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

Comment On: CMS-2009-0040-0048

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

Document: CMS-2009-0040-DRAFT-0073

NY

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General Comment

See attached file(s)

Attachments

CMS-2009-0040-DRAFT-0073.1: NY



April 27, 2010

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

To Whom It May Concern:

As executive director of the TeenScreen National Center for Mental Health Checkups at Columbia University (National Center), I am submitting comments to the Centers for Medicare and Medicaid Services (CMS) with regard to the interim final rule [CMS-4140-IFC] on implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). I am writing to encourage the agency to more clearly define scope of services as it relates to preventive services, namely to ensure coverage of mental health screenings. The National Center firmly believes the intent of MHPAEA was to require insurance plans to cover the full scope of mental health services, including prevention services. We believe that this step is necessary to ensure mental health care is covered at the same level as medical and surgical care, and to protect individuals and families from added costs associated with needed mental health care.

The National Center is a non-profit mental health initiative funded by a private family foundation. Our mission is to expand and improve early detection of mental illness by mainstreaming mental health checkups as a routine procedure in adolescent health care, schools, and other youth-serving settings. The goal of the National Center is to prevent adolescent suicide and reduce disability associated with mental illness. To achieve this goal, the National Center works to advance public policy and promote best practices to expand the availability and utilization of mental health checkups nationwide. The National Center provides voluntary mental health screenings in more than 900 sites in 43 states.

The interim final rule provides some clarification of the MHPAEA language as it addresses scope of services. The text of MHPAEA defines mental health benefits and substance use benefits as "benefits with respect to services." The language also states that:

"the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there

are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

Treatment limitations are defined as:

‘limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the *scope* [emphasis added] or duration of treatment.’

Consequently, the interim final rule does address parity, albeit very broadly, with regard to scope of services in determining that services offered across six classifications of benefits must be offered for mental health services if they are offered for medical/surgical services. Those classifications include: 1) in-network, inpatient; 2) out-of-network, inpatient; 3) in-network, outpatient; 4) out-of-network, outpatient; 5) emergency services; and 6) pharmacy. However, the National Center is concerned that these protections would still allow for separate and more restrictive limits on the scope of services provided with respect to mental health or substance use benefits as compared to medical/surgical benefits.

To further reinforce the law’s stated intention that limitations on services be no more restrictive for mental health or substance use benefits, we urge you to provide additional guidance as to categories of treatment services, where services for mental health or substance use also must be provided if medical/surgical benefits are provided within that category. These treatment categories should include:

- 1) preventive services;
- 2) treatment services; and
- 3) rehabilitative services.

While treatment and rehabilitative services routinely are associated with mental health, substance use and medical/surgical benefits, preventive benefits are more commonly thought of in terms of physical health. However, examples of valuable and cost-effective preventive mental health and substance use benefits exist, including mental health screenings. In its April 2009 recommendation, the U.S. Preventive Services Task Force’s (USPSTF) medical panel called on doctors in primary care settings to screen all adolescents age 12 to 18 annually for Major Depressive Disorder. This recommendation was based on peer-reviewed evidence that showed screening instruments developed for primary care accurately identify depression in adolescents.

Further validating the importance and cost-effectiveness of mental health screening as a preventive service, the National Research Council and the Institute of Medicine (IOM) found in their 2009 report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, screening in primary care settings offers the potential to intervene early and prevent fully developed mental health disorders. The IOM also notes a number of programs are effective and promote mental health and should be implemented more broadly. The IOM conclusions include:

- 1) interventions before the disorder occurs offer the greatest opportunity to avoid the substantial costs to individuals, families and society that these disorders entail; and
- 2) validated screening tools are available at little or no cost to primary care providers.

Reinforcing the need to expand the interim final rule to include treatment categories, namely prevention services, are research findings from the National Institute of Mental Health that have shown 50 percent of all lifetime mental health disorders start by age 14. Yet, because the early signs of a disorder often are missed, the average diagnosis regularly occurs 10 years or more after the onset of symptoms. These late stage diagnoses indicate that without widely used screenings, we are missing the two-to-four year window following the first onset of symptoms. Research has shown this to be the most effective time to intervene to reduce symptoms and prevent a full-blown mental disorder. If parity required preventive services for mental health benefits, such as annual depression screening in adolescence, to be offered on the same level as medical/surgical benefits, identification of mental illness at its earliest stages would be greatly increased and the cost to the individual and society would be greatly reduced. The IOM estimates the costs of mental illness at \$247 billion annually, and recent news reports of adolescent deaths by suicide in Palo Alto and elsewhere have highlighted the human toll in very real terms.

Given the direct correlation between access to preventive services, such as mental health screenings, and the early identification of a mental illness, the National Center urges the Departments to expand the interim final rule to include treatment categories as a criterion to determine whether health insurance plans meet the required parity standard. This will ensure parity exists across all levels of care and will remove existing barriers that prevent individuals from access to needed mental health services.

Sincerely,

A handwritten signature in cursive script that reads "Laurie Flynn".

Laurie Flynn
Executive Director
TeenScreen National Center for Mental Health
Checkups