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To: E-OHPSCA-FAQ.ebsa
Subject: Final Rule Mental Health Testimony
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I see some flaws in an overall good final rule. I am writing today as testimony to the flaws, such that they may be worked on for potential revision. I'll also include testimony I did at the state level that is very related and more detailed.

A.-D. below, followed by my state-level testimony:

A. The three-tier system is unlike non-mental health medical. Non-mental health for independently licensed providers tends to have two tiers, physician and APRN/PA. Mental health has three tiers with most insuerers, psychiatrist, psychologist, and everyone else regardless of specialization (LCSW/LPC/LMFT/LDAC/etc). Three tiers creates even greater inequity, resulting in the majority of mental health providers getting such great discounts to their pay rates, that most on the bottom tier are paid 40-60% less than their actual rates. Lower pay means larger case-loads to make up for it, being as much as doubled an ideal case-load. But, the bottom line is parity would disallow this discrepantly tiered inequity between non-mental health & mental health.

B. Specialists are paid less in important cases. With non-mental health**, specialists are paid more. Psychologists (Psy.D. in particular) are more specialized in working with individuals with codes such as 90834 than psychiatrists (latter often have programs mostly focused on medicating). Licensed marriage and family therapists spend years of post-graduate training mastering codes 90847 & 90846, yet are paid on the lowest tier. Aside from podiatry, and no longer optometry,** non-mental health pays specialists more. This isn't parity, and while it may save insurers money in the short-run, it harms the mental health system.

C. Out-of-network many insurers use a combination of arbitrary allowable amounts and the three-tier system to whittle down reimbursement for people choosing their own provider instead of providers the networks choose/obtain. With mental health, the allowed amounts for most insurers (in CT, state and town plans disallow insurers to use arbitrary allowables, but instead insurers must use amounts that are the ~averages charged by providers) are ~half the charges, which means after deductible and co-insurance, patients get a small fraction of the billed amount, costing them more to see a mental health provider via out-of-network benefits than physicians. The bottom line is parity would disallow this loop-hole by requiring the same system of determining allowable amounts out-of-network for mental as well as non-mental health. Simply requring the same deductible and co-insurance doesn't work when the allowable amount is instead reduced by the insurer.

D. Mental health providers are encouraged to *not* diagnose properly by: severely limiting payment for diagnostic sessions (90791), requiring unreasonable approval processes for psychological testing and when approved giving insufficient hours necessary to conduct a thorough evaluation, and/or severely limiting the number of diagnostic sessions (90791) either in total, before requiring approval, or in severe limits in number of units allowed. Many tests and virtually all thorough interview evaluations (equivalents to 90791, such as to see a physician for detailed questions about patient history, symptoms, etc.) in non-mental health medical are simply not

given the above limitations,
which prevents true parity from occurring with mental health.

My state level testimony was as follows:
Much of my testimony here
http://ct.gov/oha/lib/oha/legislative_testimony/full_hearing_testimony.pdf (search for "Schaperow" to see it)
is applicable to my comments on the draft Healthcare Innovation Plan.

Additionally and similarly, I'd say here:
All people, poor or rich, should have access to quality healthcare. Insurance networks often hinder this process. I've seen repeatedly that those *mental health* providers that have left most/all insurance networks are able to have a reduced caseload and can then focus on their pts better than when working under high volume. Still, if we were to pay all mental health providers well (e.g. on par with psychiatrists average salaries), some fraction may still see more clients than they can best work with. So, I can support a way to measure quality of the care. Maybe if a provider gets a certain amount from the work they do, and then a good bonus from surveys people fill out, that could help the quality situation. Of course, since mental health care often involves working with resistances and helping a person push past these, the metric ought to not be the same for psychotherapy as it is for medicating. So, a metric for each service, or possibly procedure code. Anyway, please do review my testimony at the above link to see more on how access to good healthcare in mental health has many stumbling blocks.

Also, the great shortage of psychiatrists make many of them far too overwhelmed to be most effective, *especially* when in insurance networks. Allowing psychologists, as is done in 2 other states, and other mental health providers to prescribe psychotropics (with additional training) is very important.

And, paying well for services that keep people healthy (like mental health) is important. A single trip to an ER for a panic attack can cost insurers over $10k (I know someone this happened to, even). Even paying triple to psychotherapists (including bonuses!) can cost less, and prevent unnecessary use of expensive hospital stays.

Lastly, diagnosing accurately in mental health has reached a point of being uncommon. Repeatedly I find children, for example, diagnosed with ADD/ADHD because the provider was told there was inattention. Sometimes a simple screener scale is used, but it doesn't tease out the many causes of inattention, which include: ADD, depression, anxiety, bereavement, sleep, diet (to a point), etc.
I find when someone is willing to invest in an accurate diagnosis (through psychological testing, or through psychiatric interviews by any mental health provider with diagnostic training and excellent skill, as can be measured...), the treatment is accurate, and then the time and money spent can be far lower and with far greater results than working with the wrong diagnosis. I find it tragic that this issue is rarely considered in mental health.

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