

May 3, 2010

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653
U.S. Department of Labor
Attention: RIN 1210-AB30
200 Constitution Avenue, NW.
Washington, DC 20210

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

CC:PA:LPD:PR (REG-120692-09), Room 5205
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

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

Dear Secretary Solis, Secretary Sebelius, and Commissioner Shulman:

The Illinois Alcoholism & Drug Dependence Association (IADDA) is pleased to provide comments on the Interim Final Rules (IFR) under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

IADDA is the only statewide advocacy organization in Illinois focusing solely on substance use disorder issues; we represent 49 prevention, treatment and recovery organizations across the state of Illinois. Our mission is to advocate for people invested in the substance use disorder (SUD) field, including clinicians, consumers, family members, individuals in recovery and youth. A list of our member agencies has been included in this communication (Addendum A).

There are many aspects and facets of the IFR that interest us. However, in our commentary we wish to focus on what we consider to be the most pressing issues. Above all, we view the IFR as having underestimated the importance of clarifying and specifying scope of services and medical necessity guidelines. The MHPAEA IFR refers to “generally accepted medical necessity criteria, standards and guidelines” repeatedly for the purpose of determining **scope of services** and defers specific policies to health plans and states’ departments of insurance. Therein lies the crux of the concern for the SUD treatment provider and the consumer. The issue of what constitutes medical necessity in medical care and what represents medical necessity in SUD treatment is not necessarily consistent in all circumstances. For instance, more than two-thirds of the substance abuse treatment delivered in this country is funded by and delivered by public (federal, state, and county) programs. Consequently, the evidence-based practices, standards and guidelines utilized in the public sector are neither familiar to nor used by the commercial insurance sector.

The risk, as we see it, is that health plans and employers in the State of Illinois will decide for themselves to apply stricter medical necessity standards than are appropriate to substance use disorders, a medical condition that involves multiple biological, psychological, and sociological contexts resulting in a condition for which diagnosis is composed of many clinical nuances.

In order to provide focused recommendations, IADDA has worked with addiction treatment and health insurance experts and has conducted a gap analysis on the Interim Final Rules. Our comments and recommendations are focused on rectifying the gaps identified. Those gaps include scope of services, medical necessity guidelines, covered providers, and licensure and certification.

IADDA respectfully submits the attached recommendations to further strengthen the Interim Final Rules. We appreciate the Department's consideration of these recommendations and look forward to working with you to implement these important patient protections.

Sincerely,

A handwritten signature in black ink, appearing to read "Sara M. Howe". The signature is fluid and cursive, with a long horizontal stroke at the end.

Sara M. Howe
CEO
Illinois Alcoholism & Drug Dependence Association

Recommendations

Based upon the results of our research into the laws and regulations of other states known to exemplify comprehensive parity in Substance Use Disorder (SUD) treatment and benefits, we have prepared the following recommendations for the Federal Departments of Treasury, Labor and Health & Human Services (herein referred to as “Departments”).

Guiding Principles and Values in the Treatment of Substance Use Disorders

- a. Substance use disorders are chronic medical conditions.
- b. SUD is highly treatable.
- c. Evaluating and determining the need for any SUD treatment service should be informed primarily by the clinical need and health value of the service.
- d. Treatment costs should be known, understood, and monitored by consumers, providers, third-party payers, and managed care organizations.
- e. SUD services should be provided in the most cost-effective and efficient manner possible and take place at the most appropriate level of care for an appropriate amount of time, consistent with accepted guidelines identified in the most current revision of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM PPC-2R).
- f. Treatment should be person-centered and should consider the consumer’s resources, family and home environment, the severity of the disorder, and any co-morbid or co-occurring medical or mental health problems.
- g. Health plans and managed care organizations should not design plans that exclude nationally-accepted and validated levels of care or treatments.
- h. There should be close coordination between the behavioral health benefits managers and medical management staff.
- i. Managed care staff involved in the management of SUD should have sufficient training and experience including at least one of the following certification or licensure:
 - state certification or state licensure in the SUD field
 - national certification as addiction counselors
 - certification as addictions registered nurses
 - certified by ASAM in Addiction Medicine
 - certified by the American Board of Psychiatry and Neurology, ABPN, in addiction psychiatry
 - certified by the American Osteopathic Academy of Addiction Medicine

- j. SUD treatment, in accordance with Institute of Medicine (IOM) principles, should be safe, effective, timely, and equitable, and the patient or consumer should be viewed and respected as the source of control.
- k. SUD benefits and treatment should promote self and peer management and recovery.
- l. Lastly, the following language should apply to care provided through managed care organizations in all states:

Substance Use Disorder Treatment Coverage Should Assure that:

- (a) Timely and appropriate access to care is available;*
- (b) The quantity, location, and specialty distribution of health care providers is adequate; and*
- (c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured.*

I. Scope of Services

In addition to the scope of service direction provided in the MHPAEA Interim Final Rule specific to classification of benefits, financial limitations, quantitative and non-quantitative treatment limitations – among others – we recommend strongly that the Departments, health insurers and health plans adopt the following:

A. Covered Conditions (Diagnoses)

We recommend that health plans and insurers cover all current DSM and ICD Substance Use and Substance-Related Disorders with the exception of those related to caffeine dependence.

B. Covered Services

We recommend that all health plans and insurers provide benefits for the following services, all of which can be made to align with MHPAEA’s Classification of benefits:

- ASAM Level 0.5, Early Intervention;** including school based and SUD educational programs for people who are at-risk yet do not yet meet criteria for treatment. These services include assessment.
- ASAM Level I, Outpatient Treatment;** Outpatient treatment (provided by a state licensed and/or certified agency) consists of less than 9 hours per week through a combination of services including but not limited to: individual or group counseling, motivational enhancement, brief intervention, cognitive-behavioral therapy, opioid substitution therapy, family therapy, educational groups, occupational and recreational therapy, or other psychotherapy; or case coordination, case management, chronic care and maintenance services, intentional community treatment support, or assertive community treatment as identified through assessment and individualized treatment planning. An outpatient services program with a dual diagnosis enhanced program shall offer therapies to actively address, monitor, and manage psychotropic medication, mental health treatment, and the interaction with substance-related disorders.
- ASAM Level II, Intensive Outpatient/Partial Hospitalization**
 - 1. **Level II.1 Intensive Outpatient (IOP);** (provided by a state licensed and/or certified agency); IOP includes: 9 or more hours of structured programming per week for adults and at least 6 hours per week for adolescents, through a combination of services including but not limited to: individual or group counseling, motivational enhancement, brief intervention, cognitive-behavioral therapy, opioid substitution therapy, family

therapy, educational groups, occupational and recreational therapy, or other psychotherapy; or case coordination, case management, chronic care and maintenance services, intentional community treatment support, or assertive community treatment as identified through assessment and individualized treatment planning.

2. Level II.5 Partial Hospitalization; (provided by a state licensed and/or certified agency) provides 20 or more hours of clinically intensive programming per week, as identified through assessment and individualized treatment planning. Level II.5 programs have direct access to psychiatric, medical and laboratory services, and thus are better able than Level II.1 programs to meet medical, cognitive and psychiatric needs which require daily monitoring or management but which can be appropriately addressed in a structured outpatient setting. Patients who meet Level III criteria in ASAM dimensions 4, 5, or 6 and who otherwise would be placed in a Level III program may be considered for placement in a Level II.5 program if the patient resides in a facility that provides 24-hour support and structure and that limits access to alcohol and other drugs which would include a therapeutic overnight or a supervised living situation.
3. Level II-D Ambulatory Detoxification with Extended On-Site Monitoring (provided in a state licensed and/or certified facility by a licensed and/or certified licensed independent medical practitioner) provided by trained clinicians who provide medically supervised evaluation, detoxification and referral services. Level II-D services are provided in regularly scheduled sessions and delivered under best practice procedures or medical protocols. Essential to this level of care is the availability of appropriately credentialed and licensed nurses (such as registered nurses or licensed practical nurses).

❑ **ASAM Level III, Residential/Inpatient Treatment;**

1. Level III.1: Clinically Managed Low-Intensity Residential Treatment; (Provided by a state licensed and/or certified agency) provides at least 5 hours per week of low-intensity treatment as identified through assessment and individualized treatment planning. Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education and family life. Services provided may include individual, group and family therapy; medication management and medication education. This level does not include sober houses, boarding houses or group homes where treatment is not provided.
2. Level III.2-D: Clinically Managed Residential Detoxification; (sometimes referred to as social setting detoxification) (provided by a state licensed and/or certified agency) provides 24-hour supervision, observation and support for patients that are intoxicated or experiencing withdrawal. Staffed to supervise self-administered medications for the management of withdrawal. Clinically managed detoxification services are designed to safely detoxify patients without the need for ready on-site access to medical and nursing personnel although medical consultation is available 24 hours a day.
3. Level III.3: Clinically Managed Medium-Intensity Residential Treatment; (Provided by a state licensed and/or certified agency) provides daily clinical services through a combination of services including but not limited to: individual or group counseling, motivational enhancement, brief intervention, cognitive-behavioral therapy, opioid substitution therapy, family therapy, educational groups, occupational and recreational therapy, or other psychotherapy; or case coordination, case management, chronic care and maintenance services, intentional community treatment support, or assertive community treatment as identified through assessment and individualized treatment planning. Level III.3 programs are able to address the needs of residents with certain medical problems, including patients whose biomedical conditions otherwise would meet medical necessity criteria for placement in a nursing home or other medically staffed facility.

4. Level III.5: Clinically Managed High-Intensity Residential Treatment; (provided by a state licensed and/or certified agency) designed to treat persons who have significant social and psychological problems and rely on the treatment community as a therapeutic agent. Level III.5 includes but not limited to: individual or group counseling, motivational enhancement, brief intervention, cognitive-behavioral therapy, opioid substitution therapy, family therapy, educational groups, occupational and recreational therapy, or other psychotherapy; or case coordination, case management, chronic care and maintenance services, intentional community treatment support, or assertive community treatment as identified through assessment and individualized treatment planning. Duration of treatment depends upon the patient's progress. Nevertheless, the length of stay will tend to be longer than in Level III.7 or Level IV.
 5. Level III.7: Medically Monitored Inpatient Treatment; (provided by a state licensed and/or certified agency) includes but is not limited to: individual or group counseling, motivational enhancement, brief intervention, cognitive-behavioral therapy, opioid substitution therapy, family therapy, educational groups, occupational and recreational therapy, or other psychotherapy; or case coordination, case management, chronic care and maintenance services, intentional community treatment support, or assertive community treatment as identified through assessment and individualized treatment planning. Includes a planned regimen of 24 hour professionally directed evaluation, observation, medical monitoring and addiction treatment in a residential setting.
 6. Level III.7-D: Medically Monitored Inpatient Detoxification (provided by a state licensed and/or certified agency) is an organized service delivered by medical and nursing professionals, which provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility with residential beds. Services are delivered under a defined set of physician approved policies and physician-monitored procedures or clinical protocols.
- Level IV-D:** Medically Managed Intensive Inpatient Detoxification (provided by a state licensed and/or certified agency) is an organized 24 hour service delivered by medical and nursing professionals that directs evaluation and withdrawal management in an acute care residential setting. Services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols.

In addition to the ASAM specific levels of care described above, we recommend the Departments ensure coverage of the following SUD services:

- Prevention and wellness services (as defined by the recently passed health insurance reform law)
- Telemedicine encounters
- Treatment for co-occurring disorders
- Medications and medication management services
- Case Management
- HIV Testing and Counseling
- Opioid Maintenance Therapy (OMT) and other medication assisted approaches to recovery
- Toxicology
- Outpatient Services – specifically:
 - o Screening
 - o Evaluation

- Consultations
- Diagnosis and Treatment involving:
 - psycho-educational
 - physiological
 - psychological
 - psychosocial evaluative and intervention concepts, techniques and processes provided to individuals and groups

C. Covered Providers

The range of professionals considered covered providers under the MHPAEA can and should include licensed physicians, nurses, psychologists, SUD counselors, and clinical counselors and social workers. Certification can be a function of state licensing agencies and nongovernmental agencies such as professional associations or certification boards. Certification boards are authorized to certify all SUD professionals for entry into the profession, provide professional competency exams and standards that promote excellence in care, appropriate education, and clinical training of counselors.

Some States choose to certify SUD professionals while other States license them. Most commonly, it is the medical, nursing, social work and psychologist professionals that are licensed by the State while SUD professionals are certified and/or work under the auspices of a State-licensed facility. Most States require SUD professionals to meet certain competency standards to provide clinical services.

In Illinois, certified SUD professionals may work in agencies that are licensed by the State, thus satisfying requirements for licensure. States should retain the authority to establish practices regarding the qualifications of a certified and/or licensed SUD professional. We recommend that the Departments and all health plans and insurers – including MCOs and HMOs – adopt the respective state standards, for the certification and licensure of a qualified SUD professional, in the state which the service is provided.

In the interest of normalizing standards across SUD treatment systems, it is our expectation that the Departments will assist states in establishing standards in SUD treatment licensure and certification. Consequently, IADDA urges the Departments to adopt the following language:

“All professional staff providing clinical services shall:

- *hold clinical certification in the state in which they practice; or*
- *be a licensed professional counselor or licensed clinical professional in the state in which they practice; or*
- *be a physician licensed to practice medicine in all its branches ; or*
- *be licensed as a psychologist; or*
- *be licensed as a social worker or licensed clinical social worker.”*

II. Inpatient Clarification

As is stated above, all of the services identified in Section I.B align with the classification of benefits established by the MHPAEA IFR. Many health plans that include an “inpatient” treatment benefit only cover inpatient services in acute care hospitals, not in sub-acute residential addiction treatment programs. Accordingly, it is crucial for the Departments to revise the MHPAEA IFR to provide that inpatient benefits are not limited to acute care, but rather include sub-acute care (and thus residential inpatient treatment).

Residential treatment is a more appropriate and often a more cost-effective treatment setting than a hospital for many patients. Residential treatment allows for more comprehensive and structured treatment models than are often available in inpatient acute care settings. Such programs hold national accreditations (often the same accreditations that hospitals use) and state licenses. Moreover, sub-acute inpatient care is a widely utilized (and covered) benefit for medical/surgical disorders. For example, patients recovering from stroke and other brain trauma are often admitted to a sub-acute inpatient level of care such as skilled nursing for rehabilitation. Like inpatient residential care for substance use disorder services, this sub-acute inpatient care is less intensive than typical acute care inpatient treatment, but is necessary to provide a safe environment in which patients can safely rehabilitate to a disease state for which outpatient care is appropriate. This approved treatment modality for both medical/surgical and mental health/substance use disorder treatment should not be excluded from parity requirements.

III. Medical Necessity Guidelines

MHPAEA stipulates that health plans, issuers and the states may determine - according to generally-accepted, reasonable medical standards – which medical necessity and level of care criteria to use in the management of benefits. However, MHPAEA IFR should clarify that treatment will be deemed medically necessary if prescribed or authorized by a treating physician in accordance with ASAM Patient Placement Criteria.

IV. Consumer Education and Outreach

Previous studies of state-level parity have demonstrated that extensive public education and consumer outreach is essential to realize parity's potential. The Secretaries of Labor, the Treasury and Health and Human Services should be required to establish a website and toll-free hotline for use by consumers and providers to report denials of benefits protected by the MHPAEA. Both the website and hotline should offer information about the rights of plan participants under the MHPAEA and provide resources that would enable them to appeal their plans' decisions and pursue alternative treatment services immediately, if needed (for example, through publicly funded programs). Similarly, a notice in writing from the Secretaries should be provided to each plan participant summarizing the changes in mental health and substance use disorder benefits under the MHPAEA. A public service announcement campaign (using as many different forms of media as possible) should be undertaken as well to educate the public about the MHPAEA and encourage people to seek treatment if needed.

V. Reporting

The mandated Report to the Secretary of Labor that is prescribed by the MHPAEA should include the following data, itemized by diagnosis and age group, to provide the best possible picture of the MHPAEA's effects:

- a. The number of beneficiaries seeking treatment for mental health conditions or substance use disorders
- b. The type and duration of care provided
- c. Reasons for denial of care
- d. The number and success rates of appeals
- e. A description of the educational and informational materials provided to plan participants describing their coverage under the MHPAEA
- f. The cost of care to the plan and the beneficiary
- g. The treatment settings in which services are delivered
- h. The change in the rates of usage and expenditures before and after the MHPAEA
- i. The number of plans that did not implement the MHPAEA and their reasons for not doing so (i.e. cost exemption, dropping mental health and substance use disorder benefits altogether, etc.) and

the usage rates and expenditures of those plans' participants on mental health and substance use disorder services.

VI. Enforcement

If the Report to the Secretary of Labor and the Government Accountability Office Study finds that access to substance use disorder treatment decreases in a plan after it implements the MHPAEA, such fact should be interpreted as prima facie evidence of discrimination. A plan should also be required to meet the burden of proof that it did not engage in discriminatory practices. The U.S. Department of Health and Human Services Office for Civil Rights should have the authority to conduct further investigations and impose penalties on such plans.

ADDENDUM A IADDA PROVIDERS

ABJ Community Services, Inc., Chicago, IL
Abraxas Youth and Family Services/Cornell Companies, Inc., Woodridge, IL
Addiction Counseling & Educational Service, Chicago, IL
Alternative Schools Network, Chicago, IL
Anixter Center, Chicago, IL
Aunt Martha's Youth Service Center, Olympia Fields, IL
Breaking Free, Inc., Aurora, IL
Center for Alcohol & Drug Services, Rock Island, IL
Central East Alcoholism and Drug Council, Charleston, IL
Central States Institute of Addiction Programs, Chicago, IL
Chestnut Health Systems, Inc., Bloomington, IL
Community Partnership Coalition, Woodstock, IL
Family Service & Community Mental Health Center for McHenry County, McHenry, IL
F.O.R.U.M., Chicago, IL
Gateway Foundation, Inc., Chicago, IL
Great River Recovery Resources, Quincy, IL
Haymarket Center, Chicago, IL
Healthcare Alternative Systems, Chicago, IL
Human Resources Center of Edgar & Clark Counties, Paris, IL
Human Resources Development Institute, Chicago, IL
Human Service Center, Peoria, IL
Human Service Center of Southern Illinois, Red Bud, IL
Illinois Alcohol & Other Drug Abuse Professional Certification Association, Springfield, IL
Illinois Association of Extended Care, Westmont, IL
Leyden Family Service & Mental Health Center, Franklin Park, IL
Lutheran Social Services of Illinois, Des Plaines, IL
Northern Illinois Council on Alcoholism & Substance Abuse, Round Lake, IL
Omni Youth Services, Buffalo Grove, IL
PEER Services, Inc., Evanston, IL
Pillars, LaGrange Park, IL
Prairie Center Health Systems, Inc., Urbana, IL
Prevention First, Inc., Springfield, IL
Project Oz, Bloomington, IL
Remedies Renewing Lives, Rockford, IL
Renz Addiction Counseling Center, Elgin, IL
Riverside Resolve Center, Manteno, IL
Robert Young Center for Community Mental Health, Moline, IL
Rosecrance Health Network, Rockford, IL
Schuyler Counseling & Health Services, Rushville, IL
Serenity House Counseling Services, Inc., Addison, IL
Shelby County Community Services, Shelbyville, IL
Sojourn House, Inc., Freeport, IL
South East Alcohol & Drug Abuse Center, Chicago, IL
Stepping Stones, Inc., Joliet, IL
TASC, Inc., Chicago, IL
The H Group, West Frankfort, IL
The South Suburban Council on Alcoholism & Substance Abuse, East Hazel Crest, IL
The Wells Center, Jacksonville, IL
Will County Health Department, Joliet, IL