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Comment On: IRS-2009-0008-0120
Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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Submitter Information

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General Comment

See attached file(s)

Attachments

IRS-2009-0008-0157.1: Comment on FR Doc # 2010-02167

NEW DIRECTIONS
BEHAVIORAL HEALTH
2020 W. 89th Street, Ste. 200
Leawood, KS 66206

May 3, 2010

Submitted via Federal eRulemaking Portal: http://www.regulations.gov

The Honorable Hilda Solis
Secretary, U.S. Department of Labor
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
200 Constitution Avenue, NW
Washington, DC 20210
Attention: RIN 1210-AB30

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201
Attention: CMS—4140-IFC

The Honorable Timothy Geithner
Secretary, U.S. Department of the Treasury
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224
Attention: REG-120692-09

RE: Comments on Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Dear Mr. and Mmes. Secretary:

New Directions Behavioral Health appreciates the opportunity to comment on the Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, published in the February 2, 2010 Federal Register.

New Directions is a managed behavioral health organization (MBHO) that manages approximately 2 million lives throughout the country. Our company began in 1995, and we've experienced much growth in our ability to manage members with mental health and substance use disorder (MH/SUD) conditions. We are known for being very innovative in our practices as reflected by several national awards, which have included URAC Best Practices in Health Consumer Empowerment and Protection and NCQA HEDIS Update and Best Practices Improving Patient Safety. The Vision of New Directions is to facilitate access to services, while focusing on prevention as our predominant paradigm for management of care.

New Directions is concerned that the nonquantitative treatment limitation related to medical management is being interpreted as restricting how MH/SUD conditions can be managed. We believe the results will be devastating for members with MH/SUD conditions because of the unintended consequences of this Rule.

- **Uniqueness of MH/SUD Conditions**

We perceive a lack of understanding of the unique qualities of MH/SUD conditions, and how different they are from medical/surgical (M/S) conditions. The goal of managing care for MH/SUD conditions is to insure that members timely access the most appropriate type of provider, e.g., psychiatrists for medication or behavioral health therapists for talk therapy, in the most appropriate environment. In practice, medical management processes for MH/SUD conditions are typically used to determine what is the appropriate level of care, not whether treatment is needed, and how quickly treatment is needed.

Most plans don't extensively manage M/S conditions because they are self-limiting. Visit limits may be imposed as management on certain types of treatment, such as physical therapy. Significant differences in the management processes reflect the distinct differences between these conditions, not an intent to limit access to MH/SUD services.

- **Management of MH/SUD Conditions Improves Access and Quality And Is Not A Treatment Limitation**

While managing MH/SUD conditions also lowers costs, this results from more appropriate utilization of services and higher quality services being provided, not decreased access to services. In fact, in the Supplementary Information to the Interim Final Rules for Parity, these statements are made:

> "Since the early 1990s, many health insurers and employers have made use of specialized vendors, known as behavioral carve-outs to manage their mental health and substance abuse benefits. These vendors have specialized expertise in the treatment of mental and addictive disorders in organized specialty networks of providers. ... They use information technology, clinical algorithms and selective contracts to control spending on mental health and substance abuse treatment. There is extensive literature that has examined the cost savings and impacts on quality of these organizations. ... Also, it appears that the rate of utilization in mental health care rises under behavioral health carve-out arrangements."

75 FR 5410, 5422 (2010).

- **Applicability of Least Restrictive Environment Principle**

Utilizing the "least restrictive environment" principle requires that in determining the appropriate level of care for members with MH/SUD conditions, they are placed in the least restrictive environment. This is based on the premise that persons should not be deprived of their liberties or freedom except when absolutely required and to the minimal level necessary. For example, when patients are placed in an inpatient mental health unit, frequently the doors are locked, there are limitations on visitors, time is very structured, they are deprived of personal possessions, and may

even be limited in what they can wear. Additionally, there is a significant stigma placed on members who require inpatient treatment for MH/SUD conditions. As a result, there is an emphasis on limiting the number of days that a member has to be hospitalized. The treatment goal is to determine when it is appropriate to transition the member to an intermediate level of care, such as partial hospitalization or intensive outpatient treatment.

- **Impaired Ability to Navigate Health Care System**

Members who have an MH/SUD condition are often impaired in their ability to think, to make decisions, or to make informed decisions. This creates challenges in navigating the health care system. The MBHO facilitates scheduling appointments for members with the most appropriate provider and within a time frame that is based upon the urgency of the condition. Follow-up calls are then made to verify that appointments are kept, whether medications are being taken, and to assess how the member is doing. Home visits can be arranged as necessary or other assistance offered so that treatment can be appropriately accessed.

- **Coordination of Care**

Many MH/SUD conditions are chronic or long term, with acute episodes along the way. Depending on the stage of the condition, this may require inpatient treatment, intermediate level of services, or outpatient treatment. Frequently, medications are prescribed by a psychiatrist. Because many intermediate level and outpatient therapies are delivered by behavioral health therapists, such as advance practice registered nurses, social workers, and licensed professional counselors, coordinating care among the member's primary care physician, psychiatrist, and behavioral health therapist is critical, and a primary role of MBHOs.

If there are isolated cases of companies attempting to do so based on inappropriate processes, they need to be held accountable. But where there is clinical justification based on outcomes and quality measures, those management processes must be allowed.

- **FEHBP Has Increased Management of MH/SUD Conditions**

In 2001, the Federal Employees Health Benefits Program (FEHBP) implemented full parity of MH/SUD benefits. Plans were encouraged to manage these benefits to expand coverage costs effectively while maintaining quality services. U.S. Office of Personnel Management, Mental Health and Substance Abuse Parity Frequently Asked Questions (http://www.opm.gov/insure/archive/health/consumers/parity/faq.asp). Initially, FEHBP required preauthorization after the 8th outpatient visit for MH/SUD benefits. That was changed in 2009 and now preauthorization is required for <u>any</u> MH/SUD outpatient visit, except for medical management and psychological testing.

Recommendation: Modify Rule To Clearly Allow Clinically Justified Management of MH/SUD Conditions

New Directions generally recommends requiring preauthorization after the 8th outpatient visit with a behavioral health therapist since many acute episodes resolve within that number of visits, and not requiring preauthorization for medical management with a psychiatrist. Preauthorization is typically required for inpatient services so that, along with determining the medical necessity of inpatient

services, the member's outpatient providers can be notified, and appropriate discharge planning is coordinated and accomplished.

New Directions believes managing MH/SUD conditions based on clinically justified processes that are unique to MH/SUD results in more appropriate access to services, more appropriate quality of care being rendered, and better treatment outcomes. Imposing management on M/S conditions when not clinically justified is inappropriate. Thus, there should not be strict parity required because medical management processes are not inherently treatment limitations.

Thank you for the opportunity to comment on these Interim Final Rules and for considering our suggested recommendations. If you have any questions, please contact me at jquick@ndbh.com or 913.982.8111.

Sincerely,

John F. Quick, PhD
President and CEO