



June 8, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Proposed Rule Applying the Requirements of the Mental Health Parity and Addiction Equity Act to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans (CMS-2333-P)

Dear Administrator Slavitt:

Thank you for the opportunity to comment on the Proposed Rule Applying the Requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid Managed Care Organizations (MCOs), Alternative Benefit Plans (ABPs) and the Children’s Health Insurance Program (CHIP).

The Parity Implementation Coalition (“the Coalition” or “PIC”) is an alliance of addiction and mental health consumer and provider organizations. Its members include the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine, Cumberland Heights, Hazelden Betty Ford Foundation, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, the Watershed Addiction Treatment Programs, Inc. and Young People in Recovery. In an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders, these organizations advocated for more than twelve years in support of parity legislation and are committed to the prompt and effective implementation of MHPAEA.

SUMMARY OF COMMENTS

The Parity Implementation Coalition applauds CMS for including the following provisions in the proposed rule and we urge that they be included in the final rule:

- **Alignment of Medicaid Parity with Commercial Parity**
We applaud CMS for aligning mental health and substance use disorder (MH/SUD) benefits for Americans covered by certain Medicaid plans with benefits required of private health plans and insurance. Congressional intent to apply parity protections to these plans is clear and an individual should not be denied access to non-discriminatory MH/SUD benefits simply because of the type of health coverage he or she has.

- **Application of Parity Protections to Beneficiaries MCOs & ABPS**

We applaud CMS for reaffirming that all beneficiaries who receive services through managed care organizations or under alternative benefit plans have access to MH/SUD benefits at parity regardless of whether services are provided through the managed care organization or another service delivery system. Additionally, the full scope of the proposed rule applies to CHIP, regardless of whether care is provided through fee-for-service or managed care. Again, the type of coverage an individual has should not dictate what type of access he or she has to MH/SUD benefits and we thank CMS for including this provision.

- **State Reporting Requirements**

We applaud CMS for requiring states that do not provide all services through a MCO to provide evidence of compliance with this rule when they submit MCO contracts to the CMS Regional Office for review and approval.

- **Cost Exemption and Rate Setting**

We agree with CMS that an increased cost exemption for parity is not needed and support building any increased costs associated with parity into the state's rate setting structure.

We believe that any costs associated with bringing Medicaid and CHIP coverage into compliance with parity will be minimal. We also believe, as does CMS, that proper implementation of parity may well save money as more beneficiaries will be able to access appropriate care for their MH/SUD conditions, resulting in fewer emergency department visits and hospitalizations as well as improved physical health. Building any costs associated with adding services or removing treatment limitations into the actuarially sound rate methodology is appropriate.

- **State Flexibility**

We agree states should have flexibility in how they apply parity protections across delivery systems rather than having to include all MH/SUD benefits and services in contracts.

However, the Parity implementation Coalition has concerns about the following provisions, which are summarized below and then described in greater detail:

- **Scope of Service**

Scope of service protections and examples should be clarified in the final rule.

- **Terminology**

Medicaid has different definitions of intermediate care and other terms that are used to describe MH/SUD services than the same terms that are used in the commercial sector. The Medicaid parity final rule must list and clarify key terms that are used differently in the Medicaid and commercial markets, what they mean in each setting and how this affects the parity protections offered to plan participants.

- **Long Term Care**

The PIC believes the definition of long-term care services in Medicaid must not exclude essential MH/SUD services and levels of care commonly provided in the community, including intensive outpatient, partial hospitalization and residential treatment services.

We believe excluding "long term" care services in the proposed rule violates MHPAEA and the Affordable Care Act (ACA) and the assertion that these services are not typically covered by commercial plans is incorrect.

Members of the Coalition believe the categorical exclusion of long term care misconstrues the parity requirements to mean that parity only applies to Medicaid and CHIP services that are also covered by commercial insurance. We find no basis in the statute for this interpretation and application.

- **Intermediate Care Services**

In addition to the need for definitional clarity of this term in both the Medicaid and commercial sectors, the PIC believes this should correlate with the treatment of intermediate care in the commercial parity final rule (i.e. intermediate services provided by the plan must be included in comparable classifications in both the MH/SUD and medical/surgical classifications).

To ensure compliance over the long term, states must be required to report expenditures on MH/SUD intermediate care services and comparable medical/surgical services within one year after the Medicaid parity final rule is in effect in that state.

- **Effective Date**

The PIC disagrees with the proposed effective date of 18 months after the final rule is published. Only states that can demonstrate to CMS that they cannot comply within 12 months should be allowed 18 months to comply with the final rule. CMS should include in the final rule “benchmarks” that all states must meet to show progress in implementing the regulation between release of the final rule and the day it goes into effect.

CMS should release the final rule expeditiously so all parity protections can be implemented and enforced as soon as possible.

We recommend CMS use its oversight authority to ensure requests for additional services and funding in the 18th month after the final rule goes into effect are verified by CMS and that the additional funding is necessary to ensure states are using the funds only for services necessary for parity compliance.

- **Disclosure and Compliance Methodology**

The PIC agrees with CMS that states should be required to have a compliance methodology and make that methodology available on a public website. We believe regardless of delivery system, all state or MCO parity analyses and documentation of compliance should be approved by CMS and be available on a public website so that current and future enrollees and/or their authorized representative can be informed about the extent to which enrollees will be able to access their coverage. The PIC also believes the final rule should clarify what the other federal laws governing disclosure are, including the Claims Procedure Act, the ACA and ERISA.

The PIC recommends that the final rules specify what a compliant financial requirements, quantitative treatment limitation and non-quantitative treatment limit methodology is that needs to be completed and disclosed to allow for a full parity-compliance disclosure and verification.

- **Fee for Service**

CMS must clarify in the final rule that only beneficiaries receiving both their MH/SUD and medical/surgical benefits through a fee-for- service delivery system are not provided parity protections.

- **IMD Exclusion**

The PIC supports efforts to reform the Institutions of Mental Disease (IMD) exclusion.

- **Medications**

CMS must reaffirm in its final rule that the application of more stringent treatment limitations on MH/SUD medications than those applied to other medications is a violation of federal law.

SCOPE OF SERVICE

Recommendation

Scope of service protections and examples should be clarified in the final rule and these scope protections should be consistent with MHPAEA and implementing regulations as well as the scope protections in the ACA.

Discussion

Similar to the scope protections in the 2013 MHPAEA final rule for commercial plans, the members of the PIC believe that the Medicaid proposed rule included scope protections for beneficiaries in Medicaid ABPs by reminding states/plans that beneficiaries must receive all 10 essential health benefits including: 1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance use disorder services, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) laboratory services, 9) preventative and wellness services and chronic disease management and 10) pediatric services including oral and vision care. Many of these benefit categories include long term care services and there does not appear to be any language in the ACA that would allow for permitting restrictions of MH/SUD long term care services while permitting these services for medical/surgical disorders.

PIC also believes that example 9 from the 2013 final rule (below) should be included in the Medicaid Parity final rule to help clarify for beneficiaries and plans the specific parity protections that should be applied to plan participants' benefits.

“Example 9. (i) Facts. A plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) Conclusion. In this Example 9, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of substance use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

TERMINOLOGY

Recommendation

Medicaid has different definitions of intermediate care and other terms that are used to describe MH/SUD services than the same terms that used are in the commercial sector. The Medicaid parity final rule must list and clarify key terms that are used differently in the Medicaid and commercial markets, what they mean in each setting and how this affects the parity protections offered to plan participants.

Discussion

PIC members support the inclusion of Section 428.900 entitled “Meaning of Terms” in the proposed rule. However, this list is insufficient to clarify the distinct definitions of certain terms that may have very different meanings when used in the Medicaid proposed rule versus the MHPAEA final rule.

For example, under Medicaid regulations intermediate care can mean primarily residential services/facilities often provided to individuals with intellectual disabilities. The lengths of stay can be as long as multiple years. Intermediate services in the MHPAEA final rule published in 2013 refer to a range of services that are in-between acute hospital and professional office-based services such as intensive outpatient, partial hospitalization and residential services. These services are for variable lengths of stay ranging from short term to intermediate and on occasion longer terms and do not always include room and board.

To avoid confusion, CMS should include a list of terms that have different meanings in Medicaid and commercial plans and clarify how these meanings apply in the context of parity protections provided in Medicaid and the commercial market.

LONG TERM CARE

Recommendations and Rationale

The proposed rule would exclude all long term care services from the definition of medical/surgical and MH/SUD services in the Medicaid and CHIP context. The Preamble states:

"We are also proposing that the definition of ‘medical/surgical services’ clearly exclude long term care services in the Medicaid and CHIP context." Additionally The proposed rule states, "Additional long term care services and supports, such as personal care, home and community based services, or long term psycho-social rehabilitation programs, are also commonly included in benefit packages for all or targeted populations of Medicaid and CHIP beneficiaries, **but these benefits are not typically provided in a commercial environment.**" (emphasis added)

We outline below a number of reasons why this proposed exclusion is not valid and other interpretations and examples of the proposed rule’s exclusion of long term care that would be problematic.

1. Categorical Exclusion

We strongly disagree with the proposal’s definitional exclusion and the legitimacy of the underlying rationale. We recommend that CMS provide a definition of long term care services that delineates those types of long term care services that are subject to the parity rule. This definition should also clearly state those services that are excluded and a statutory/regulatory basis for this exclusion.

First, the credibility of the CMS assertion depends entirely on how long-term care services are defined. The proposed rule does not define the term and this is highly problematic as this permits complete definitional freedom in benefit design to label a service/level of care (e.g., residential) as long term care and exclude it from the requirements of the parity rule. The categorical exclusion without a specific definition does not provide a bright line distinction or principled basis to decide between what services should be considered long term and the rationale. There are many services covered in the commercial sphere that are comparable in type of service and are both

short and long term: residential, office-based care and, home-based care. So can these be provided for medical/surgical conditions but not for MH/SUD because they are “long term care”? This opens the door for arbitrary decisions that can be wholly justified on any basis or plausible rationale that characterizes the services as long term, and it precludes any systematic basis to audit compliance with applicable MHPAEA requirements.

The Medicaid program allows for the coverage of long term care services through several vehicles and over a continuum of settings. This includes institutional care and home and community-based long term care. In fact, commercial insurers do cover many of these benefits. Recently CARF International, which accredits many medical and behavioral residential community-based services, surveyed its accredited facilities to determine which of these accept both Medicaid and commercial insurance. As you can see from the attached letter from CARF, the vast majority of their programs, both medical and behavioral, which are both short term and long term in nature, accept commercial insurance. Further, a significant portion of the commercial insurance spending is for beneficiaries with "long term" and "chronic" conditions who need and receive both long and short term care for the treatment and rehabilitation of those illnesses.

This contradicts the statement that commercial insurers do not typically reimburse for long-term care.

Second and, more importantly, under §1932(b)(8) of the Social Security Act, Medicaid MCOs and CHIP are required to comply with the requirements of MHPAEA **“to the same extent that those requirements apply to a health insurance issuer that offers group health insurance.”** To assert that services or benefits not offered in the commercial sector is a basis for exclusion under the Medicaid rule totally misconstrues and misapplies the meaning of the requirements cited above.

MHPAEA does not require that any service or benefits be offered or not offered for any specific MH/SUD. The statute provides that if the services are offered they must meet MHPAEA's requirements. Specifically, if a group health plan offers both medical/surgical benefits and MH/SUD benefits, the financial requirements or treatment limitations applicable to such MH/SUD benefits:

- Can be no more restrictive than the predominant financial requirements of treatment limitations applied to all medical and surgical benefits covered by the plan
- And there can be no separate financial requirements or treatment limitations that are applicable only with respect to mental health or substance use disorder benefits

The proposed rule's approach misconstrues the intent and substance of the parity requirements in that it de facto means that parity only applies to Medicaid and CHIP services that are also covered by commercial insurance. We find no basis in the statute for this interpretation and application. The proper interpretation of MHPAEA and 1932(b)(8) is that the parity requirements apply to all covered services/benefits in Medicaid and CHIP, and the parity requirements apply to all services/benefits covered by a commercial health plan.

We do recognize that there may be statutory or payment requirements, such as the Institutions for Mental Disease (IMD) payment prohibition, which necessitate that certain services be exempted from parity requirements, and this may be a legitimate basis for exclusion. However, there is no discussion of any relevant interplay between the proposed rule and the IMD exclusion.

In sum, the real question is the statutory legitimacy of excluding a category of undefined services/benefits on the basis that parity does not apply where there is no symmetry of services between those covered by Medicaid and a commercial arrangement. There may be some differences, but there are, in fact, many similarities within the category at issue: long term care services. So even if this was a legitimate criterion for defining services not subject to parity requirements under Medicaid it is factually incorrect. If this is considered a valid basis for distinguishing and it stands in the final Medicaid rule it may well open a Pandora's box that goes beyond the category of long term care services. Conceivably, there are other services that would not be considered long term care per se, but are not covered by commercial insurers and are covered by Medicaid plans. Within the context of the benefits classification scheme proposed, the same "principle" used to exclude long term care could be argued to exclude other services as well.

The categorical exclusion of long term care services from the benefits definition is wrong and the criteria upon which this exclusion is based is invalid. The final Medicaid rule should provide a definition of excluded benefits based on statutory or regulatory requirements and not on criteria that have no basis in MHPAEA's requirements.

2. Other Possible Interpretations of the Proposed Rule's Treatment of Long Term Care

We also believe that these other interpretations of the proposed rule's treatment of long term care would violate MHPAEA and likely the ACA. For example, if the final rule for Medicaid parity does not clarify the definition of long term care that are consistent with MHPAEA and other federal statutes, interpretations of the proposed rule could include:

- Any residential treatment (in the non-IMD category) for MH/SUD benefits for over 6 months would be considered "long term" and therefore would not be protected by parity
- All community based programs such as psychosocial rehabilitation for MH/SUD benefits would not be approved for a longer term stay (i.e. beyond 3 months) unless there is evidence of a severe and persistent mental illness or substance use disorder (but language applying this type of limitation is not required for medical and surgical disorders)
- Any community based intervention for MH/SUD would only be reimbursed if there is a concurrent utilization review at 30 days or visits and only those beneficiaries that have need of acute treatment (not long term care) can be approved for a longer stay and this requirement is not applied to medical conditions.

These examples of alternative ways to interpret the current language in the proposed rule are inconsistent with the statutory requirements of MHPAEA both on a plain reading of the statutory language as well as the intent. If any commercial insurer were to apply these exclusions they would violate MHPAEA's treatment limitations definition.

The MHPAEA statute states:

"(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) **and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.**" (emphasis added)

"(iii) Treatment limitation. - The term "**treatment limitation**" includes limits on the **frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.**" (emphasis added)

The long term care exclusions as outlined above violate the definition of a treatment limitation in that it restricts the limits on the frequency of treatment or number of visits or days and "other similar limits on the scope and duration of treatment." Additionally, it violates the treatment limit language that prohibits "no separate limitation that is applicable only with respect to mental health or substance use disorder benefits."

CMS has stated that MHPAEA applies to Medicaid MCOs if they have both medical and MH/SUD benefits. Further, CMS concluded that MHPAEA applies to CHIP and ABPs without requirement that these benefits be managed by a MCO. There is no exception in MHPAEA for an exclusion of "long term" care services from a parity protection and, to the contrary, the statute expressly prohibits this type of limitation. It would be a mistake for Medicaid, the largest insurer for the mentally ill and addicted and the only insurer for most disabled individuals with mental illness and substance use disorders, to have a double standard with a more stringent limitation for Medicaid beneficiaries as compared to individuals covered in the private sector by commercial insurers.

3. EHB and Long Term Exclusions

If the long term care language in the proposed rule stands, the long term care exclusion in the proposed rule as well as the potential interpretations are likely to be inconsistent with the EHB statutory language of the ACA in regards to the ABP population - this is clarified in the same proposed Medicaid parity regulations in which this "long term" care exclusion discriminatory language is proposed.

The proposed rule states: "In the proposed ABP parity rules, we are also proposing to add the definition of **“essential health benefits (EHB).” Since 2014, all non-grandfathered health insurance coverage in the individual and small group markets, Medicaid benchmark and benchmark-equivalent plans** (now also known as ABPs), and Basic Health Programs (if applicable) must cover EHBs, which include items and services in 10 statutory benefit categories, that are substantially equal in scope to a typical employer health plan. Consistent with the requirements set forth in 45 CFR part 156, EHBs are comprised of (1) Ambulatory patient services; (2) Emergency services; (3) Hospitalization; (4) Maternity and newborn care; (5) Mental health and substance use disorder services, including behavioral health treatment; (6) Prescription drugs; (7) Rehabilitative and habilitative services and devices; (8) Laboratory services; (9) Preventive and wellness services and chronic disease management; and (10) Pediatric services, including oral and vision care." (emphasis added)

The 10 EHB classes make no differentiation between long term and short care and there does not appear to be anything in the ACA that allows for a greater restriction on MH/SUD benefits as compared to medical/surgical benefits. Is it the intent of the proposed Medicaid parity rule to restrict these essential benefits for only MH/SUD?

4. Clinical Rationale

Numerous studies have shown that for both Medicaid and commercial insurers, the patients with chronic, long term medical and behavioral diseases drive a significant proportion of spending. Further, it is well documented that most chronic and long term medical conditions (i.e. diabetes, cancer, coronary artery disease) have significant co-morbid MH/SUD conditions which increase the medical spending from 100% to 300% as compared to those patients without a co-morbid and often long term MH/SUD. It is illogical to restrict MH/SUD services for those chronic long term illnesses that, along with similar chronic medical conditions, need both short and long term care.

If CMS moves ahead with what may result in arbitrary exclusions of long term care for MH/SUD only, the following clinical scenarios could happen:

- A person with a bipolar illness who has been seeing a psychiatrist for 2 years once a month would be denied parity protections if the state Medicaid agency or the MCO defines as long term more than one year of treatment.
- If a person with schizophrenia is being treated in an ACT team or in community based psycho social rehabilitation programs and participates periodically for several months in one year and need services the next year, that could be defined as long term and then the patient would lose their parity protections.
- A patient with diabetes who is depressed and is in need of "long term" MH/SUD treatment to help with the depression and their diabetes could be denied this care without parity protection.

INTERMEDIATE CARE SERVICES

Recommendation

In addition to the need for definitional clarity of the term “intermediate care services” in both the Medicaid and commercial sectors, the PIC believes this should correlate with the treatment of intermediate care in the commercial parity final rule (i.e. intermediate services provided by the plan must be included in comparable classifications in both the MH/SUD and medical/surgical classifications).

To ensure compliance over the long term, states must be required to report expenditures on MH/SUD intermediate care services and comparable medical/surgical services within one year after the Medicaid parity final rule is in effect in that state.

Discussion

The parity final rule states:

“The Departments did not intend that plans and issuers could exclude intermediate levels of care covered under the plan from MHPAEA’s parity requirements. At the same time, the Departments did not intend to impose a benefit mandate through the parity requirement that could require greater benefits for mental health conditions and substance use disorders than for medical/surgical conditions. In addition, the Departments’ approach defers to States to define the package of insurance benefits that must be provided in a State through EHB.

Although the interim final regulations did not define the scope of the six classifications of benefits, they directed that plans and issuers assign mental health and substance use disorder benefits and medical/surgical benefits to these classifications in a consistent manner. This general rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must assign covered intermediate mental health and substance use disorder benefits to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.

These final regulations also include additional examples illustrating the application of the NQTL rules to plan exclusions affecting the scope of services provided under the plan. The new examples clarify that plan or coverage restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services must comply with the NQTL parity standard under these final regulations.”

The parity final rule clarifies that intermediate care services do not always fit neatly into the inpatient or outpatient classifications. As a result, while not providing a definition of intermediate care services, the final rule did provide plans with the flexibility to put these services in one of the existing 6 classifications in the same way that they assign comparable medical/surgical services.

Because there is such great flexibility in the way that plans can assign and cover intermediate care services, we believe the Medicaid parity final rule must clearly articulate that parity applies to intermediate care services. The PIC is concerned that plans or states could misread the long term care provisions in the Medicaid proposed rule to deny coverage of routinely covered MH/SUD services and benefits such as intensive outpatient, partial hospitalization and residential treatment.

In response to CMS’ request for comments on the flexibility in the assignment of and definition of intermediate care services, given our Coalition’s experience with exclusions and/or lack of reimbursement for partial hospitalization and residential, post the 2013 final rule, we think aligning the treatment of intermediate care with the commercial MHPAEA final rule is appropriate in the near term. To ensure compliance over the long term, states must be required to report expenditures on MH/SUD intermediate care services and comparable medical/surgical services within one year after the Medicaid parity final rule is in effect in that state.

EFFECTIVE DATE

Recommendation

The PIC disagrees with the proposed effective date of 18 months after the final rule is published. Only states that can demonstrate to CMS that they cannot comply within 12 months should be allowed 18 months to comply with the final rule. CMS should include in the final rule “benchmarks” that all states must meet to show progress in implementing the regulation between release of the final rule and the day it goes into effect in that state.

CMS should release the final rule expeditiously so all parity protections can be implemented and enforced as soon as possible.

We recommend CMS use its oversight authority to ensure requests for additional services and funding in the 18th month after the final rule goes into effect are verified by CMS and that the additional funding is necessary to ensure states are using the funds only for services necessary for parity compliance.

Discussion

MHPAEA was signed into law by President Bush in 2008. Final regulations governing parity in the commercial health insurance market were not released until 2013, and these proposed regulations for Medicaid and CHIP were released more than five years after the last congressional action on parity. While we understand that our healthcare system is undergoing historic changes and that there have been significant demands placed on HHS and states to develop and implement regulations governing the future of health policy, we have been frustrated with the slow implementation of the parity law. If, as proposed, states are given 18 months after the finalization

of this rule to bring their Medicaid and CHIP programs into compliance with parity, it will be close to 10 years after the enactment of the parity act before all of the parity regulations are fully enforceable. This is far too much time, especially in light of the twin epidemics of suicide and overdose deaths, and we strongly encourage CMS to implement this rule as quickly as possible.

CMS has explained that states require 18 months from the finalization of the rule to bring their programs into compliance, because managed care contracts may need to be revised and state legislative action may be required before a state can come into compliance with the regulations. While we understand that states often need time to implement significant changes to their Medicaid and CHIP programs, states have known for many years that parity applied to these programs and that these programs needed to generally be in compliance, even absent regulations.

In a November 4, 2009 State Health Official Letter¹, CMS told states that “MCOs or PIHPs must meet the parity requirements of MHPAEA, as incorporated by reference in title XIX of the Act, for contract years beginning after October 3, 2009.” Regarding the application of parity to CHIP, the letter told states that “This requirement was effective as of April 1, 2009.” The letter went on to tell states that they:

“Will need to begin to assess their own compliance with the MHPAEA parity requirements prior to the issuance of MHPAEA regulations. For States that use MCOs or PIHPs to provide Medicaid benefits, a review of current contract language with the plans should occur before the next contract year begins to ensure that MHPAEA parity requirements are in place. Similarly, each State will need to review its CHIP plan to determine if the CHIP State plan imposes more restrictive requirements on mental health or substance use disorder benefits than on medical/surgical benefits.”

States were clearly made aware that their Medicaid and CHIP plans needed to meet parity requirements before the issuance of these proposed regulations, both in guidance from CMS and in the law. Section 3(d)(2) of the CHIP Reauthorization Act made it clear that states were required to make a good faith effort in both their Medicaid and CHIP programs to comply with the requirements prior to the issuance of any regulations or risk losing federal financial participation. Medicaid ABPs that have been implemented since the passage of the ACA, including all ABPs implementing the ACA’s Medicaid expansion, have had to comply with parity. CMS has repeatedly told states of the parity compliance requirement for these plans.

Because parity has already been in effect for Medicaid and CHIP plans absent the regulations, states should only need to implement the provisions of the regulations that differ in approach or detail from the guidance that has already been given to them by CMS. Therefore, we believe that full compliance should take no longer than 12 months from finalization of the rule for all or almost all states, and most states should be able to comply much sooner. We encourage CMS to shorten the timeline for compliance from 18 months from finalization to no more than 12 months, unless a state can demonstrate to CMS that meeting the requirements of the final rule in 12 months is not possible. If a state can demonstrate the genuine need for the full 18 months, CMS could extend the implementation deadline for that state, but only if that state can show that it continues to make strong progress implementing parity in the interim.

In addition to our request that compliance be required no more than 12 months after the finalization of this rule for states that cannot meet exemption criteria, we ask CMS to include in

¹ <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf>

the final rule “benchmarks” that all states must meet to show progress in implementing the regulation between release of the final rule and the day it goes into effect. Such benchmarks should include demonstrating to CMS that the state has a plan in place to bring its coverage into compliance, that all MCO contracts that are implemented or renewed before the deadline fully comply with the parity regulations, that all fee-for-service CHIP and ABP coverage meets parity requirements, and that the state has taken all steps for compliance absent some of the more time consuming steps, like renegotiating MCO contracts or passing state authorizing legislation. States and CMS should also make compliance reports public.

Similarly, we urge CMS to quickly release the final rule so all parity protections can be implemented and enforced as soon as possible.

DISCLOSURE AND COMPLIANCE METHODOLOGY

Recommendation

The PIC agrees with CMS that states and MCOs should be required to have a compliance methodology and make that methodology available on a public website. PIC members recommend that full disclosure of all documentation of compliance is required for plans covered under Sections 428.900, 440.395 and 457.496.

The PIC finds that the notice requirements for MCOs in current regulations are not sufficient for providing the detail contemplated by the MHPAEA requirement to provide a specific reason for denial regarding medical necessity denials. Further, current Medicaid regulations are not sufficient to guide how a compliance analysis should be implemented and disclosed. Medicaid beneficiaries are entitled to equivalency in this regard and while the ERISA provisions which apply under the final rule do not apply to Medicaid we recommend that CMS use its authority under 1902(a)(4) to revise those Medicaid notice provisions to provide similar requirements to those provided under 29 CFR Section 2560.503-1, in combination with 29 CFR 2590.715-2719.

Discussion

The PIC supports the language in the proposed rule that requires States to make their parity compliance plan public and to require MCOs to conduct an appropriate compliance analysis. The proposed rule states, "As proposed in §438.920, states would be required to make available to the public their methods of complying with these proposed rules within 18 months after the rule is finalized."

The proposed rule also states:

"We expect that states will include in the MCO, PIHP and PAHP contracts a methodology for the MCO, PIHP or PAHP that will establish and demonstrate compliance with parity requirements (including, in some instances, developing a crosswalk with other entities that are part of the service delivery system for enrollees). This methodology would have to ensure that all MCOs, PIHPs, or PAHPs included in the delivery system work together to ensure any MCO enrollee in a state is provided access to a set of benefits that meets the requirements of this rule regardless of the MH/SUD benefits provided by the MCO."

Despite this requirement, the PIC is concerned that without additional guidelines as to what is an appropriate compliance analysis and what of that analysis must be disclosed there will be a lack of compliance with MHPAEA. We have seen the lack of disclosure requirement specificity hamper the implementation of parity in the commercial sector and we are therefore proposing that the

final Medicaid regulations include specific guidance on what is an appropriate compliance analysis and disclosure.

CMS should add to the Medicaid final rule that the following elements are needed to complete a compliance analysis:

- **Financial Requirements and Quantitative Treatment Limits:** A complete analysis of each financial requirement and quantitative treatment limitation applied to the MH/SUD benefits as compared to the medical/surgical benefits in the same classification. Based on the Medicaid parity final rule, the plan attests that these requirements and limitations are compliant with the parity law. The MCO and/or the state Medicaid agency further affirms that these analyses are in writing.
- **Non-Quantitative Treatment Limits (NQTLs):** Each NQTL applied to a MH/SUD benefit needs to be analyzed using a two-part test that determines whether the NQTL is (1) comparable to, and (2) applied no more stringently than the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to medical/surgical benefit in the same classification.

Further, the plan or the state Medicaid agency should conduct an analysis of each NQTL applied to a MH/SUD service and compare it to the applicable medical/surgical service. The plan should attest that all of the following factors were considered and analyses and processes were conducted:

- Specific evidentiary standards relied on to evaluate any factors used in the analysis are identified and defined;
- A method to apply these specific evidentiary standards to each service category was developed, defined, identified and applied in a comparable manner;
- The results based on the analyses of the specific evidentiary standards in each service category were recorded; and
- The plan's specific findings for these service categories, and how these findings led to the conclusions regarding comparability and stringency of application are recorded.

The PIC further recommends that each state Medicaid Agency and/or MCO will attest to this process and methodology when they state that they are in compliance with MHPAEA and the Final Medicaid Parity Rules to CMS. Further, the specific analyses will be disclosed to CMS when they audit for compliance and/or will be disclosed when an adverse benefit determination has been made and the beneficiary or authorized representative appeals this adverse determination and alleges a parity violation.

Other recommendation on disclosure:

The PIC finds that the notice requirements for MCOs in current regulations are not sufficient for providing the detail contemplated by the MHPAEA requirement to provide a specific reason for medical necessity denials. Further, the current Medicaid regulations are not sufficient to guide how a compliance analysis should be implemented and disclosed.

Medicaid beneficiaries are entitled to equivalency in this regard and while the ERISA provisions which apply under the FR do not apply to Medicaid we recommend that CMS use its authority under 1902 a 4 to revise those Medicaid notice provisions to provide similar requirements to those provided under 29 CFR Section 2560.503-1, in combination with 29 CFR 2590.715-2719.

FEE FOR SERVICE

Recommendation

CMS must clarify in the final rule that only beneficiaries receiving both their MH/SUD and medical/surgical benefits through a fee-for-service delivery system are not provided parity protections.

Discussion

The Parity Implementation Coalition is pleased that the Medicaid Parity Proposed Rule affords parity protections to individuals receiving coverage through Medicaid ABPs, MCOs, CHIP, prepaid inpatient health plans (PIHPs) prepaid ambulatory health plans (PAHPS) and fee-for-service (FFS) (if such services are carved out of the scope of the MCO contract). However, the PIC believes that beneficiaries, their authorized representatives, providers and plans could benefit from a chart that explains which insurance arrangements/plans must meet parity requirements and which do not.

We found that when the MHPAEA final rule was issued, such a chart clarifying what types of plans were and were not required to comply with MHPAEA did not exist. As a result, there was much confusion among beneficiaries about whether the MHPAEA final rule applied to plans such as Medicare, Department of Defense (DoD) and the Federal Employee Health Benefits Program (FEHBP).

IMD

Recommendation

The PIC supports efforts to reform the Institutions of Mental Disease (IMD) exclusion.

Discussion

Federal law prohibiting Medicaid reimbursement for care provided in “Institutions of Mental Diseases” (IMD) excludes federal financing for care provided to patients with MH/SUD in residential facilities and psychiatric hospitals with more than 16 beds. This exclusion results in barriers for Medicaid beneficiaries who seek psychiatric hospital or residential treatment services for MH/SUD. This barrier is particularly troubling given the twin suicide and overdose epidemics currently faced in the U.S.

While the PIC understands that the IMD exclusion is a long standing payment exclusion under federal law, this exclusion is at odds with the spirit of the federal parity law. Our Coalition agrees with the analysis done by CMS in its Proposed Rule to Strengthen Care for Medicaid and CHIP enrollees that there is an acute shortage of access to care for MH/SUD services and thus the PIC supports effort to reform the IMD exclusion.

MEDICATIONS

Recommendation

The Medicaid final rule must reaffirm that the application of more stringent quantitative and non-quantitative treatment limitations on MH/SUD medications than those applied to medical/surgical medications are violations of federal law.

Discussion

PIC members appreciate that federal agencies, including CMS, have issued bulletins on improving access to addiction medications, but that guidance is insufficient. State Medicaid programs are still often imposing discriminatory limitations on medications for mental health and particularly substance use disorders.² Such restrictions may include, but are not limited to:

- Limits on dosage not based on clinical guidelines;
- No coverage of one or two of only three Food and Drug Administration (FDA) approved medications to treat opiate/alcohol dependence;
- Lifetime limits on certain addiction medications unlike other medications covered under the plan;
- Complex initial prior authorization and reauthorization requirements that become more stringent with each reauthorization period; and
- Limited coverage for counseling while requiring counseling as a preauthorization/reauthorization requirement.

Since there are so few medications approved to address the opioid misuse and overdose epidemic, the final rule must clarify that states must cover all FDA-approved medications for addiction. We also request that CMS monitor claims data to quickly identify and remedy discriminatory coverage and access barriers to medications that treat mental illness and addiction.

CONCLUSION

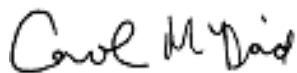
The Parity Implementation Coalition looks forward to working with CMS as it issues and implements a Medicaid parity final rule.

Please contact Sam Muszynski (IMuszynski@psych.org) or Carol McDaid (cmcdaid@capitoldecisions.com), Co-Chairs of the Parity Implementation Coalition, if you have any questions or if we can be of further assistance.

Sincerely,



Irvin L. Muszynski, JD
Co-Chair, Parity Implementation Coalition



Carol McDaid
Co-Chair, Parity Implementation Coalition

² Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment. American Society of Addiction Medicine, 2013. <http://www.asam.org/advocacy/aaam>

June 5, 2015

Carol McDaid
 Co-Chair
 Parity Implementation Coalition
 101 Constitution Ave. NW
 Suite 650 East
 Washington, DC 20001

Dear Ms. McDaid:

Please find attached descriptions for CARF-accredited program categories that are “long-term care” in nature, outside the boundaries of nursing home care, and have revenue streams from both Medicaid and commercial insurance for payment of services. It is our understanding that this information may help provide clarity to what is defined as “long-term care” as it relates to the application of The Mental Health Parity and Addiction Equity Act (MHPAEA) and a current request for comments on CMS-2333-P, Application of MHPAEA to Medicaid and CHIP.

The following is an illustrative listing of programs currently accredited by CARF, extracted from our database on the funding sources identified by the providers, as long term in nature, for those specific programs and when the payers for such services are both Medicaid and commercial insurance payers.

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I hope this information is constructive to your efforts.

Regards,

Brian J. Boon, Ph.D.
 President/CEO

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Behavioral Health

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is a multidisciplinary team approach that assumes responsibility for directly providing acute, active, and ongoing community-based psychiatric treatment, assertive outreach, rehabilitation, and support. The program team provides assistance to individuals to maximize their recovery, ensure consumer-directed goal setting, assist the persons served to gain hope and a sense of empowerment, and provide assistance in helping the persons served become respected and valued members of their community. The program provides psychosocial services directed primarily to adults with severe and persistent mental illness who often have co-occurring problems, such as substance abuse, or are homeless or involved with the judicial system.

The team is the single point of clinical responsibility and is accountable for assisting the person served to meet his or her needs and to achieve his or her goals for recovery. Multiple members of the team are familiar with each person served to ensure the timely and continuous provision of services. Services are provided on a long-term care basis with continuity of caregivers over time. The majority of services are provided directly by ACT team members, with minimal referral to outside providers, in the natural environment of the person served and are available 24 hours a day, 7 days per week. Services are comprehensive and highly individualized and are modified as needed through an ongoing assessment and treatment planning process. Services vary in intensity based on the needs of the persons served.

Assertive Community Treatment has been identified as an effective model for providing community-based services for persons whose needs and goals have not been met through traditional office-based treatment and rehabilitation services. Desired outcomes specific to ACT services may include positive change in the following areas: community tenure, independent living, quality of life, consumer satisfaction of the person served, functioning in work and social domains, community integration, psychological condition, subjective well-being, and the ability to manage his or her own health care.

In certain geographic areas, Assertive Community Treatment programs may be called Community Support programs, Intensive Community Treatment programs, Mobile Community Treatment Teams, or Assertive Outreach Teams.

Community Integration (COI)

Community integration is designed to help persons to optimize their personal, social, and vocational competency in order to live successfully in the community. Activities are determined by the needs of the persons served. The persons served are active partners in all aspects of these programs. Therefore, the settings can be informal in order to reduce barriers between staff members and program participants. In addition to services provided in the home or community, this program may include a psychosocial clubhouse, a drop-in center, an

activity center, or a day program.

Community integration provides opportunities for the community participation of the persons served. The organization defines the scope of these services based on the identified needs and desires of the persons served. A person may participate in a variety of community life experiences that may include, but are not limited to:

- Leisure or recreational activities.
- Communication activities.
- Spiritual activities.
- Cultural activities.
- Vocational pursuits.
- Development of work attitudes.
- Employment activities.
- Volunteerism.
- Educational and training activities.
- Development of living skills.
- Health and wellness promotion.
- Orientation, mobility, and destination training.
- Access and utilization of public transportation.

Note: The use of the term persons served in Community Integration may include members, attendees, or participants.

Day Treatment (DT)

Day treatment programs offer person-centered, culturally and linguistically appropriate, comprehensive, coordinated, and structured treatment services and activities. A day treatment program consists of a scheduled series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency in order to assist the persons served in achieving the goals identified in their person-centered plans. Day treatment programs are offered four or more days per week, typically with support available in the evenings and on weekends. A day treatment program may prevent or minimize the need for a more intensive level of treatment. It may also function as a step-down from inpatient care or partial hospitalization or as transitional care following an inpatient or partial hospitalization stay to facilitate return to the community.

Inpatient Treatment (IT)

Inpatient treatment programs provide coordinated and integrated services in freestanding or

hospital settings. Inpatient treatment programs include a comprehensive, biopsychosocial approach to service delivery. There are daily therapeutic activities in which the persons served participate. Inpatient treatment is provided 24 hours a day, 7 days a week. The goal of inpatient treatment is to provide a protective environment that includes medical stabilization, support, treatment for psychiatric and/or addictive disorders, and supervision. Such programs operate in designated space that allows for an appropriate medical treatment environment.

Integrated Behavioral Health/Primary Care (IBHPC)

Integrated Behavioral Health/Primary Care programs have an identified level of medical supervision and are supported by an “any door is a good door” philosophy. These programs allow for choice and are capable of assessing the various medical and behavioral needs of persons served in an integrated manner. Programs demonstrate competency to identify and treat behavioral health concerns, such as mental illness and substance use disorders, and general medical or physical concerns in an integrated manner. Integration is the extent to which care is coordinated across persons, functions, activities, and sites over time to maximize the value of services delivered to persons served. Programs may also serve persons who have intellectual or other developmental disabilities and medical needs, or those who are at risk for or exhibiting behavioral disorders.

Models may include, but are not limited to, the following: contractual, where two separate, legal entities enter into an agreement to staff and operate a single program either at a location specifically identified for the provision of integrated care or located within another institution (such as a school-based health center); a distinct, integrated program located within a larger entity such as a Veterans Health Administration campus; the colocating of complementary disciplines such as the placement of behavioral staff in a primary care setting (as in a federally qualified health center) or primary care staff in a community mental health center; or a single organization that incorporates both behavioral health and primary care services into an integrated model. Although most integrated models focus on primary care, the standards could also be applied to an integrated system located in specialty care settings such as Ob-Gyn and HIV.

Intensive Outpatient Treatment (IOP)

Intensive outpatient treatment programs are clearly identified as separate and distinct programs that provide culturally and linguistically appropriate services. The intensive outpatient program consists of a scheduled series of sessions appropriate to the person-centered plans of the persons served. These may include services provided during evenings and on weekends and/or interventions delivered by a variety of service providers in the community. The program may function as a step-down program from partial hospitalization, detoxification, or residential services; may be used to prevent or minimize the need for a more intensive level of treatment; and is considered to be more intensive than traditional outpatient services.

Outpatient Treatment (OT)

Outpatient treatment programs provide culturally and linguistically appropriate services that include, but are not limited to, individual, group, and family counseling and education on wellness, recovery, and resiliency. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity. Outpatient programs may address a variety of needs, including, but not limited to, situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, and substance use disorders and other addictive behaviors.

Partial Hospitalization (PH)

Partial hospitalization programs are time limited, medically supervised programs that offer comprehensive, therapeutically intensive, coordinated, and structured clinical services. Partial hospitalization programs are available at least five days per week but may also offer half-day, weekend, or evening hours. Partial hospitalization programs may be freestanding or part of a broader system but should be identifiable as a distinct and separately organized unit.

A partial hospitalization program consists of a series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency. Partial hospitalization programs are typically designed for persons who are experiencing increased symptomatology, disturbances in behavior, or other conditions that negatively impact the mental or behavioral health of the person served. The program must be able to address the presenting problems in a setting that is not residential or inpatient. Given this, the persons served in partial hospitalization do not pose an immediate risk to themselves or others. Services are provided for the purpose of diagnostic evaluation; active treatment of a person's condition; or to prevent relapse, hospitalization, or incarceration. Such a program functions as an alternative to inpatient care, as transitional care following an inpatient stay in lieu of continued hospitalization, as a step-down service, or when the severity of symptoms is such that success in a less acute level of care is tenuous.

Residential Treatment (RT)

Residential treatment programs are organized and staffed to provide both general and specialized nonhospital-based interdisciplinary services 24 hours a day, 7 days a week for persons with behavioral health disabilities or co-occurring disabilities, including intellectual or developmental disability. Residential treatment services are organized to provide environments in which the persons reside and receive services from personnel who are trained in the delivery of services for persons with behavioral health disorders or related problems. Residential treatment may be provided in freestanding, nonhospital-based facilities or in clearly identified units of larger entities, such as a wing of a hospital. Residential treatment programs may include domestic violence treatment homes, nonhospital addiction treatment centers, intermediate care facilities, psychiatric treatment centers, or other nonmedical settings.

Medical Rehabilitation

Comprehensive Integrated Inpatient Rehabilitation Program

A Comprehensive Integrated Inpatient Rehabilitation Program is a program of coordinated and integrated medical and rehabilitation services that is provided 24 hours a day and endorses the active participation and preferences of the person served throughout the entire program. The preadmission assessment of the person served determines the program and setting that will best meet the needs of the person served. The person served, in collaboration with the interdisciplinary team members, identifies and addresses his or her medical and rehabilitation needs. The individual resource needs and predicted outcomes of the person served drive the appropriate use of the rehabilitation continuum of services, the provision of care, the composition of the interdisciplinary team, and discharge to the community of choice.

The scope and intensity of care provided are based on a medical and rehabilitation preadmission assessment of the person served. An integrated interdisciplinary team approach is reflected throughout all activities. To ensure the transparency of information the program provides a disclosure statement to each person served that addresses the scope and intensity of care that will be provided.

A Comprehensive Integrated Inpatient Rehabilitation Program clearly identifies the scope and value of the medical and rehabilitation services provided. Dependent on the medical stability and acuity of the person served, a Comprehensive Integrated Inpatient Rehabilitation Program may be provided in a hospital, skilled nursing facility, long-term care hospital, acute hospital (Canada), or hospital with transitional rehabilitation beds (Canada). Through a written scope of services, each program defines the services provided, intensity of services, frequency of services, variety of services, availability of services, and personnel skills and competencies. Information about the scope of services and outcomes achieved is shared by the program with stakeholders.

Outpatient Medical Rehabilitation Program

An Outpatient Medical Rehabilitation Program is an individualized, coordinated, outcomes-focused program that promotes early intervention and optimizes the activities and participation of the persons served. The program, through its scope statement, defines the characteristics of the persons it serves. An assessment process initiates the individualized treatment approach for each person served, which includes making medical support available based on need. The program includes direct service provision, education, and consultations to achieve the predicted outcomes of the persons served. Information about the scope and value of services is shared with the persons served, the general public, and other relevant stakeholders.

The strategies utilized to achieve the predicted outcomes of each person served determine whether the individual program is single discipline or an interdisciplinary service. A Single Discipline Outpatient Medical Rehabilitation Program focuses on meeting the needs of persons served who require services by a professional with a health-related degree who can address the assessed needs of the person served. An Interdisciplinary Outpatient Medical Rehabilitation

Program focuses on meeting the needs of persons served that are most effectively addressed through a coordinated service approach by more than one professional with a health-related degree who can address the assessed needs of the person served.

The settings for Outpatient Medical Rehabilitation Programs include, but are not limited to, health systems, hospitals, freestanding outpatient rehabilitation centers, day hospitals, private practices, and other community settings.

Home and Community Services

Home and Community Services (HCS) are person centered and foster a culture that supports autonomy, diversity, and individual choice. Individualized services are referred, funded, and/or directed by a variety of sources. In accordance with the choice of the person served, the services provided promote and optimize the activities, function, performance, productivity, participation, and/or quality of life of the person served.

The Home and Community Services may serve persons of any ages, from birth through end of life. Services may be accessed in a variety of settings including, but not limited to, private homes, residential settings, schools, workplaces, community settings, and health settings. Services are provided by a variety of personnel, which may include health professionals, direct support staff, educators, drivers, coaches, and volunteers and are delivered using a variety of approaches, supports, and technology.

Services are dynamic and focus, after a planning process, on the expectations and outcomes identified by both the person served and the service providers. The service providers are knowledgeable of care options and linkages to assist the person served; use resources, including technology, effectively and efficiently; and are aware of regulatory, legislative, and financial implications that may impact service delivery for the person served. The service providers are knowledgeable of their roles in and contribution to the broader health, community, and social services systems.

Home and Community Services must include at least one of the following service delivery areas:

- Services for persons who are in need of specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need.
- Services for persons who need assistance to access and connect with family, friends, or co-workers within their homes and communities.
- Services for persons who need or want help with activities in their homes or other community settings.
- Services for caregivers that may include support, counseling, education, respite, or hospice.

Note: A service provider seeking accreditation for Home and Community Services is not required to provide all four of the service delivery areas identified in the service description.

However, it must include in the site survey all of the service delivery areas it provides that meet the service description.

Interdisciplinary Pain Rehabilitation Program

An interdisciplinary pain rehabilitation program provides outcomes-focused, coordinated, goal-oriented interdisciplinary team services. The program delivers services that focus on the unique needs of persons who have persistent pain, including:

- Minimizing impairments and secondary complications.
- Reducing activity limitations.
- Maximizing participation and quality of life.
- Decreasing environmental barriers.

An interdisciplinary pain rehabilitation program recognizes the individuality, preferences, strengths, and needs of the persons served, their families/support systems, and stakeholders. The program encourages appropriate use of healthcare systems and services by the persons served and their families/support systems and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

An interdisciplinary pain rehabilitation program fosters an integrated system of care that optimizes prevention, recovery, adaptation, inclusion, and participation. The program utilizes current research and evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in pain research.

A program seeking accreditation as an interdisciplinary pain rehabilitation program must include in the survey application and the site survey all portions of the program (inpatient, outpatient, etc.) that the organization provides and that meet the program description.

Residential Rehabilitation Program

Residential Rehabilitation Programs are provided for persons who need services designed to achieve predicted outcomes focused on home and community integration and engagement in productive activities. Consistent with the needs of the persons served services foster improvement or stability in functional and social performance and health. These programs occur in residential settings and may be transitional or long term in nature. The residences in which the services are provided may be owned or leased directly by the persons served or the organization.

Opioid Treatment Program

Outpatient Treatment (OT)

Outpatient treatment programs provide culturally and linguistically appropriate services that include, but are not limited to, individual, group, and family counseling and education on wellness, recovery, and resiliency. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity. Outpatient programs may address a variety of needs, including, but not limited to, situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, and substance use disorders and other addictive behaviors.