



MASSACHUSETTS PSYCHIATRIC SOCIETY

40 Washington Street, Suite 201
Wellesley Hills MA 02481-1802
(781) 237-8100 FAX (781) 237-7625
email: mps@psychiatry-mps.org

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May 3, 2010

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D. C. 20201

Re: File Code: CMS-4140-IFC

Dear Sirs:

The Massachusetts Psychiatric Society (MPS), the medical specialty society representing more than 1,600 psychiatric physicians in Massachusetts, appreciates the opportunity to submit these comments on the Departments of Labor, Health and Human Services, and the Treasury (The Departments) interim final rule (IFR) on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Sections 511 and 512 of PL 110-343, October 3, 2008) (MHPAEA).

As a District Branch of the American Psychiatric Association (APA), we strongly support the comments submitted by APA regarding the Interim Draft Regulations. We would like to offer comments from the perspective of a professional organization serving the public in Massachusetts, a state with strong parity legislation, high managed care penetration for almost 20 years, nearly universal insurance, with extensive experience with mental health carve out organizations (also known as Managed Behavioral Health Organizations) and which is at the forefront in the process of payment reform.

In our experience, the state parity legislation has been a significant step in improving access to psychiatric care, particularly with local insurers and with insurers who do not carve out mental health and substance abuse services. Insurers covered by the state parity law are no longer, for many conditions, able to limit care based on diagnosis alone and impose arbitrary limits on care. However, particularly for insurers who are exempt from parity (self-insured plans and plans written out of state) and for insurers who use national carve out organizations, significant limitations continue to exist. Many citizens are not aware of their mental health benefit until the very time that they need to access them. Many do not know that their insurer has carved out mental health services to a for profit national carve out organization which imposes an entirely different set of conditions for mental health and substance abuse treatment than is the case for the rest of medical care. The proposed regulations would insure that medical necessity criteria are readily available and would allow for greater transparency in the delivery of care. The inclusion of substance abuse treatment in the regulations is critical, given the pervasiveness of substance use disorders and the human and economic toll that they take on our citizens.

As such, regulation in the area of "non quantitative" treatment limits is critical. As practiced currently, mental health treatment is doled out in sessions or days and is often more stringently limited than is medical care by means of overly aggressive micromanagement by insurers and carve outs. Mental health conditions, like medical conditions, vary in symptomatology, length of illness and severity. Care for all conditions must be delivered based on the nature of the condition, not on arbitrary annual or lifetime limits. As an example, bipolar disorder and schizophrenia, like diabetes, are lifelong conditions. Using up annual or lifetime limits for psychiatric conditions makes as little sense as would be the case for diabetes or heart disease. Given the well known toll that conditions such as depression take on citizens, families and their employers, it is in the interest of all that effective treatment is made available for this and other major psychiatric conditions. Insurers will often suggest that parity legislation opens the floodgates of indefinite psychiatric treatment for relatively non-severe condition. If psychiatric conditions, as proposed in these regulations, are treated with greater parity, then treatment would be authorized for psychiatric conditions not in an unlimited way, but in a way that is consistent with medical conditions.

An essential part of parity is the inclusion of multiple levels of care, such as day treatment and other rehabilitative services. Here again the principle of parity would dictate the provision of these services in a way analogous to rehabilitation admissions and physical therapy are common for medical/surgical conditions.

We strongly support the single combined deductible as proposed in the regulations. Separate deductibles, by definition, treat mental health conditions differently from other conditions and have been used to shift further costs to persons in need of mental health services. Separate deductibles also encourage the use of another layer of bureaucracy to manage them, most often for profit, national carve out companies. We are confident that health insurers are as capable of providing and managing mental health care as they are for medical/surgical care.

Finally, in Massachusetts, discussions are underway to consider global payments for medical services. In our view, the integration of mental health treatment in any proposed global payment system is critical to provide comprehensive medical care to the public. We believe that the proposed regulations will further this integration and that such integration is consistent with the overall goal of parity for mental health and substance abuse services.

We thank you for the opportunity to present our comments and perspective and would welcome the opportunity to discuss further details of these comments.

Sincerely,



Eugene J. Fierman, MD
Chair, Legislative Committee



Theo C. Manschreck, MD
President
Massachusetts Psychiatric Society