



Institute for Research,  
Education, and  
Training in Addictions

May 27, 2009

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

RE: Paul Wellstone and Peter Domenici Mental  
Health Parity and Addiction Equity Act of 2008

Dear Sir/Madam:

On behalf of the Institute for Research, Education and Training in Addictions (IRETA) we are grateful for the opportunity to submit the below comment as you proceed with this potentially historic legislation. IRETA is an independent 501© 3 organization begun in 1999 to help align science, service and policy in the addictions nationally. As such, IRETA works daily with policy makers, insurers (public and private), providers, research, consumers and their families. IRETA maintains an internationally frequented web site ([www.ireta.org](http://www.ireta.org)) and has offices in Pittsburgh, Pa, and Albany, NY. IRETA has been an active supporter of this legislation for nearly the entire 10 years of its being. IRETA is overseen by a national, prominent Board of Directors.

We say “potentially historic legislation” because, as always, the truth of this Act’s relevance remains in its implementation. Five centuries ago the famous French philosopher Rene Descartes split the body and mind in his philosophy of science and medicine has remained in this chiasm of understanding ever since. Medicine was defined as the physical and the mind was left as separate and more often only a small component of illness. Science today regularly refutes the Cartesian split and points out that not only do 80% of all illnesses have origins in behavioral and mental life but that the healing to reverse those illnesses can also come from using those same mental pathways as part of the remedy. In short, the mind and the body are inextricably connected as one in all illness. So you see why this new legislation offers some much “potentially” historical significance. It opens the door to tomorrow’s medicine, a door too long held closed by a partial understanding of what constitutes illness and healing and what can also be brought to bear in tomorrow’s approaches to societal health and individual wellness.

Still, many say this Act is an illusion. Besides being a word to rally around “parity” must now be defined by those who pay for it. Further the belief is that if we reduce parity to payment those who do pay will keep us in the 15<sup>th</sup> century view. No greater threat to our evolution exists than defining what we see and know by old maps and telescopes that have only financial lenses. Columbus knew this and he had no maps. We do. Are we awakening to our modern science and re-defining a moment in history and the evolution of medical practice (e.g. integrating care) or are we reducing that hard won vision to an old lens that says if it can’t be paid for it isn’t real? This, for me, is the fundamental concern. As we implement “parity” we must agree first it is parity and not perpetrate an illusion to taxpayers and society in general. Once you affirm “parity” in approach to illness then have the discussion of payment. You will have already modernized the course for a 21<sup>st</sup> century medicine and not reduced it by its part, i.e. payment or medically restrictive definitions of medical necessity upon which payment is based. Let this Act set the course.

A next concern lies with the correct cost evaluation of this Act in implementation.

First, each health plan needs a clear benefit plan for consumers. As provided in the Act, OMB will study the cost of that utilization to assure any new costs do not exceed proscribed limits over the early years of implementation. Please be sure each plan has clear benefits and measures actual behavioral costs over the exact period of analysis compared to the charges and costs of those same plans over the previous five years. Research says good “parity” will reduce health costs in general for a less than 1% investment up front. Let’s also measure that. Still, in anticipation of parity it is not unthinkable for risk holders to build cost before implementation so as to offset anticipated new costs or to build increases beyond those provided by the numerous actuaries in testimony supportive of this Act.

In this sense the terms “medical benefits” and “medically necessary” care demand clarity and a definition that works for a true evaluation of parity and for consumer access to modernized care. Medical necessity cannot be left to medical acuity or crisis care but should reflect a more modern understanding of the role of mind and body by ensuring access to a broad array of evidence based practices in prevention, intervention, treatment and recovery supports. Science and best practice along with the doctor/patient relationship should be the final determiner of medical necessity, not the payer. The payer has a specific role in working with the employer and best science and practice in advising what benefit should be promulgated and how it can be managed for optimal financial and clinical outcome. Management of care is critical to achieve full continuity of care, coordination of treatment and true efficiency.

Fail first and step policies should not allowed unless indicated in the primary doctor-patient care. Nothing should transcend the doctor-patient relationship. Moreover, treatment panels and provider fees should be carefully monitored so as to protect both providers and consumers from profiteers, less than skilled practitioners and phantom panels or care that becomes inaccessible. All lessons learned painfully in the past ten years. Care should also be taken to not dismantle any pre-existing state legislation that may have earlier been established on “parity” and be working for that state in ways that meet or exceed the terms of this Act. If a benefit is denied, the patient and doctor should have at least two levels of timely appeal, the final one before non-financially involved parties. Care may then proceed with the potential of full retrospective payment or partial payment as determined in appeal. A particularly challenging element remains in the transfer of needed information to care-managers who are also holding financial accountability. Can care management be clinical first and only when determined to be not clinically necessary or appropriate care become both clinical and financial in review? Also, certain laws protecting patient confidentiality will need to be clarified (e.g. 42 CFR) as care management will also need to know enough information to make a determination of care appropriateness. Some states have even more restrictive confidentiality laws that despite their valid reason for existing cannot be used to preclude access to a clinically determined appropriate level of care. Finally, as an economic and patient safety

concern, when a lower level of care is possible but not available the patient should be afforded continued care at the higher level until such care can be found and the benefit of the initial care can be sustained.

I again thank you for the opportunity to have comment in this potentially historic Act and its implementation. Obviously many have work for years to have our health plans catch up to our science. This Act potentially opens the dawn of a new beginning of health care understanding for this Country and its citizens and we are honored to have had this opportunity and serve ready to assist further in more detail based on our experience, and knowledge of science and best practice today.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Flaherty". The signature is fluid and cursive, with a long horizontal stroke at the end.

Michael T. Flaherty, Ph.D.  
Executive Director