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

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TN

Submitter Information

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General Comment

See attached file(s)

Attachments

CMS-2009-0040-DRAFT-0072.1: TN

Scope of service/continuum of care:

The regulations state that the criteria for decision-making shall be the same for MH/SA conditions as it is for medical-surgical conditions. If a health plan does opt to cover a specific mental health condition, then the regulations should require that treatment for that condition conform to established standards for treatment, which preferably include evidence-based practices.

We would like to see the regulations specify the inclusion of evidence-based recovery and rehabilitative services: for example, practices such as assertive community treatment, illness self-management and recovery, supported housing and employment, and cognitive behavioral therapy. These are all services that have shown promise for leading to better outcomes for persons with serious mental illnesses and addictions.

Medical management and medical necessity:

The regulations state that the same criteria for medical management techniques, such as pre-authorization or utilization review, shall be applied in the case of MH/SA as in medical-surgical benefits. It would be helpful if the regulations could give some examples as to how criteria should be selected and used by health plans for both medical-surgical and MH/SA treatment services.

In addition to "medical necessity," we would like to see services included based on "clinical necessity," which are often services necessary for the longer-term rehabilitation of those with serious mental illnesses/addictions or those well known for mental health promotion, substance abuse prevention, and early intervention.

Provider networks:

The regulations state that provider networks for MH/SA and medical-surgical benefits shall be comparable. In Tennessee, some health plan MH/SA provider networks are inadequate due to a shortage of mental health professionals and psychiatric hospitals willing to accept the rates offered by health plans. Inadequate provider networks limit access to care. Federal regulations should address network adequacy requirements that would help ensure the MH/SA network is as robust as the medical-surgical network and facilitate credentialing/billing/coding mechanisms that provide enhanced access.

Formulary design:

The regulations permit formularies with different financial tiers if the tiers are based on reasonable factors (such as cost, efficacy, generic vs. brand, mail-order vs. retail) without regard to whether the drug is prescribed for medical-surgical or MH/SA benefits. Supplemental rebates from drug manufacturers often determine whether a brand name drug receives "preferred" (lower copay) or "non-preferred" (higher copay) status. There is some indication that people are more able to access brands on the medical-surgical side

and more often forced into generics on the MH/SA side because the MH/SA brands tend to be more expensive. We would like to see the regulations specify that brand drugs for MH/SA conditions without a comparable generic be available and not excluded based solely on cost, if this is the case on the medical-surgical side.

General Comment:

We are concerned that health plans may choose to restrict medical-surgical benefits to bring them in line with their pre-parity MH/SA benefits rather than expand the MH/SA benefits to achieve parity. Likewise, we are concerned that some employers or health plans may drop their MH/SA benefits entirely rather than be required to comply with the new regulations. Although the authors of the regulations state their belief that this will not be the case, it would be helpful if some research could be done in this area.

We would also like the regulations to include incentives that encourage parity by maintaining and/or expanding MH/SA benefits—better aligning them with medical-surgical benefits. We believe that reimbursement incentives will be necessary in ensuring access to and quality of care, particularly in relation to appropriateness of providers and the application of integrated models to achieve better health and mental health outcomes.

We applaud the passage of federal health reform with its requirement for inclusion of MH/SA benefits in the basic benefit package for all health plans in the individual and small group markets.