CALIFORNIA COALITION FOR MENTAL HEALTH

Submitted by email to: E-OHPSCA.EBSA@dol.gov

May 3, 2010

American Association for Marriage and Family Therapy California Division
California Alliance of Child and Family Services
California Association of Health Facilities
California Association of Marriage and Family Therapists
California Association of Mental Health Patients Rights Advocates
California Association of Social Rehabilitation Agencies
California Council of Community Mental Health Agencies
California Hospital Association
California Institute for Mental Health
California Mental Health Advocates for Children and Youth
California Mental Health Directors Association
California Mental Health Planning Council
California Network of Mental Health Clients
California Primary Care Association
California Psychiatric Association
California Psychological Association
California Society for Clinical Social Work
California Women's Mental Health Policy Council
Disability Rights California
Mental Health Association in California
Mental Health Association of Santa Barbara
NAMI California
National Association of Social Workers, California Chapter
Occupational Therapy Association of California, Inc.
Orange County Coalition for Mental Health
San Diego Coalition for Mental Health
Service Employees International Union, Local 1021
Suicide Prevention Advocacy Network, California
United Advocates for Children and Families

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

Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Attention: CMS--4140—IFC

Internal Revenue Service
Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224
Attention: REG-120692-09

RE: RIN 1210-AB30: Interim Final Rules, Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Document ID EBSA-2009-0010-0409)

To The Departments:

The California Coalition for Mental Health (CCMH), which is comprised of 29 California associations and organizations that represent providers, families and consumer of mental health services - roughly 16 million beneficiaries and insureds - would like to commend the Departments for the thorough and comprehensive interim regulations which adequately and appropriately interpret and seek and in large part succeed in implementing both the letter and the spirit of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). We believe that the interim final rules (IFR) represent the beginning of a framework to make the implementation of the MHPAEA a success that will meet the aims and goals of the authors, sponsors and supporters of this seminal Federal legislation.

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CCMH would ask that in any immediately contemplated revision that the Departments not alter the architecture of these regulations nor their terms, conditions or definitions, but seek only to clarify certain provisions - which the CCMH will comment on - with the aim of providing strengthened protections for patients who require mental health or substance use treatments and/or care and their treatment providers.

Specifically, we ask that the elements preserved in further iterations include the distinctions between financial requirements and quantitative as well as non-quantitative treatment limitations – and their related definitions - understandings absolutely necessary to successfully address discrimination in the coverage and the treatment of these disorders.

CCMH also strongly supports the approach and language embodied in these elements of the interim regulations:

- Predominant limitation applied to substantially all benefits standard
- Not more stringent/restrictive standard
- Six discrete classifications of benefits
- A single deductible for MH/SU and Medical Services
- Classification of MH/SU providers with PCPs for the purpose of determining cost sharing standards

The Departments have invited additional comments on *"whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage"* since the regulations do not define scope of services, necessary levels of care or service levels beyond the rough conceptual scheme identified in the six classes of benefits. Neither do the interim regulations address access standards nor attempt to assure a clinically appropriate continuum of care.

CCMH believes that the experience of California in implementing a mental health insurance parity statute in the last decade demonstrates that rules that define scope of benefits, access standards and appropriate continuum of care are necessary without which the legislative intent of the MHPAEA will be frustrated.

Scope of Benefits

Six classifications of benefits are identified in the IFR for the purpose of applying parity. It must be clear in the regulations that plans would be prohibited from creating further classifications beyond the scope of the parity mandate for the purposes of circumventing the parity mandate. The notion that all covered benefits are described in the universe of the six classifications should be clearly and unambiguously articulated in strengthened language. The use of the term Benefits in this instance also must be clearly identified as analogous to the scope or range of services available whether within individual classifications or within the aggregate of the six classifications.

There are a number of provisions of the MHPAEA and the IFR which requires parity in the range of services provided and each operates to clearly forbid unpermitted variation among and between the six classifications. For instance, the articulation of distinct classes of treatment limitations - i.e., quantitative as well as non-quantitative limitations - serves as an effective parsing tool to better analysis and determine the degree of parity between mental health and

medical scope of services. It is particularly critical to retain the language regarding non-quantitative treatment limitations currently in the IFT in order to assess plan compliance.

The Departments must provide clear guidance so that the obligation of the states to oversee and enforce the final regulations is effective and uniform. This will require a refined scheme of further guidance not now in the IFT so that the Departments as well as the states can perform their oversight and enforcement functions properly in a coordinated, congruent fashion consistent with the MHPAEA and IFR.

One of the most compelling reasons for this expansion beyond the current scope of the IFR lies in the fact that California is unique in having a Department of Insurance, and an Insurance Commissioner, as well as a Department of Managed Health Care with mostly contiguous but some overlapping jurisdictions. This triumvirate presents unique problems in MHPAEA and IFT oversight both at the state and federal levels, and it is one reason underscoring the need to have further guidance from the federal level.

As well, the other 49 states lack a Department of Managed Health Care so will lack the staff, expertise and perhaps even the body of regulatory and statutory authorities to address purely managed care issues – which comprise a large part of MHPAEA - another reason to provide further federal structure for those states.

The California Code of Regulations (CCR), Title 28, Section 1300.67, provides a floor for basic health care services that are required to be covered by plans and which must include selected mental health pertinent services:

- Physician Services
- Other Licensed Health Professional Services
- Inpatient Hospital Services
- Ambulatory Care Services (Outpatient Hospital Services)
- Diagnostic Laboratory and Radiological Services
- Therapeutic Radiological Services
- Home Health Services
- Preventative Health Services
- Health Education Services
- 24- Hour Emergency Health Services

On the other hand, California Health and Safety Code Section 1374.72, California's mental health parity statute, provides for the following covered services:

- Outpatient Services
- Inpatient Hospital Services
- Partial Hospitalization Services
- Prescription Drugs (if a plan contract includes prescription drug coverage)

On the other hand, there is a strong presumption that the MHPAEA would – at least for medium and large size employers – require a scope of mental health services in California no more restrictive than the CCR Title 28 regulations cited above provide for health services. Thus the health-comparable specialty mental health services would include:

- Psychiatrist Services
- Licensed Mental Health Professional Services
- Inpatient Psychiatric Services
- Day Treatment Intensive Services
- Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Adult Residential Treatment Services
- Crisis Residential Treatment Services
- Psychiatric Health Facility Services
- Case Management
- Medication and Medication Support Services
- Psychiatric Nursing Facility Services
- Electroconvulsive Therapy (ECT)

This scope of services (with the exception of ECT) is provided in CCR, Title 9 Regulations which govern California's Specialty Mental Health Medicaid Program (Medi-Cal). Not surprisingly there has been strong sentiment amongst mental health advocates supporting, and equally strong insurer and plan resistance to, this scope of services being applied to private insurance and plans. Again, although California's parity statute does not support this range of benefits, MHPAEA and IFR would require this scope of services to achieve parity.

California Health and Safety Code Section 5600 et seq provides another kind of definition of mental health services:

Any service directed toward early intervention in, or alleviation or prevention of, mental disorder including, but not limited to:

- Diagnosis, evaluation, treatment, personal care, day care, respite care, special living arrangements, community skill training, sheltered employment, socialization, case management, transportation, information, referral, consultation, and community services.
- Rehabilitation and Support Services—treatment and rehabilitation services designed to stabilize symptoms, and to develop, improve, and maintain the skills and supports necessary to live in the community.
- Services and programs designed for persons with mental disabilities should be client centered, in recognition of varying individual goals, diverse needs, concerns, strengths, motivations, and disabilities.
- Treatment and rehabilitation in the most appropriate and least restrictive setting.
- Services to meet the special needs of children and youth, adults, and older adults as well as those with dual and multiple co-occuring health, substance use, and/or health disorders.
- All services should be provided in a manner to be sensitive to cultural diversity.

Regardless of whether publicly or privately covered mental health and substance use disorders are diagnosable and respond well to treatment. However, many of the more severe disorders are chronic and appropriately addressing the various dimensions of these disorders requires a nuanced understanding and a broad range of medical, clinical and educational services.

Recovery in a mental health context, like rehabilitation in a more purely medical context, must be included as a central feature of covered services.

The MHPAEA and IFR requires that the scope of such services are subject to the "comparable and no more stringent" test as well as the "predominant and substantially all" standard. Section 5600 et seq sets out minimum standards for California public mental health services. Some clearly may have no counterpart in private health services and this is admittedly a very broad scope of services, yet this elucidation serves as a useful sort of check list to evaluate comparable private sector health services to determine the applicability to and appropriate range of mental health services in the private sector.

Access denied is parity defeated

A recent journal article which surveys the process of implementation of California's mental health insurance statute (AB 88, Thomson, 2000) concludes:

> "[California] state regulators recognized that compliance with the benefit requirements [within the California Mental Health Insurance Statute] was but one step to achieving the objectives of the parity law. More regulatory oversight was instituted about five years after the initial implementation . . . The 2008 federal parity law mandates assessments of compliance, coverage, and costs; however, experiences in California . . . . suggest that monitoring of health plan performance **should include monitoring health plan performance related to access and quality, in addition to monitoring coverage and costs . . ."**[1] (emphasis added)

Mathematica in 2002 issued a report[2] on the implementation of AB 88. The overarching intent of AB 88 was to improve access to mental health treatment for those adults and children diagnosed with the most severe, biologically-based mental disorders.

However, Mathematica reported that as early as 2000 there were widespread stakeholder community concerns (including from employers) about the adequacy of provider panels, particularly about the numbers of psychiatrists (especially child psychiatrists) available for the expanded mental health benefits mandated by AB 88. In particular Mathematica found widespread concurrence that the reported size of mental health provider networks was misleading because of the number of providers not taking new patients or only available to a very few new managed care patients. This phenomenon of large lists of providers with at best limited availability to new patients came to be called "phantom panels."

The existence of phantom panels ultimately constrains the ability of the law to overcome the stigma and discrimination associated with mental illness and substance abuse, and to improve access to mental health services. Mathematica went on to report that payment issues, i.e., low rates of reimbursement, figured significantly in reducing access to mental health services.

In concluding, Mathematica recommended further strategies to address provider unavailability and increase access to mental health services. Among those strategies were expanded efforts to

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[1] *Psychiatric Services* 60:1589–1594, December, 2009.

[2] A Snapshot of the Implementation of California's Mental Health Parity Law, March 2002, Prepared for the California HealthCare Foundation, by Mathematica Policy Research, Inc., Princeton, NJ.

recruit and re-credential psychiatrists, as well as a reduction of administrative burden on mental health providers.

California's Department of Managed Health Care (DMHC) itself has reported [3] a significant volume of complaints about phantom panels for patients seeking mental health treatment. Not surprisingly it also found that an increase in reimbursement rates to mental health professionals by itself is not enough to remedy the situation because, among other things, widely perceived administrative complexity and burdens on clinician practices as a direct result of managed care has resulted in many mental health clinicians refusing to accept or limited the number of managed care patients in their practice.

A number of conditions[4] are necessary to prevent and reverse 'flight' from managed care behavioral organizations by mental health professionals.

One, contracts must be understandable and fair. [5] Two, reimbursement rates must be fair and equitable, and meet "community standards". Three, reimbursement must be reliable and timely. Four, utilization review must be rational, evidence based, and serve the mental health needs of the patient. Five, psychiatrist and primary care physicians, and other mental health professional relationships must work in an integrated fashion that facilitates communication and coordinated care for common patients.

And six, mental health clinicians want to practice clinical disciplines not be "paper pushers" spending long periods of unpaid administrative time justifying and obtaining authorizations and processing claims. The so-called "hassle factor" causes many psychiatrists to "vote with their feet" leaving patients who believed they were insured
with the frustration of dealing with a managed care organization which has inadequate mental health resources.[6]

A pair of surveys of the San Francisco Medical Society further underscores this point with a dismal 25% - 33% rate of managed care participation among psychiatrist members of the Society.[7]

CCMH believes that resolving the issue of mental health network adequacy is of paramount importance in any attempt to increase access to care. Further, the Departments must insure that plans also demonstrate provider network sufficiency with regard to the subspecialties recognized in the mental health disciplines.

CCMH believes that this experience in California strongly supports the idea that the Departments must develop regulations addressing timely access to care. Whether or not the California model,

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[3] Department of Managed Health Care, Mental Health Parity in California Mental; Health Parity Focused Survey Project; A Summary of Survey Findings and Observations, 2006.
[4] Testimony of Lawrence Lurie, MD, Chair, American Psychiatric Association Managed Care Committee, to DMHC CAP, January 5, 2005.
[5] Managed Care Survey of members by the California Psychiatric Association, 2005.
[6] Written testimony of the California Psychiatric Association to DMHC, September 21, 2007: 2007 DMHC draft of access regulations.
[7] Access to Psychiatric Care Survey for San Francisco, Larry Lurie, MD. and Richard Shadoan, MD, San Francisco Medical Society, 2003/2005.

as represented by the Access Regulations of the DMHC[8], is appropriate on a national scale is not an issue that CCMH addresses here.

Out of Network Care

The CCMH would urge the Departments to develop further guidance relative to the issue of non-contracted providers or out of network care. A high degree of utilization of out of network care is often a function of the inadequacy of plan provider networks.

Inadequate networks can lead to delays in access to critical mental health services. Inadequate networks can also result in complete inability to obtain services on the part of beneficiaries or insureds. A factor which serves as perverse disincentives for plans to provide adequate networks is that many patients seeking mental health services give up and pay out of pocket for a non-contracted provider because obtaining a qualified mental health provider who is "in network" and who has openings to see new patients proves to be difficult, time consuming, and sometimes impossible, even for a highly motivated and sophisticated beneficiaries.

The aim of a new regulation component addressing these issues would be to provide simple, easy procedures for the patient to obtain network mental health services without long, suspenseful and anxiety provoking delays. Point of service options for patients will serve as a critical indicator of a plans network capacity and ability to provide meaningful access to services.

Plans need to be required to report in a meaningful way on the degree to which they utilize single case agreements and out of network care provided when reasonable timelines for obtaining network care are not possible for the patient. A means of capturing data about the incidence of patients who try, fail and give up needs to be developed and become required plan reporting.

The CCMH recommends that when a patient is unable to obtain timely services within reasonable elapsed time standards consistent with plan obligation to provide timely access there needs to be a further specified elapsed time period during which the plan must obtain that service for the patient. ***If the plan tries and fails to obtain that service for the patient within the specified time frame it needs to be clear that if a patient subsequently obtains the services of a provider, when the plan has an allotted time to do so and has failed to obtain a provider within those time frames, then the plan must pay the usual, customary and reasonable rate of any provider that the patient has obtained.***

The CCMH believes that such a provision serves as an incentive to plans to take steps which will ensure more robust networks of providers as well as being fair to patients who must access and utilize services. As mentioned above, an adequate provider panel in regard to subspecialties is not only a critical dimension of providing quality care and providing appropriate access to care, but of timely care.

Summing Up

The authors of the journal article note as well;

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[8] California Code of Regulations, Title 28, Section 1300.67.2.2, accessed online at http://wpso.dmhc.ca.gov/regulations/docs/regs/20/12614202231445.pdf, April 29, 2010.

> "The experience in California suggests that a limited list of diagnoses may be unnecessary for cost-containment purposes, and such a list may produce unintended consequences, such as delays in seeking treatment, incentives for "upcoding" from less severe to more severe diagnoses, and a reversal of previous practice to assign the least severe diagnosis to avoid labeling and stigma. Health plan executives indicated that managed care arrangements and medical necessity determinations allowed for adequate cost containment under parity."[9]

The Departments have wisely introduced the concept of non-quantitative treatment limitations in the IFR, and the intent of related language from the IFR seems clearly to dig deep into managed care practices to excise the effects of non-equal treatment of mental and substance use disorders relative to treatments for other health disorders. At the end of the day there should be neither distinction nor arbitrary dividing line between the body and the brain and the treatments thereof.

Randall Hagar, President

[9] *Psychiatric Services* 60:1589–1594, December, 2009