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May 28, 2009

The U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4137-NC
P.O. Box 8017
Baltimore, MD 21244-8010

RE: Request for information- MHPAEA

To Whom it May Concern:

Kentucky Protection and Advocacy (P&A) is an independent state agency that advocates for the rights of individuals with disabilities in the state of Kentucky. We submit these comments in response to the Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 published in the Federal Register on April 28, 2009.

In enacting the MHPAEA, Congress made clear that the goal of this new law was to remedy the long history of employers and insurers not providing comparable coverage for mental health and substance use treatment versus medical and surgical benefits. In order to achieve this goal, the implementing regulations must reflect the patient/consumer focus and protective intent of this law and ensure access to care.

Kentucky P&A's response to the *Request for Information* follows:

A. Comments Regarding Economic Analysis, Paperwork Reduction Act and Regulatory Flexibility Act

2. Are there unique costs and benefits for small entities subject to MHPAEA (that is, employers with greater than 50 employees that maintain plans with fewer than 100 participants)? What special consideration, if any, is needed for these employers or plans? What costs and benefits have issuers and small employers experienced in implementing parity under State insurance laws or otherwise?

Currently, there is no provision in the new law that allows for special considerations for small entities. Kentucky P&A believes that the law should not

permit such special considerations, and that small entities that are subject to MHPAEA should be required to comply in the same manner as other plans subject to MHPAEA.

3. Are there additional paperwork burdens related to MHPAEA compared to those related to MHPA 1996, and, if so, what estimated hours and costs are associated with those additional burdens?

While acknowledging the potential for MHPAEA to create additional paperwork burdens, no consideration should be given to any additional burden associated with the costs of making a request to the federal government for exclusion from the parity requirements.

B. Comments Regarding Regulatory Guidance

1. Do plans currently impose other types of financial requirements or treatment limitations on benefits? How do plans currently apply financial requirements or treatment limitations to (1) medical and surgical benefits and (2) mental health and substance use disorder benefits? Are these requirements or limitations applied differently to both classes of benefits? Do plans currently vary coverage levels within each class of benefits?

The MHPAEA defines the term "financial requirement" as *including* deductibles, co-payments, coinsurance, and out-of-pocket expenses. The statute likewise defines the term "treatment limitation" as *including* limits on the frequency of treatment, number of visits, or days of coverage "or other similar limits on the scope or duration of treatment."

But these definitions should not be interpreted as the only treatment limitations and financial requirements to which parity applies under the new law. Other examples of treatment limitations that plans disproportionately use to limit the "scope or duration of treatment" for mental health or substance use conditions include the following:

- Prior authorization requirements that are applied more frequently and with higher standards for approval;
- More restrictive medical necessity and appropriateness criteria;
- "Fail first" policies that require consumers to suffer adverse outcomes from a preferred treatment or medication before the treatment or medication recommended by their providers will be covered;
- Exclusion of certain specialized services like collaborative care, assertive community treatment, residential treatment, and partial hospitalization;
- Higher evidence-based standards;
- More frequent restrictions on treatments due to experimental status;
- Stricter cost effectiveness requirements;
- Lower provider fees;

- Limitations on covering specific types of providers;
- More restrictive provider licensure requirements;
- More limited preferred provider networks or phantom networks with invalid phone numbers and names of providers no longer practicing or accepting new patients;
- Requirements to prove current threat of harm to self or others as the justification for inpatient care; and
- Separate deductibles or lifetime limits.

The MHPAEA regulations should clarify that the parity standard applies to these other types of treatment limitations as well. Plans that manage their mental health and substance use benefits using these techniques must do so in a nondiscriminatory way.

Regulations implementing the MHPAEA must also take into account evidence indicating mental health and substance use benefits have thus far been much more strictly managed than medical and surgical benefit. States with preexisting parity laws have not seen large increases in mental health and substance use care utilization, presumably due to strict medical management. Thus, it is critical that the regulations make clear that utilization management techniques qualify as treatment limitations and as such may not be applied to mental health and substance use benefits in a discriminatory and more restrictive fashion.

Lastly, there has been debate in the field regarding whether or not there should be a single deductible that includes both physical health care services and mental health care services, or "separate but equal" deductibles for these services. Given that the primary goals of parity legislation are to prohibit discriminatory insurance practices and affirm that mental health and substance use disorder treatments are integral components of comprehensive health care, creating discrete but equal deductibles undermines these goals by suggesting that it is necessary to treat physical and mental health services differently. Kentucky P&A strongly suggests that one single, inclusive deductible for physical health care and mental health services is necessary to avoid further discrimination.

2. What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?

The following terms and provisions should be clarified in the regulations:

- Parity means equal to or better than—The regulations should emphasize that financial requirements or treatment limitations for mental health and substance use benefits must be "no more restrictive than" those for medical and surgical benefits as stated in the MHPAEA.

- Impact on state parity laws—Clarification is needed to emphasize the continued applicability of state laws that provide for greater protection of mental health and substance use benefits.
- Application of the MHPAEA to Medicaid managed care plans—Since the 1996 parity law applied to Medicaid managed care plans, the regulations should make clear that the new parity law applies to these plans as well.
- Application of the MHPAEA to CHIP—Since the 1996 parity law applied to the Children's Health Insurance Program, the new parity which amends the old, should also apply to CHIP.
- The MHPAEA prohibits separate cost sharing and treatment limits—The statute clearly prohibits separate deductibles and other cost sharing and treatment limits but this is not well understood.

3. What information, if any, regarding the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

MHPAEA requires plans to provide the criteria they use to make medical necessity determinations to any current or potential enrollee or contracting provider upon request. Most medical necessity standards used by the health plans seem to focus on the following criteria:

- customary standards of practice—whether the treatment accords with professional standards of practice;
- evidence-based practices—whether there is sufficient evidence to demonstrate effectiveness;
- medical services—whether the treatment is considered medical as opposed to social or custodial; and
- costs—whether the treatment is considered cost-effective by the insurer.

The following additional clarifications would make these criteria better:

- Evidence from national experts should be considered if peer-reviewed literature is not available;
- Services must be available to maintain or restore function and to prevent or ameliorate medical conditions in addition to treating injuries or illnesses; and
- Cost effectiveness does not necessarily mean lowest cost.

The regulations should require plans to do the following:

- Set timeframes for disclosure of medical necessity criteria;
- Detail appeal and enforcement mechanisms;

- Make available to beneficiaries, upon request, the standards used to determine the criteria for medical necessity (e.g., standard of practice, strength of the evidence base, and definition of medical conditions) with regard to mental health and substance use treatments; and
- Make available to beneficiaries, upon request, the standards used to assess whether the medical necessity criteria have been met for medical and surgical benefits.

4. What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

Individuals should be provided with more information than is now typically received when a service is denied to them based upon medical necessity. A plain language explanation of why this particular service was not considered appropriate at this time for this person should be required. The regulations should specify that consumers may request at no charge copies of the documentation the plan used to make the coverage determination at issue; set timeframes for disclosure of reasons for claims denials; and outline the process for appealing the determinations, including time frames and enforcement mechanisms.

5. To gather more information on the scope of out-of-network coverage, the Departments are interested in finding out whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. If so, how is such coverage the same as or different than out-of-network coverage provided for medical and surgical benefits?

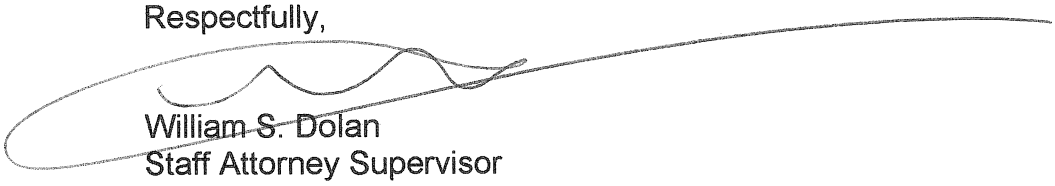
The regulations should require that plans provide information to consumers regarding the relative availability of in-network and out-of-network providers for each of the medical specialties in order to evaluate the adequacy of the networks and their equivalence.

7. Other issues?

An issue to be addressed is whether only covering mental health medications constitutes providing a mental health benefit such that the parity requirements in the MHPAEA are triggered. To exclude medications from consideration as mental health benefits would imply that the new parity requirements do not apply to this essential form of mental health treatment. This result would be inconsistent with the intent of the MHPAEA to ensure equity between mental health/substance use benefits and medical/surgical benefits.

We appreciate the opportunity to provide these comments.

Respectfully,



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