

April 28, 2010

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-4140-IFC, Interim Final Rule under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; (Vol. 75, No. 21), February 2, 2010

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the interim final rule from the Centers for Medicare & Medicaid Services, Employee Benefits Security Administration and Internal Revenue Service (referred to as “the agencies” hereafter) on the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA).

The AHA supports the parity standards set forth by the agencies in the interim final rule. The manner in which this landmark legislation is implemented will greatly impact access to and the affordability of mental health and substance use (MH/SU) disorder benefits. This interim final rule takes an important step in making certain that implementation is complete, systematic and thoughtful. Patients who suffer from these conditions are among the most vulnerable Americans, and the parity standards will help ensure that mental health and substance use benefits are treated equally in health plan benefit designs, which, in turn, will help ensure access to and the affordability of MH/SU care.



FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS

The MHPAEA prohibits group health plans and health insurers from applying financial requirements or treatment limitations to MH/SU benefits that are more restrictive than the “predominant” financial requirements or treatment limitations applied to “substantially all” medical/surgical benefits.

Under the rule, financial requirements are defined as deductibles, copayments, coinsurance and out-of-pocket maximums. There are two types of treatment limitations: quantitative (such as frequency of treatment limits) and non-quantitative (such as fail-first policies and step-therapy protocols). The regulations prohibit plans from applying cumulative financial requirements (such as deductibles) or quantitative treatment limitations (such as visit limits) for MH/SU benefits that accumulate separately from cumulative financial requirements or quantitative treatment limitations for medical/surgical benefits. **We applaud the agencies for imposing this ban, which will help ensure access to and affordability of mental health and substance use disorder health care.**

In addition, we support the agencies’ decision to essentially keep in place the current parity standard, effective since 1998, as it applies to annual and lifetime dollar limit financial requirements.

The rule acknowledges that some group health plans have lower copayments for primary care providers than for specialty care providers and that, often, MH/SU providers are defined as specialty care providers. However, the rule makes clear that there cannot be a separate classification of generalists and specialists in determining whether certain financial requirements or treatment limitations meet the MHPAEA parity requirements. **The AHA supports this provision.** As the agencies recognize, health plans commonly categorize certain MH/SU providers as specialists for purposes of applying a higher copayment level, which can have an extremely negative effect on patient access to care.

Regarding non-quantitative treatment limitations, the rule states that the processes, strategies, evidentiary standards and other factors used to apply non-quantitative treatment limitations to MH/SU benefits in a category have to be comparable to and applied no more stringently than the processes, strategies, evidentiary standards and other factors used to apply to non-quantitative treatment limitations to medical/surgical benefits in the same category. However, the agencies acknowledge that different clinical standards may be used in making these determinations. **The AHA agrees with this policy – it is reasonable to require parity as a general rule while allowing differences only where clinically appropriate.**

The agencies also solicit comments on whether it would be helpful to provide examples of how the parity analysis would be applied to non-quantitative treatment limitations.

Conducting parity analyses is not a simple task and we support the agencies providing additional examples to help ensure that they are being done correctly.

SCOPE OF SERVICES

In the rule, the agencies state that not all treatments or treatment settings for MH/SU conditions correspond to those for medical and surgical conditions, but they do not provide a formal crosswalk that links medical/surgical benefits (such as skilled-nursing facility benefits) to their corresponding MH/SU benefits (such as residential treatment benefits).

In our comment letter on the agencies' Request for Information on MHPAEA (see <http://www.aha.org/aha/letter/2009/090526-cl-cms4140-nc.pdf>), we asked that the agencies provide such a crosswalk. **We again make this request, as we believe that it will provide critical guidance to plans on how to appropriately implement parity.** Table 1 below gives our suggestions for the most appropriate linkages. While this is not an all-inclusive list of MH/SU services, it provides examples along the continuum.

Table 1: Suggested Linkages of Medical and Surgical Benefits to Their Most Analogous Mental Health or Substance Use Benefits

Medical and surgical benefit	Mental health or substance use benefit
Inpatient general acute hospital treatments	Inpatient psychiatric hospital treatments
Outpatient hospital treatments	Partial hospitalization program Intensive outpatient program Electroconvulsive therapy treatments
Skilled-nursing facility treatments	Psychiatrically based residential treatments

In addition, this type of crosswalk would encourage plans to integrate their MH/SU benefit and medical and surgical benefit structures into one benefit structure, where an inpatient hospitalization is simply considered an inpatient hospitalization, whether it is for psychiatric or general acute care. By no longer thinking of MH/SU and medical and surgical as two distinct types of health care benefits, we can make progress toward overcoming the stigma and discrimination often associated with MH/SU conditions.

This crosswalk also brings to light another issue that we request the agencies provide guidance on. Specifically, the interim final rule states that, when examining whether MH/SU benefits are being offered at parity with medical/surgical benefits, a plan must only compare benefits within the same category. The rule identifies six categories of benefits:

- Inpatient, in-network;
- Inpatient, out-of-network;

Ms. Marilyn Tavenner

April 28, 2010

Page 4 of 4

- Outpatient, in-network;
- Outpatient, out-of-network;
- Emergency care; and
- Prescription drugs.

The AHA urges the agencies to consider including a category for post-acute care, or, as an alternative, providing more instruction on which category post-acute care should fall into. At the present time, it is unclear into which category, if any, certain post-acute benefits, such as skilled-nursing facility benefits, fall. More detail would help ensure that parity is provided appropriately, as well as offer protections for providers and patients alike.

That said, the AHA strongly supports the agencies' creation of distinct categories for out-of-network benefits. These categories reflect congressional intent to apply parity to out-of-network services, which is particularly important for mental health professionals and their patients, since plan enrollees often seek mental health services out-of-network.

If you have any questions, please feel free to contact me or Joanna Hiatt, senior associate director for policy, at (202) 626-2340 or jhiatt@aha.org.

Sincerely,

Rick Pollack
Executive Vice President