

From: [Florence Fee](#)
To: [E-OHPSCA-FAQ.ebsa](#)
Subject: Parity Law Final Rule public comments submittal
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Attachments: [NHMHParityFRPublicComments.docx](#)

Dear Sir/Madam,

Our organization, NHMH - No Health without Mental Health, submits herewith our comments on the Parity Law Final Rule, which was issued November 8, 2013 by the Departments of Labor, Health & Humans Services and Treasury.

Thank you for your kind consideration of our comments.

Best regards,

Florence Fee

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December 4, 2013

The Honorable Thomas E. Perez
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health & Human Services
200 Independence Ave, SW
Washington, DC 20201

The Honorable Jacob Lew
Secretary
U.S. Department of Treasury
1500 Pennsylvania Ave., NW
Washington DC 20220

Dear Secretaries Perez, Sebelius, and Lew:

The undersigned organization, **NHMH – No Health without Mental Health**, www.nhmf.org, a patient advocacy nonprofit, respectfully submits the following comments on the Parity Law Final Rule, published November 8, 2013.

The Final Rule, in furtherance of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Parity Law), provides additional guidance and clarification on the required parity between behavioral health (BH) benefits, and medical/surgical benefits, in group and individual health plans.

As the President and Vice President have stated, behavioral health conditions should no longer be treated by our society differently from other illnesses. NHMH believes that in order to make that statement a reality, BH **services** need to be fully available in the general medical setting, where 80% of BH patients go for care. As you know, the overwhelming majority of BH patients avoid the BH sector (mental health centers, etc.) for care for a multitude of reasons, preferring instead to go to their primary care doctor and hoping that he/she can address both their medical and BH needs together in a coordinated fashion.

NHMH believes that BH service integration into the medical sector can only be accomplished if health plans offer BH services as part of medical benefits, with common provider payment procedures. By so doing, BH professionals would become part of medical provider networks, and would be able to work with physical health provider colleagues in coordinating medical and BH services where most BH patients are seen. This would end our current care delivery system's segregation, i.e. BH care in one silo, and medical care in another.

The unitary, integrated healthcare system we advocate, where medical and BH care are coordinated from a common, collaborative treatment plan, would have one budget, and use common coding and billing rules. In other words, medical and BH claims would be adjudicated through a single pathway. In

this way, BH practitioners will actually be able to make a meaningful, measurable contribution to the patient's whole health care, leading to better outcomes, better delivery of services, and lowered costs. This is clearly what patients and families are asking for.

The Parity Law and the Final Rule represent limited, albeit very important, steps, but they are not the endgame itself. The larger goal is to ensure BH access to care, particularly for the 60% of American BH patients who currently receive no BH treatment. These are patients seen in the medical setting where vanishingly few BH professionals work due to payment procedures for BH services. Without addressing this neglected area of BH and medical care integration, an enormous, unsustainable economic burden on our society will persist, i.e. excess medical costs, estimated at \$290+ billion annually, for poorly treated or untreated BH patients. (Melek et al from Milliman, Inc. 2013 [<http://www.psychiatry.org/File%20Library/Practice/Professional%20Interests/Integrated%20Care/APA-Millman-Report-8-13-2013.pdf>]). Parity and the ACA create the **opportunity** for, but not the reality of, better BH access and care.

There is no question that Parity is vital and commendable in putting BH insurance health plan benefits on an equal footing with medical/surgical health plan benefits. Parity also helps to create a new perception among the broader public that both BH and medical services are equal elements of total healthcare.

Now we must focus on BH and medical **services delivery on par**.

The main barrier to BH integration into primary care is that under the present bifurcated, silo-ed care delivery system, BH providers are prevented by complicated payment procedures from working and getting paid in primary care. As mentioned, primary care is where the majority of BH patients present.

As a result of the current Administration's seminal and historic healthcare reforms, we are beginning to address the bifurcated service delivery issue that is the chief barrier to better BH access and care. The ACA promotes care delivery reforms, such as the development of Accountable Care Organizations (ACOs) and the implementation of Patient Centered Medical Homes (PCMHs), where the **potential** for integration of BH services into the medical setting exists. These care delivery models are considered to be foundational pillars of reform, however they need to include BH services as core components. Without such inclusion, we are back to large numbers of untreated BH conditions driving up medical costs.

As long as BH providers remain outside of medical provider networks in health plans, and as long as BH services are not paid as part of "medical" insurance benefits, BH providers will not be able to practice in primary and specialty medical settings where the majority of BH patients seek help.

The current segregated medical-BH system only permits BH practitioners in the medical sector with complicated, onerous payment workarounds. In most situations, such workarounds are inconsistent from plan to plan, and do not allow the delivery of services that add value or permit a living wage. Further, primary care clinics and clinicians are unwilling to include BH providers in their onsite work processes since they are money losers, not paid by current medical/surgical health plan contracts.

The net result, at both the clinical and financial level, is a continuation of untreated BH conditions in the medical setting leading to:

- * Persistent medical and BH illness and symptoms, especially in patients with the highest health care needs and costs (including many in the growing Medicare population),
- * Impairment and disability, and
- * High medical care service use and cost

This at a time when multiple models of integrated medical-BH service delivery have been shown to lead to improved total health and lowered cost.

To summarize, Parity and other ACA care delivery reforms are major milestones, but represent only a start in the process of assimilating BH into total health. We have a way to go to establish the reality of BH services *on par* with medical services so that we can, in effect, treat the whole patient.

The solution lies in integrating BH care into primary and specialty medical care and BH benefits into medical benefits. This will require core changes in the way that BH payment for services are made. Payment changes can only take place over several business cycles, thus need to be initiated today. As payment reform occurs, integrated medical and BH delivery programs can be developed that allow evidence-based care in the medical setting, where most BH patients are seen.

One of the main arguments advanced by the managed BH organization insurance industry (current BH payers) is that the serious and persistent mentally ill patient population, and those with significant substance abuse, require standalone BH services. We do not disagree with this. A specialty BH sector to care for the seriously mentally ill will remain a necessity, with solid integration of evidenced-based medical care, just as there is a need for specialty heart, lung, renal, surgical, obstetrical and pediatric services. The **majority** of BH care, however, should be delivered in the primary care medical sector. This is not possible when separate funds are paid for BH services.

Where we do disagree with the BH insurance industry is that a separate payment system is needed for specialty BH services to be delivered. We recommend that specialty BH health be supported as any other subspecialties in medical care, i.e. from the same budget and coordinated with mainstream primary care medical services.

In conclusion, we ask that your Departments work where appropriate to accelerate collaborative care delivery reform models, which include BH providers as part of health plan networks, and BH services as part of medical benefits. We also ask that you convey to the health insurance industry the critical importance of making BH benefits part of medical benefits as essential to getting us to the Triple Aim.

Thank you for your past and future work to ensure that BH access and care for the 25 million Americans with untreated BH disorders becomes a reality in our healthcare system.

Respectfully,

NHMH – No Health without Mental Health

Florence C. Fee, J.D., M.A.
Executive Director

Roger Kathol, M.D. (Board certified psychiatry, internal medicine)
Member of the Board