

PUBLIC SUBMISSION

As of: May 27, 2009
Received: May 27, 2009
Status: Pending_Post
Tracking No. 809b9255
Comments Due: May 28, 2009
Submission Type: Web

Docket: EBSA-2009-0010

Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: EBSA-2009-0010-0001

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Document: EBSA-2009-0010-DRAFT-0158

Comment on FR Doc # E9-9629

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General Comment

May 27, 2009

Office of Health Plan Standards and Compliance Assistance

Employee Benefits Security Administration

Room N-5653

U.S. Department of Labor, 200 Constitution Avenue, NW

Washington, DC 20210

Attention: MHPAEA Comments Regarding Federal Register Notice April 28, 2009

The Ohio Council of Behavioral health & Family Services Providers welcomes the opportunity to respond to your "Request for Information" on The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Ohio Council is a full service trade association that represents over 180 non-profit addiction treatment, mental health and family service providers in Ohio.

Enacted on October 3, 2008 the MHPAEA aims to ensure parity between mental health and substance use disorders (MH/SU) and medical/surgical benefits in

group health plans that offer coverage for both. MHPAEA amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code) to create new requirements and amend several of the existing group market mental health parity provisions. Enactment of MHPAEA followed years of consideration of this issue by Congress, and a long history of documented problems with MH/SU coverage affecting millions of individuals and families.

In Network Access: Reducing Cost-Shifting to Consumers

Provider credentialing and network characteristics affect cost-sharing and timely access to the appropriate type or scope of service. Restrictive provider network designs often are used to help manage risk for adverse selection but they also increase consumer cost-sharing for out-of-network services. Given that the intent of MHPAEA was to protect consumers from unequal access, cost-sharing, and scope of treatment, the MHPAEA implementing regulations should include guidance to health plans on how to ensure in-network access to mental health and addiction services in addition to addressing other critical issues of out of network care and medical management of the benefit. We recommend that the regulations address the following:

Require that applicable health plans enroll “essential community providers” in their network in order to assure access for high-risk or special needs clients/patients. By definition, this would include behavioral health providers who are trained, licensed or credentialed to serve the needs of individuals with serious mental illness and addiction disorders. Adoption of this concept would ensure that behavioral health providers would be included in the network offered by a health plan.

Provide guidance to plans on how to conduct ample outreach and education to consumers/patients and their families to educate them about the availability of mental health and addiction providers in the provider network. Individuals must have access to accurate provider network information in order to avoid additional out-of network cost-sharing that may occur because in-network providers are not accessible or available.

Ensure that there are standards that require networks to have sufficient enrolled, participating providers to assure access to services equal to other health services. Based on our experience, we are especially concerned that providers may be listed in a network, but in reality are not accepting new patients, an obvious contradiction. The standards should be the same standards as primary care in terms of wait time for appointments, travel distance or travel time. Access to specialized services should have at least the same geo-access standards as would be applied in the local service area to hospital/inpatient care for medical-surgical. Wait time for appointments should be specified in hours for emergency, crisis, or urgent care and days for routine outpatient. For example, for geo-access standards, Minnesota requires 30 minutes or 30 miles for outpatient mental health (same as primary care); 60 minutes or 60 miles for hospital.

Provider competencies and scope of practice of enrolled providers and

treatment programs should match the benefit design. Restrictions on the type of MH/SU providers and services included in the network commonly limit access and increase consumer cost-sharing unequal to what other health services. To cover a type of treatment, but not enroll providers would be illogical and inconsistent with the purpose of the MHPAEA.

“Financial Requirement” and Treatment Limitations on Benefits

If a health plan covers mental health and addiction services, the MHPAEA law prohibits “limitations on the frequency of treatment, number of visits or days of coverage, or other similar limits on the duration or scope of treatment” under the plan that are more restrictive than the predominant limitations applied to substantially all the medical-surgical benefits. In addition, the Act stipulates that there must be “no separate treatment limitations that are applicable only with respect to MH/SUD benefits.” For example, if a plan offers a full continuum of benefits under medical/surgical benefits and only one or two services, such as detoxification and outpatient services, for alcohol and other drug treatment, under the MH/SUD benefit, the plan will likely not be in compliance with the parity requirements in this Act. It is important for the regulations to emphasize those limitations which have the effect of shifting more financial risk or responsibility to the patient than for medical surgical services will violate the Act. The MHPAEA regulations should articulate that limitations of services have to meet the “requirements of the Act” i.e., should prohibit restrictive limitations on scope of treatment that has the effect of shifting risk to the consumer or to secondary coverage.

Ohio Council members have identified a range of treatment limitations often used to deny or make care more difficult to access, including: limits on yearly sessions and/or requiring more paperwork after a certain number of sessions; requiring providers to be in-network (on their panel) for coverage/reimbursement, the practical effect of which is to force chronic patients to choose another provider leading to lack of continuity of care and doctor/patient relationship; requiring prior-authorizations for out of network services that are rarely, if ever approved; and medical necessity criteria that effectively restrict appropriate and timely care. In addition, the following are specific examples of practices that often result in limitations in MH/SU care:

- Annual and lifetime caps
- Deductibles
- Coinsurance
- Out-of-pocket expenses
- Limits on the frequency of treatment, number of visits, and days of coverage
- Utilization review
- Coverage based on completing assessment/review with exceedingly short time frames (as little as an hour) or in face to face assessments in the state of the plans’ corporate headquarters
- Pre-authorization practices
- Medical necessity and appropriateness criteria, including ever-changing criteria lacking clear definitions for specific levels of care such as “inpatient,” “rehab” or “residential”

- Coverage requirements based on patient completing an entire course of treatment
- “Fail first” policies such as the patient has to fail 1 – 2 times at outpatient treatment within the last year to be eligible to use detoxification or residential benefits
- Utilization review being conducted by professionals with no training in mental health or addiction
- Exclusion of certain levels of care like residential treatment or partial hospitalization (in or out of network)
- Review of treatment services as to whether or not services are evidence-based
- Review of treatment as to whether or not services are experimental
- Review of treatment as to whether or not services are cost effective
- Fee schedules that do not enlist an adequate supply of providers to assure access
- Limit on specific providers or geographic licensure requirements in the state of the plan’s corporate headquarters
- Preferred provider networks (including elimination of providers from network if they allow a plan participant to self pay for care deemed “not medically necessary” by plan)
- Prohibiting plan coverage for eating disorders
- Prohibiting plan coverage for MH/SUD services required due to court order

Scope of Treatment

While frequency, duration or number of visits or days of coverage can be objectively measured, what is meant by “scope of treatment” will require more definition in the regulations. The regulations should provide guidance and clarification on the types of covered treatment and how other services whether new or long established become accepted. It is the intent of the MHPAEA that the scope of services offered under the mental health and addiction benefit are consistent with the level applied to substantially all medical-surgical benefits. Although “services” are referenced throughout the statute, additional guidance is necessary to ensure that the covered treatment and services are of sufficient type, duration, frequency, and intensity to “correct or ameliorate” the episode of illness for the covered conditions.

The regulations should articulate that the covered services and level of care should be appropriate to the covered diagnoses. Services recognized as community standards or evidenced-based practices for a given condition should be covered. For example, for major depression, coverage of only medications prescribed through primary care would restrict access to psychotherapy in the benefit design, thus shifting the cost for this benefit to the patient. Similarly, for medication-based addiction treatment, coverage of the medication only would leave patients without access to critical psychosocial rehabilitation services, a community standard. Medication for the treatment of mental health and addiction disorders has been proven to be critical to many individual’s recovery and should be part of the scope of treatment offered under the benefit, no less than for medication for other medical and surgical conditions.

The regulations should recognize that the scope of treatment for mental illness and addiction disorders should be no more restrictive than what is available

substantially for other chronic health conditions such as diabetes, epilepsy, heart disease, or respiratory conditions. Comprehensive disease management, chronic care, or packages of services with proven efficacy for treatment and rehabilitation services for people with serious mental illness, addictions and emotional disturbance should be covered if similar approaches are covered for substantially all other chronic health conditions. Comprehensive approaches that organize and coordinate packages of care can structure copayments and other cost-sharing to provide an incentive to active engagement in treatment.

We also urge that the regulations address “exclusion” provisions in health plan contracts. Common exclusions especially relevant to MH/SU include court-ordered treatment and experimental or investigative treatment that restrict the scope of treatment or services that would otherwise be appropriate to the patient’s diagnosis and functional condition. For example, court-ordered treatment that would otherwise be covered by a health plan could be covered when court decision is based on a diagnostic assessment and plan of care developed by a licensed professional within the plans provider network. Under MHPAEA, it is appropriate for healthplans to look to research evidence and expert consensus opinion to make coverage decisions; however, the regulations should not permit more restrictive exclusionary criteria for “experimental” or “investigative” treatments applied to MH/SU than for other health conditions.

State Pre-emption Issues

As the regulations are drafted special attention must be given to ensure that Federal parity regulations pre-empt weaker state laws, but do not supplant state laws that provide more protection to enrollees. Specific areas to consider include States with weaker substance abuse treatment requirements and State laws that limit parity to certain conditions versus MHPAEA that may apply parity to a broader list of disorders.

Medical Necessity

Medical necessity determinations are critical to equal access to appropriate care. Denials of care are denials of payment to the provider—directly shifting responsibility to the patient to either seek another plan of care or pay out of pocket for an otherwise covered benefit. Further, restrictive utilization management has the potential to shift risk and cost to government programs once a patient qualifies. The parity law regulations must provide guidance and predictability to healthplans, consumers and providers regarding how medical necessity is defined and criteria used to make utilization management decisions.

A current Federal standard to consider while developing MHPAEA regulations exists under Medicare statute, which states “no payment may be made... for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” (42 U.S.C. 1395y (a) (1) (A)) There are specific areas that regulations should address in order to assure that this flexibility does not become a means to make other provisions of the law irrelevant. Regulations

should require:

- Clinical criteria for admission/authorization, continuing care and discharge should be used for utilization decisions and these criteria must be available to enrollees and their providers at the initiation of treatment.
- There must not be a “fail-first” policy. If a service is necessary and appropriate, failure in another service should not be required as a prerequisite to authorization.
- Health plans to make information available to providers on covered benefits, limitations, and authorization procedures so that they can verify before initiating a plan of care.
- Health plans to make mental health/substance use disorder medical necessity criteria available to current or potential beneficiaries and providers upon request.
- Health plans to make reasons for payment denials available to beneficiaries and their providers through a process specified in the regulations.
- No pre-emption of stronger State laws: Federal regulations regarding utilization review and definition of medical necessity should not pre-empt criteria defined in state statute that provides more benefit and consumer protections.
- Medical necessity should be based on local community standards and expert consensus opinion. Benefits and scope of services covered should be defined to include those necessary to sustain or maintain functioning when without the service the patient would deteriorate.
- Medical necessity determinations for MH/SU have inappropriately shifted financial responsibility to the government or secondary payers. In order to protect the government from assuming this risk, medical necessity criteria should be not less restrictive than Medicaid in the state in which treatment is performed. Government subrogation rights would allow recovery of the cost of services when utilization management decisions have the effect of shifting risk and responsibility for covered benefits to Medicaid, Medicare, or a state government sponsored program.

Appeals and Independent Review of Denial of Reimbursement or Payment for Services

Parity for mental health and addictions services represents a significant change that will present implementation challenges for health plans and providers. As with any regulatory change, problems getting it right can be anticipated and plans to assist and respond must be put in place. To be effective, information about how to access internal member services or ombudsman assistance, appeals procedures and independent review must be made readily available to enrollees and easy to access. The MHPAEA regulations must provide guidance and standards for appeals and independent review that provide no less consumer protections than those that would exist for other health services. We recommend that the regulations specify:

- Independent review must be available to re-consider utilization management decisions within a specified time period. The appeal or review process must be communicated to patients and the requesting provider. Summary results of review decisions must be available to plan members, network providers, state regulators, and the public.

- If state law requires medical necessity criteria for various services to be publicly available without request, the state law pre-empts the federal statute.

- Otherwise covered services/treatment should be covered while an appeal is pending.

- Health plans and providers must inform consumers through an “advanced beneficiary notice” that they may be liable for the cost of services when denied or limited by management decisions.

- Health plans should not be able to deny or limit an otherwise covered service without also recommending another allowable plan of care to the patient and/or provider.

- There should be a mechanism for expedited appeal for situations in which a crisis or urgency that cannot be delayed without putting the patient at risk. Coverage should not be denied in situations where an emergency or urgency made prior approval unfeasible.

We thank you for the opportunity to comment on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Sincerely,

Pat Bridgman, Associate Director