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BEHAVIORAL HEALTH SYSTEMS

Behavioral Healthcare Programs for Business & Industry Since 1989

May 3, 2009

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4140-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Re: Comments on Interim Final Regulation
Mental Health Parity and Addiction Equity Act of 2008

Dear Sirs:

Behavioral Health Systems (BHS) was formed in 1989 as a privately held Alabama corporation. We created and administer a preferred provider organization (PPO) of mental health-related hospitals, physicians and professionals. BHS markets this PPO to large, private employers under a "carve-out" arrangement, through which BHS administers their employees' mental health/substance abuse benefits. BHS staff oversees the care provided through this network, and processes all claims between the employer client and BHS providers.

BHS is an open-model PPO which contracts with a broad network of specialty providers on a negotiated fee-for-service basis. This ensures maximum freedom of choice, and the ability of BHS to handle any size member volume.

BHS offers the lowest cost structure possible for mental health and substance abuse benefits on a fee-for-service rate basis, with no risk borne by BHS. This ensures maximum cost savings accrue directly to the client, that they have full knowledge of cost and utilization, and that client preferences regarding plan design/coverage limits are easily accommodated.

Employers currently participating in the BHS managed care/EAP programs have realized a savings in the 25 – 50% range, while at the same time increasing benefits to their employees over the previously administered plan.

BHS has the sole endorsement of the Employers Coalition for Healthcare Options (Alabama), the Associated Builders and Contractors of Alabama, and the Louisiana Business Group on Health as the endorsed mental/nervous provider on behalf of their memberships, and maintained a similar endorsement from the Alabama Healthcare Council during its existence.

BHS represents 500 clients, 502,000+ covered lives, and 11,000+ providers across the nation. The opinions expressed below are not only BHS' opinion. We have thoroughly discussed MHPAEA and the interim final regulation with all BHS clients, and this represents the opinion of the BHS client base.

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Nonquantitative Treatment Limitations

We ask that the Departments eliminate the nonquantitative treatment limitations from the final regulation. The implications of the nonquantitative treatment limitations will cause plan costs to exceed those originally projected and more employers will opt out of mental health parity due to costs or entirely eliminate mental health and substance use disorder benefits from their plans, to the detriment of the employers/members.

BHS believes the nonquantitative treatment limitations introduced a new concept into mental health parity that is not in the MHPAEA statutory language. This impression is shared by many within the behavioral health field. Persons involved have indicated that nonquantitative limitations were not the intent during the legislation drafting process, and that such limitations are not specifically provided for in the statutory language. The statutory examples are only quantitative.

MHPAEA provides that financial requirements and treatment limitations for mental health and/or substance abuse disorder benefits cannot be more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits. However, in introducing nonquantitative treatment limitations, the interim final rule developed a new method for establishing parity, i.e., that such limitations "be comparable to, and applied no more stringently than" the limitations applied to medical/surgical benefits. This second method is not found in the MHPAEA.

Having reviewed the nonquantitative treatment limitations, it appears the intent of the interim final regulation is the elimination of the stand-alone behavioral health carve-outs. This is not in accordance with the MHPAEA statute and appears to be a violation of anti-trust regulations.

Medical Management Standards (Utilization Review)

Behavioral health carve-outs must be allowed to use specialized guidelines for a precertification and managed care process. There are inherent differences between behavioral and general medical conditions. Behavioral health benefits are more prone for abuse in terms of elective care. Medical/surgical providers recommend far fewer services that are elective in nature. People seek to continue supportive behavioral health care long after active treatment has returned them to their normal level of functioning. Indeed, BHS has seen many treatment plans where the primary or only treatment goal is to "raise self-esteem." No health plan should have to pay for such elective services! However, the interim final regulation potentially limits the plan's ability to manage such services through utilization review. A plan beneficiary could argue that because the medical plan administrator does not perform utilization review of outpatient medical/surgical services, the behavioral health administrator may not do so. The medical plan administrator does not need to review outpatient services since they, unlike behavioral health services, are seldom elective.

In analyzing the economic impact of the interim final regulation, the Departments extol the ability of managed behavioral health organizations "...through their specialized expertise in the treatment of mental and addictive disorders and organized specialty networks of providers..." to contain costs while attaining an increased utilization rate for mental health care. The Departments cite the OPM which encouraged use of behavioral health carve-outs for the FEHBP because of the carve-outs' ability to use utilization management to control utilization and spending. The carve-outs succeed in controlling costs through ensuring access to medically necessary care at the least restrictive level of care, without artificial plan limitations. The Departments themselves note "parity in a world dominated by behavioral carve-outs has meant

increased utilization rates, reduced provider fees, reduced rates of hospitalization and fewer very long episodes of outpatient care. Intensive treatment was more closely aligned with higher levels of severity." Yet the interim final regulation seems to impede the behavioral carve-outs from performing utilization review any differently from medical/surgical plan administrators, thereby eliminating all the advantages otherwise to be gained from using behavioral carve-outs.

Provider Admission to Participate in a Network

If not eliminated, the Departments must clarify this nonquantitative treatment limitation to ensure that (1) behavioral preferred provider networks are allowed to limit their networks to behavioral health specialists, and (2) plans may require that members obtain behavioral health services through a behavioral health specialist. BHS supports the position that behavioral conditions should be treated by behavioral specialists. The Departments acknowledge that "a shift in source of treatment from primary care physicians to mental health professionals could lead to more appropriate care, and thus, better health outcomes." Without clarification, more persons will revert to obtaining treatment through primary care and other non-specialty providers who are not trained in psychotropic medications, with a resulting decrease in outcomes.

Provider Reimbursement Rates

The interim final rule introduced a nonquantitative treatment limitation on plans' calculation of usual, customary and reasonable rates. **In the final rule, the Departments must consider that there cannot be usual, customary and reasonable rate parity when medical/surgical and behavioral health have different procedure codes, services, and provider types/specialties.**

The final rule must also acknowledge that both medical/surgical and behavioral health preferred provider organizations negotiate contractual rates for network providers, and that these negotiated rates are confidential. Confidential contractual negotiations cannot be examined on a parity basis.

Fail-First Policies or Step Therapy Protocols

The final rule must confirm that this limitation, if not eliminated, does not disallow the use of valid criteria to determine the appropriate level of care. For example, the American Society of Addiction Medicine's Patient Placement Criteria is widely recognized and used as the guideline for patient placement, continued stay and discharge for patients with alcohol and other drug abuse problems. The Departments must clarify this proposed nonquantitative treatment limitation to allow application of ASAM and similar criteria to determine the least restrictive level of care. Otherwise, plans may be forced to pay for extended stays in "boutique" residential facilities when the appropriate level of care is an intensive outpatient program.

Conditioning Benefits on Completion of Treatment

The interim final rule prohibits conditioning benefits on completion of a prior course of treatment. **In particular, the rule, by requiring continued coverage of substance abuse treatment following successive relapses, actually empowers the user and promotes recidivism.** It is a BHS goal to ensure the effectiveness of benefit dollars spent by discouraging recidivism. Non-compliance with the prescribed post-discharge aftercare treatment plan is the most common and prevalent factor asso ciated with recidivism. Individuals diagnosed with substance abuse or a serious mental illness are likely to be the least compliant with the treatment regimen. BHS has implemented several methods of reducing recidivism, including:

- Required participation in an aftercare program of up to two years duration following active treatment.
- Frequent contact with the patient and family to provide support and promote the patient's participation in the prescribed aftercare program.

- A benefit penalty of a loss of benefits for a particular level of care to discourage patient non-compliance.

By not allowing the plan to limit the number of treatment episodes, the interim final rule forces the employer to terminate a non-compliant employee in order to contain plan costs, and requires the plan to pay multiple episodes of treatment for non-compliant dependents whose coverage cannot be terminated.

This nonquantitative treatment limitation is causing many BHS clients to consider eliminating substance abuse benefits. It also interferes with the employer's drug-free workplace policies.

Separate but Equal

Plans must be allowed to maintain separate but equal deductibles and out-of-pocket maximums. The Departments acknowledge that the MHPAEA language can be interpreted to support both allowing separate but equal deductibles and out-of-pocket maximums and requiring integrated deductibles and out-of-pocket maximums. In prohibiting the separate but equal viewpoint, the Departments considered potential costs to complete the necessary interfaces at $35,000 or more per interface. "A low-end estimate of the first year cost for MBHOs and insurers to create, on average, at least 20 new interfaces would be $700,000 per insurer." Let us assure the Departments that while large national MBHOs may have these funds, for BHS and similar smaller companies this amount is prohibitive. The situation is further complicated by the reluctance of medical/surgical plan administrators, in an effort to force self-insured employers to terminate their behavioral carve-outs, to complete any interfaces or supply any necessary information to the carve-outs. If the employer is forced to "carve-in" behavioral benefits to the medical/surgical plan administrator, the employer loses all the advantages (experienced administration, specialty provider network, negotiated rates, etc.) of the behavioral carve-out.

One BHS client, intent on keeping patients financially involved with their treatments, has already stated that if it cannot have a separate but equal deductible, it will eliminate all mental health and substance use disorder benefits from its health plan. Again, this penalizes the employer/members who do not have access to mental health-related treatment.

Scope of Services/Continuum of Care

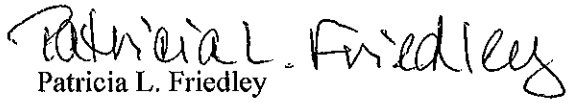
The Departments must clarify their positions on scope of services/continuum of care. In the Overview, the Departments acknowledge that the regulations do not address the scope of services and that not all treatments or treatment settings (i.e., counseling or residential treatment) for mental health or substance use disorders correspond to those for medical/surgical treatment. This acknowledgement gives the impression that the plan need not extend parity to mental health services which have no corresponding medical/surgical service.

On the other hand, the interim final regulation establishes six benefit classifications into which all services must be classified. This gives the impression that any behavioral covered service must be covered at parity to the medical/surgical benefits in that classification, regardless of whether there are corresponding medical/surgical services. Clarification is needed.

BHS supports the Departments' allowing the plan to define which services fall into each of the six benefit classifications.

BHS appreciates the opportunity to comment on this important regulation. We strongly urge the Departments to act promptly to resolve outstanding questions and ambiguities, and issue the final regulation. If the final regulation is not issued well before January 2011, most plans will have the burden of facing yet another plan year of attempting to make "reasonable interpretations" of MHPAEA and its interim final regulation, leaving the plans open to potential beneficiary legal actions if the plans' interpretations are ultimately not allowed by the final regulation.

Sincerely,



Patricia L. Friedley
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