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Regulations Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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## General Comment

Carolina Behavioral Health Alliance appreciates the opportunity to submit the attached questions and comments regarding the recent published regulations for the Mental Health Parity and Addictions Equity Act.

## Attachments

**IRS-2009-0008-0133.1:** Comment on FR Doc # N/A

As a small MBHO owned by three North Carolina medical schools and a proponent for mental health parity, I must comment on the interpretation of the law outlined in the Interim Final Regulations.
The medical schools entered into the behavioral health managed care business to assure that health care dollars were being spent on health care and not Wall Street. Our philosophy has been to "to the right things for the right reasons" by making sure patients get efficient and effective care at the right level, that providers are paid adequately and that we are good stewards of the health plans resources.

We were delighted when the parity bill passed so that those suffering from brain disorders could get the care they so deserve; however, the interim regulations interpretation of the law could mean less care for these folks rather than more care. Interpreting the law to include non quantitative limitations such as utilization review for outpatient services (or levels of services not reviewed on the medical side) will prevent directing patients to the most appropriate provider and level of care as well as prevent reviews that assure continued services meet medical necessity criteria, resulting in exorbitant costs for health plans and poorer outcomes for patients. More is not necessarily better when treating mental illness and some providers will take advantage of this and create patient dependency on the therapist. To equate therapist with primary care physicians (the most likely predominant medical outpatient provider) is not based on sound judgment. Equating psychiatrist with PCP is an equitable comparison but therapist should be equated with therapist on the medical side and not with PCPs. By giving therapist an open checkbook with no oversight will lead to some therapist seeing patients two, three times a week for years when there is no evidence to substantiate this intensive level care. It would be cost prohibitive to review all potential benefit abuse retrospectively and would require medical chart reviews by psychiatrists.

If a MBHO has contracts with in-network providers that have agreed to pre-authorization and utilization review procedures but hold the patient harmless to no more charges than their copays, coinsurance and OOP costs, will these contracts be negated by these regulations and if so how can the government override contracts between two private entities.

Under the Federal Register /Vol. 75, No. 21/Tuesday, February 2, 2010/ Rules and Regulations on page 5436 under (4)(ii)(C) it states non quantitative treatment limitations include "Standards for provider admission to participate in a network, including reimbursement rates" Please explain what "including reimbursement rates" means. Surely it does not mean that reimbursement rates must be on par with medical reimbursement rates. Would this not be price fixing if a carve-out MBHO had to share its rates with medical vendors or vice versa?

Can a plan waive the deductible for mental health and substance use disorders even though a deductible is applied on the medical benefits?

The regulations promote the value of MBHOs management of behavioral health benefits in containing costs under a parity benefit but then deny the continued use of management

procedures that are not also performed under the medical benefit. If this is the case, health plans will find other ways of containing costs, such as only covering a few specific diagnoses or possibly dropping behavioral health coverage all together. This could end up with enrollees having less coverage rather than equal coverage and could increase indirect costs to employers through increased absenteeism, increased presenteeism, loss productivity, disability claims, worker's compensations, etc.

The costs of just implementing these regulations will be overwhelming to health plans and then once implemented their cost will more than likely rise exponentially causing plans to take drastic measures in order to continue offering any health plan coverage. Let's not throw out the baby with the bath water!!

Judy Briggs
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