The rules do not address the coverage, or lack of coverage, for court-ordered treatment or involuntary holds. Although USPRA supports minimizing the use of intrusive or mandated treatment, it is essential that service delivery systems maintain the capacity to detain persons who pose an imminent threat to others without resorting to law enforcement intervention. The current rules do not provide any services within the benefit categories for these situations. The Department is encouraged to include these services within the scope of services.

We also urge the Department to address which diagnoses and conditions will be covered and which services will be offered to persons receiving services in States with no mandated mental health or substance abuse benefits. Failure to do so will dilute the breadth and quality of services offered. It will be incumbent upon providers, plans and persons receiving services to remain vigilant to additional requirements or limitations. The implementation of these rules hinges on clarifying the scope of services.

We are concerned that the rules do not address the fact that differences among States will significantly impact plans and providers that provide benefits in multiple States. Many persons with behavioral health needs move across State lines, sometimes to obtain better care. Yet the rules do not address the portability of benefits across State lines. We urge the Department to address this oversight.

USPRA understands that a large majority of persons who have medical insurance do not need to use behavioral health benefits, even if offered within their coverage. However, the rules do not apply to employers with fewer than 50 employees. This is a significant portion of the U.S. working population. Indeed, many persons with mental health concerns hold entry level positions with small employers so as to avoid the pressures that often come with working for larger corporations. If the small employer is not required to have coverage, persons in recovery from mental illness will be severely limited in their employment options. We urge the Department to consider including small employers in the rules.

We support the effort to ensure that MH/SUD benefit limitations are not more stringent than medical benefits in the same classification. We encourage the Department to offer additional clarification and guidance to interpret and apply these classifications. We commend the

Department for that portion of the rule that establishes standards to measure plan benefits so that medical/surgical benefits can be compared with SUD/MH benefits, including prescription medication benefits.

We applaud the effort to align medical and mental health care practice, reimbursement and outcomes. The inevitable long term benefit will be the need for service providers to work more closely together to address the “whole person” through integration of care and sharing of data, methodology and quality outcomes. The blending of funding and systems of care will be encouraged and enhanced. USPRA has long been a proponent of person-centered service delivery models and we believe that the MHPAEA is a tool that can enhance these efforts.

USPRA is keenly aware of the need for persons in recovery from MH/SUD issues to retain ultimate control of their personal health information. One of the challenges emerging from the MHPAEA is the need to share information across the spectrum of providers, plans and persons in services. Electronic record keeping will be the key to efficient information sharing. We hope that health care reform legislation will help to address this gap. Yet USPRA cautions the Department to offer guidance and standards regarding the nature of the information that can and should be shared in order to protect the privacy of the individual.

Ideally, the passage of the law and the promulgation of the rules will reduce discriminatory practices toward persons with mental health or substance abuse disorders and open new opportunities for improved treatment. The new rules will encourage persons to seek care when needed and remove many disincentives inherent in current healthcare plans. As expected, the “devil is in the details” and many questions remain unanswered about the real impact on the American public. We hope that these comments are informative and will prove useful during the implementation of the MHPAEA.

Sincerely,

A handwritten signature in black ink, appearing to read 'MG', followed by a long horizontal flourish.

Marcie Granahan
CEO