



*A continuum of psychiatric
and chemical dependency services*

May 3, 2010

EMAIL: <http://www.regulations.gov>

RE: Federal Rulemaking Portal

Dear Sir:

On behalf of Bournewood Health Systems which is a major provider of acute psychiatric inpatient, partial hospital, and outpatient services in the Metro and Greater Boston areas of Massachusetts, I am offering comments relative to **File Code CMS-4140-IFC; Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008.** Bournewood Health Systems admits more than 3,800 inpatients, and close to 1,000 partial hospital patients per year. Bournewood's programs provide a full continuum of psychiatric and dual diagnosis care to adults and adolescents and has been in continuous operation on its present site since 1895.

As a direct provider of behavioral health services, we at Bournewood Hospital see first hand the challenges that face individuals with severe mental and substance use conditions when arbitrary restrictions limit access to essential treatment. For example, many patients who are ready for discharge from the inpatient level of care could benefit from participation in 5-10 visits in a partial hospital program to ease their transition back to the community, and then to an even lesser intense outpatient level of care. Unfortunately, some insurers do not provide coverage for the partial hospital level of care, which ironically, can result in high costs when some patients inevitably relapse and require re-hospitalization at a significantly higher expense to the insurance provider. More importantly though, relapses and re-hospitalization are unnecessarily traumatic to patients' mental and emotional health, and disruptive to their personal, family, social, and professional lives. We strongly believe that patients, who transition back to their normal lives through brief treatment in a partial hospital program, are less likely to relapse.

The intent of the federal parity law is to give Americans access to mental health services on the same basis as medical/surgical services. That is why Congress voted to require behavioral health treatment and financial requirements that are no more restrictive than those that are placed on general healthcare services. We at Bournewood join hundreds of other psychiatric care providers who applaud this step to end longstanding discrimination. Mind and body are not separate; benefits should not be treated differently. The interim final regulation understands this principle and provides good examples to help ensure that treatment or financial requirements are not overly restrictive for behavioral health.

The requirement in the interim final regulations for a single combined deductible (vs. separate deductibles for medical/surgical and behavioral health) is an important step toward the goal of truly integrated health care. We support this requirement. The manner in which the mental health/substance use benefit is managed can substantially restrict access to mental health/substance use services. Therefore, the management of the benefit can be a form of a treatment limit, which the interim final regulation confirms. We agree that mental health/substance use benefits can be managed, but they should not be managed in a more restrictive way compared to medical/surgical benefits. We support the language in the interim final rule confirming that managed care processes and strategies are a form

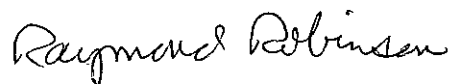
of treatment limitation. For example, utilization management reviews are required on a daily basis for psychiatric patients by some insurance companies. Patients therefore only know a day at a time whether or not they will have coverage to remain in the hospital or partial hospital program for another 24 hours. It is unfair to these individuals to face the uncertainty and anxiety over the potential loss of care every day they remain in treatment. As mentioned above, premature and abrupt loss of necessary care often leads to relapse and re-hospitalization rather than a successful reintegration into the community with decreasing intensity of treatment and support.

Medical necessity determinations through pre-certification and concurrent review are two areas that have been particularly problematic for behavioral health patients. It is not infrequent for patients in crisis to wait for preauthorization to receive treatment or to know only a day at a time what services they may have coverage for. We support efforts to ensure equity in the way precertification and concurrent review are applied to both behavioral and medical benefits. In Massachusetts, we believe that the scrutiny for physical health is not nearly at the level of scrutiny for behavioral health. In fact, the Massachusetts Association of Behavioral Health Systems, an organization that represents 47 inpatient mental health and substance abuse facilities that collectively admit over 45,000 patients per year and provide the vast majority of acute inpatient behavioral health services in Massachusetts, has filed legislation which would balance the application of medical necessity determinations by providing more authority for treating physicians than for insurance company reviewers. This is despite the extensive experience in Massachusetts with parity laws, having passed the first parity law in 2000, and then more recently, an expansion of that law in 2008.

Our association's decision to file legislation is the result of realizing that removal of day and dollar limits essentially does not lead to parity if the behavioral health services are going to be more rigorously managed, scrutinized, and denied. Parity with medical/surgical benefit management would be a major step forward in providing better access to needed services for the patients we serve, and would help lead towards true parity which we believe the Congress intended.

We appreciate the opportunity to offer these comments and hope that the Interim Final Rules are officially promulgated.

Sincerely yours,

A handwritten signature in cursive script that reads "Raymond F. Robinson".

Raymond F. Robinson
President
BourneWood Hospital