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Comment On: IRS-2009-0008-0119
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General Comment

We've attached our comments in the pdf file submitted, below.

Attachments

IRS-2009-0008-0148.1: Comment on FR Doc # 2010-02166

ParitasHealth

May 3, 2010

Our thanks to the Departments of The Treasury, Labor, and Health and Human Services for the opportunity to comment a second time on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, also known as the MHPAEA. We are principals and co-owners of ParitasHealth, a firm providing consultation and training on mental health parity compliance. Our blog is located at www.paritas-health.com. As health care consultants with advanced degrees in psychology and the law, our experience includes development of behavioral health care networks for most states in our nation, leadership for mental health parity preparation and administration, and compliance consultation for major health plans throughout the United States.

The Interim Final Rules issued for the MHPAEA have requested comments on the scope and definitions of non-quantitative means for management of health and behavioral health benefits. We provide our comments below under two general categories, *"Scope"* and *"Non-quantitative Means."*

SCOPE

1. Health plans and payors often provide behavioral health coverage, with quantitative limits, for services not specifically listed in the Interim Final Regulations' six classifications. These behavioral health benefit designs often include coverage for intensive outpatient programs, partial hospitalization programs, in-home therapy, and residential treatment. Guidance would be desirable to ascertain if MHPAEA mandates coverage of these services. ***If MHPAEA does mandate such coverage, a "care-continuum crosswalk" specifying the equivalent medical services would aid plans and payors with uniform compliance across the care continuum.*** For example, such a "crosswalk" might identify that outpatient facility care could be considered the medical equivalent to intensive outpatient care, and home health visits could be the medical equivalent of in-home psychiatric nursing visits or in-home psychotherapy visits. The "crosswalk" would provide guidance for plans seeking to provide benefits for a continuum of behavioral health services, comparable to the continuum of other, covered health services.
2. Some states mandate coverage for services, but with a day or dollar cap. In some instances, the mandated services are outside the six classifications referenced in the Interim Final Rules. The question that we have is whether those state caps will still stand, given MHPAEA. For example, if a state mandates coverage for residential care for substance abuse or mental health conditions, with a quantitative (dollar or day limit) cap, will the payor now be required to offer a residential benefit with a less stringent cap? ***Examples of scope and duration of services not referenced in the six classifications,***

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but referenced in state parity mandates, could promote consistent compliance with the MHPAEA.

NON-QUANTITATIVE MEANS

1. Some plans are introducing Value Based Insurance Design (VBID) for select medical conditions, such as diabetes and hypertension. VBID has been defined as "**A methodology for identifying clinically beneficial screenings, lifestyle interventions, medications, immunizations, diagnostic tests and procedures, and treatments for which co-payments or coinsurance should be adjusted or eliminated due to their high value and effectiveness when prescribed for particular clinical conditions.**"[1] A fundamental purpose of VBID is to decrease financial barriers to purchasing "high value" services, with the goal of improving patient adherence and avoiding higher, future medical costs. Such plans often offer patients lower copays for services and medications, contingent upon participation in, for example, a disease management program. ***If a plan offers VBID for one or more medical conditions, are they obligated under MHPAEA to offer such a benefit for one or more behavioral health conditions?*** Additional examples using VBID could provide further clarification.
2. Further guidance is requested regarding the role of Employee Assistance Plans ("EAPs") as gatekeepers or gateways to care. The Interim Final Rules specify that requiring a consumer to exhaust the EAP benefit before using his/her major medical program's behavioral health benefits would be a violation, unless a similar process applies for medical/surgical benefits. But what if notification, or screening, by the EAP, is required? If a patient's plan doesn't require the patient to contact their PCP before non-emergent care, would requiring a patient to call their EAP, before receiving non-emergent behavioral health care, be considered a violation? ***The current rules aren't clear about EAP notification or telephonic or face-to-face screening by the EAP. These are common practices, particularly among self-insured companies.*** Additional examples regarding EAPs could promote compliance.
3. Finally, we would like to comment regarding non-quantitative tools and practices used to manage behavioral health care. We are concerned that synchronization of behavioral health medical necessity criteria with other health medical necessity criteria will result in less emphasis being placed on psychosocial factors as discharge determinants. Insufficient emphasis on psychosocial criteria may result in increasing re-admissions, to the detriment of the Member and the plan or payor. ***Examples of tools that address***

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[1] Fendrick, A. Mark, "Value-Based Insurance Design: Returning Health and Wellness to the Health Care Cost Debate," presentation at http://www.nypsystem.org/pdf/Mark_Fendrick.pdf, University of Michigan Center for Value-Based Insurance Design (http://www.vbidcenter.org/).

psychosocial criteria, such as the ASAM criteria[2] for addictions and the LOCUS criteria[3], may be helpful. Similarly, synchronization of behavioral health case or care management practices with deficit-oriented, "medical model" case management practices could slow the adoption of recovery-oriented care management. The President's New Freedom Commission on Mental Health[4] has advocated for the adoption of recovery-oriented care models emphasizing Consumer strengths and empowerment. ***Examples of model practices could further clarify the variations in case management that are permissible.***

Please contact us at mhennessey@paritas-health.com if additional information would be helpful.

Respectfully submitted,

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[2] *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders,* (Second Edition - – Revised), April, 2001.

[3] *Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version 2010,* American Association of Community Psychiatrists, March 20, 2009.

[4] *Achieving the Promise: Transforming Mental Health Care in America.* The President's New Freedom Commission on Mental Health, July, 2003.