As of: May 28, 2009
Received: May 28, 2009
Status: DoNotPost
Tracking No. 809bc380
Comments Due: May 28, 2009
Submission Type: Web

PUBLIC SUBMISSION

Docket: EBSA-2009-0010
Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: EBSA-2009-0010-0001
Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Document: EBSA-2009-0010-DRAFT-0240
Comment on FR Doc # E9-9629

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General Comment

May 28, 2009

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4137–NC, P.O. Box 8017,
Baltimore, MD 21244–8010

RE: Request for Information Regarding the Paul Wellstone and Pete Domenici
Mental Health Parity and Addiction Equity Act of 2008

I am grateful for the opportunity to comment on the MHPAEA of 2008. I am a healthcare consultant, a psychologist, and a lawyer with experience in healthcare policy and management in the public, private for-profit, and private non-profit sectors spanning three decades. My company, Integral Healthcare Solutions,

LLC, has a Web site, at http://integralhs.com/, which provides more detail about my background and our current work with companies seeking to meet national healthcare accreditation standards.

My comments will be limited to three areas of concern:
1. utilization management (medical necessity determinations),
2. cost-benefit calculations, and
3. coordination between the behavioral health and medical/surgical domains.

Utilization Management/Medical Necessity

Your notice specifically requests information about utilization management:

What information, if any, regarding the criteria for medical necessity determinations made under the plan (or coverage) with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

This is an area of particular expertise for me and my firm, both because I have served as Chief Operating Officer and General Counsel of URAC (http://www.urac.org/), the premier accreditation organization in the area of medical management, and because my firm has specialized in assisting applicants for URAC accreditation since 2002.

One of the most thoroughly worked areas in the world of managed health care is utilization management ("UM"), which is defined by URAC as the "evaluation of the medical necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities." URAC has promulgated national quality guidelines for UM since 1990, and has just recently released v. 6.0 of those standards, which apply to all organizations seeking the accreditation, whether or not they are mental health organizations. URAC's standards provide explicit requirements for the development and approval of criteria for medical necessity determinations and the process for disclosing that information to patients and providers. In addition, URAC's UM standards set forth exacting requirements for the qualification, supervision, credentialing, and available resources for the personnel involved in the review of requests for medical necessity determinations at every stage, including administrative, initial clinical review, peer clinical review, and appellate clinical review.

In addition, I encourage you to take your inquiry into standards and best practices for medical management further than the relatively narrow world of utilization management. Much of the promising work of the last few years has been in the maturation of such medical management processes as case management ("CM"), disease management ("DM"), and in the rise of independent review organizations ("IROs"). Should your inquiry take you into these arenas, I again encourage you to tap the invaluable resource of accreditation organizations such as URAC. In addition to its two UM accreditation programs ("Health Utilization Management" and "Workers Compensation Utilization Management"), URAC operates accreditation programs for Disease Management Organizations, Case

Management Organizations, and Independent Review Organizations.

Accreditation programs are a dominant mode of establishing standards for healthcare organizations. Not only do purchasers of healthcare coverage often require accreditation, but both state and federal government agencies lean on national accreditation organizations like URAC, NCQA, and JCAHO as complementing federal regulatory standards. In doing so, regulators bring in the accreditors' valuable expertise in healthcare business practices while helping to standardize requirements across jurisdictional boundaries.

Your request also seeks "best practices" in the development and disclosure of UM criteria. As valuable resource as any in identifying those best practices will be both the accrediting organizations and the companies, like Integral Healthcare Solutions, that have worked for years with organizations who have taken medical management beyond that required by regulators and accreditors to the realm of best practices. I encourage you to tap into both types of organizations to gain a rich view of the best practices you seek.

Cost-Benefit Analysis

The process that DHHS and DoL face in coming months is daunting. In particular, however, the questions you pose, "What direct or indirect costs would result? What direct or indirect benefits would result?", are literally incalculable. What we know, or even can reasonably estimate, about costs and benefits of the implementation of MHPAEA is dwarfed by what we do not know.

What is of particular concern, however, is that we are likely to know much more about the costs than we are the benefits, an imbalance of information that, I fear, may skew the discussion about costs and benefits. Existing claims frequency and severity data – the source of much of the "cost" side of the discussion – is plentiful and accessible, particularly when compared to information on the benefit side. We have been keeping track of what visits and treatments cost for many years.

On the other hand, our efforts to understand the connection between mental health other areas, such as physical health and work productivity, are more recent and less robust. Yet, what "benefit" data are available nearly uniformly suggest that the benefits are likely to be huge. Every week, as new studies are published, the already strong case for the general statement that appropriate attention to mental health yields dramatic benefits in terms of somatic health and work productivity grows even stronger. As a trainer in stress reduction techniques, I am most familiar with the research connecting stress with a vast array of physical problems, from immune disorders to the healing of wounds to cancer, and I can tell you that the evidence is compelling.

In sum, do not be misled by any imbalance of "hard" numbers between costs and benefits. A fair assessment of current data, filtered through the understanding that we simply have paid more attention to cost than to benefit, will be essential in your evaluation process.

Coordination Across the Boundary Between Mental Health and Somatic Health

Much attention has been paid to the leveling of benefits between mental health and substance abuse (MH/SA) and somatic health (SH) that the MHPAEA seeks to attain. Less public attention has been directed to the flow of information across the invisible but real boundary between the world of MH/SA and that of SH. Yet, as any provider or health plan administrator on either side of that boundary can tell you, despite years of conversation, administrative reorganizations, and the emergence of new medical management approaches, the level of coordination of information and care across that boundary in this country is, for the most part, primitive. This is so despite the fact that the Institute of Medicine's 10th Rule of Redesign is "Cooperation among clinicians is a priority." Specifically, the IoM's 2001 Crossing the Quality Chasm report notes that "Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care."

Certainly, the rapid emergence and maturation of case management and disease management systems and technologies in the last decade has done much to help make the boundary more porous. However, it is still generally true that the MH/SA and SH providers and plans pass too little information to each other, particularly given what we know about the intimate relationship between the two.

The opportunity that the MHPAEA presents, therefore, is not merely about leveling the financial support for care between the MH/SA and SH side of the healthcare arena. It is a precious chance to support the true integration between the two, for there can be no true parity or equity for mental health and substance abuse care so long as those two domains exist in informational isolation as compared to the various modalities of treatment within the SH domain.

The common theme, then, among these issues I raise today is that it is, and always has been, absurd to treat MH/SA and SH as distinct, unconnected realms of human health. That is the message of the MHPAEA, and it must be the methodology of the rule-making process to implement it.

Again, thank you for the opportunity to weigh in on this vital issue. Please feel free to contact me at tgoddard@integralhs.com for further information or discussion.

Sincerely yours,

Thomas G. Goddard, PhD, JD
Chief Executive Officer

TGG/tac