ABHW

Association for Behavioral
Health and Wellness

Advancing benefits and services in mental health, substance use and behavior change.

June 10, 2014

The Honorable Thomas Perez
Secretary of the U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Dear Mr. Secretary:

The Association for Behavioral Health and Wellness (ABHW) is writing to comment on the Department of Labor's document, "Self-Compliance Tool for Part 7 of ERISA: HIPAA and Other Health Care-Related Provisions".

ABHW is an association of the nation's leading behavioral health and wellness companies. These companies provide an array of services related to mental health, substance use, employee assistance, disease management, and other health and wellness programs to approximately 125 million people in both the public and private sectors. ABHW and its member companies use their behavioral health expertise to improve health care outcomes for individuals and families across the health care spectrum. In particular, ABHW members are involved in management of behavioral health benefits under group health plans as managed behavioral health organizations (MBHOs).

We support the development of a federal self-compliance tool to ensure compliance with parity and appreciate that you have made this document publicly available. We would appreciate a similar document being made available to states to help guide their implementation of the Mental Health Parity and Addiction Equity Act. Following thorough review of the tool, we would like to provide you with recommended changes to help clarify certain areas in the document.

In question 40, we would like to add an example that clarifies all services for a covered diagnosis need not be included in the benefit, as long as the service is excluded based on a comparable and no more stringent application of the processes, strategies, evidentiary standards, and other factors that are used for medical/surgical.

- For example, when medical/surgical chooses to cover diagnosis A and applies certain factors to outpatient treatment (i.e. variability in cost and quality, cost in relation to outcome accomplished), it ends up excluding service Z (an outpatient treatment for diagnosis A). When applying those same factors from the medical/surgical side in a comparable and no more stringent manner on the outpatient mental health/substance use disorder side, a health plan that chooses to cover diagnosis B, ends up excluding services X and Y (outpatient treatments for diagnosis B).

Regarding the "tip" in question 42, we believe the weight (bolding) of that section should also be on the first sentence, "**Do not focus on results**". It is important to emphasize that disparate results in areas like

denial rates, percentage subject to prior authorization, or provider reimbursement amount) are acceptable, as long as the same underlying processes and strategies are applied comparably and no more stringently to mental health and substance use disorders benefits.

In the "Questions You Might Ask" section we would like to see question one include more specificity and guidance around what a documented analysis should include. We suggest that the tool advise that proper documentation for an NQTL analysis include the following:

- Classification being analyzed
- Type and description of each NQTL
- Overall explanation of how each NQTL is applied on both the general medical side and the behavioral health side (note: this may include definitions, the process that is followed, a list of requirements, standards, or other strategies)

We request that the following examples be added to the "Additional Illustrations" section in the same question:

- Plan X indicates that not all of their inpatient medical hospitalizations use DRGs (in this example, some per diem contracts exist). These reimbursement/clinical review protocol agreements are individually negotiated and contractually based with each facility. In general, the standard utilization review process for non-DRG medical hospitalizations by Plan X requires precertification of member admission with incremental concurrent reviews with the frequency of reviews dictated either by provider status (quality care/utilization efficiency) or condition/case severity. With regard to psychiatric hospitalizations, the Plan has no DRG arrangement and uses concurrent reviews and precertification for all admissions.

  The concurrent review frequency and process is also determined by the unique clinical presentation, the condition severity, and the expected recovery course. For example, a behavioral health unit admission for an adult alcohol detoxification may be approved with no concurrent review scheduled until the fourth day of admission based on most standard detox cases being resolved within three days of care. On the other hand, an admission for major depression with suicidal behaviors may be approved for one day with a concurrent review conducted on the second day to assess current lethality and review the treatment plan that had been developed to stabilize the individual and plan a return to the community care. The next concurrent review for this case would be based on the treatment plan and level of continued acuity. A comparable example for a medical/surgical unit is an adult with chest pain who is admitted under observation status for further stabilization and evaluation including hydration, enzymes monitoring, and telemetry to further assess symptom severity and the need for more intensive treatment. A concurrent review is conducted the following day and further approval for continued stay dependent on the assessment findings and the recommended course of care.

  The comparability of mental health/substance use disorder inpatient hospitalizations to medical/surgical inpatient hospitalizations is colored by the fact that the vast majority of mental health/substance use disorder inpatient hospitalizations are following an emergency admission whereas oftentimes medical/surgical admissions are scheduled or represent non-emergent procedures. Medically necessary emergency inpatient admissions subject to pre-notification requirement are not denied service for both mental health/substance use disorder and medical/surgical conditions. Even though not every non-DRG medical hospitalization uses the exact same utilization review protocol, Plan X applied similar "processes, strategies, evidentiary standards" in determining a utilization review process for all non-DRG inpatient hospitalizations, whether medical/surgical or mental health/substance use disorder. Thus, Plan X's utilization review approach for psychiatric hospitalizations is permissible because it is applied in a comparable and no more stringent approach than the process for non-DRG medical hospitalizations. The fact that there is some variation on the

utilization review frequency and process for the non-DRG medical hospitalizations does not foreclose the use of case specific concurrent reviews and uniform precertification/notification procedures for all psychiatric hospitalizations.

- Plan Z applies a management process for outpatient services, for concurrent review, that identifies treatments that may involve medically unnecessary services based on a set of criteria that includes: outpatient services beyond a certain number of visits per episode of treatment, treatments subject to longer treatment durations with increasing probability of medically unnecessary services over the duration of the treatment, visits that may involve multiple services per visit, services that have the potential to be billed the same service with multiple levels of coding, relatively low/moderate cost per service, increase in costs as a percentage of total spend based on experience, variability of rates of progress for patients during a treatment episode, a portion of patients who never obtain complete resolution of their condition resulting in on-going management for a chronic condition. These criteria are applied to both medical/surgical and mental health/substance use disorder services with the services meeting these criteria subject to concurrent review which involves the comparable process of clinically reviewing the identified cases and services with an appropriate clinical peer of the treating provider and, if necessary, issuing an adverse benefit determination if the services are not medically necessary under the plan's guidelines. Thus, it appears the plan is using the same criteria and process and applying the criteria and process comparably and no more stringently, consistent with the NQTL requirements.

  A somewhat concrete example of the above scenario is x, y, and z medical illnesses receive concurrent review (or some other management) after the average number of visits needed to treat these illnesses (based on scientific research) is exceeded. These illnesses were selected for concurrent review (or some other management technique) based on two criteria (outpatient services beyond a certain number of visits per episode of treatment and variability of rates of progress for patients during a treatment episode). On the behavioral health side a, b, c, d, and e behavioral health illnesses receive concurrent review (or some other management technique that is also done on the medical side in similar scenarios) after the average number of visits needed to treat these illnesses (based on scientific research) is exceeded. Theses illnesses were selected for concurrent review based on same two criteria, applied with the same stringency, (outpatient services beyond a certain number of visits per episode of treatment and variability of rates of progress for patients during a treatment episode) that were applied on the medical side.

- Plan X evaluates their provider network using quality metrics specific to the provider's specialty (e.g. medical guidelines and best practices, regulatory measures, accreditation measures, access to services metrics, provider performance over time, patient outcomes, etc.). These metrics are applied to both medical/surgical providers, and mental health/substance use providers for the purpose of developing performance-based incentives and programs. Plan X uses a variety of types of incentives and programs across its network depending on the existing contractual relationship with the provider, existing payment mechanisms, and negotiates particular incentives and programs individually with each provider. Even though mental health and substance use providers may use different incentives and programs than medical surgical providers, Plan X applied comparable "processes, strategies, and evidentiary standards" when developing and implementing its performance based incentives and programs. In addition, although the terms of a particular incentive or program may be different depending on the type of provider, type of contract, type of service affected, or type of reimbursement available, the variation in terms for mental health and substance use providers are not applied in a more stringent manner than those terms applied to medical providers. Differences in rates, based on quality metrics achieved by a particular provider, are allowed.

We also suggest that you add a comment or question to the self-compliance tool that recommends that an employer or health plan sponsor ensures that its vendors are sharing the appropriate information with each other so that the appropriate parity analysis can be made.

Based on new disclosure requirements in the final rule, ABHW respectfully requests that the scope of these provisions be appropriately limited. Also, as you move forward with the application of these provisions to MHPAEA, we ask that you make clear which health plans are subject to these requirements.

We understand the MHPAEA requirements related to disclosure of medical necessity criteria and communication of the reason for any denial of coverage or reimbursement under the plan. We further understand the final rule contained additional language about disclosure that called to our attention two existing disclosure provisions.

ERISA section 104 and the claims and appeals regulations limit disclosure to plan participants, claimants, or their authorized representative. We assume that disclosure of the information required under these provisions will continue to be limited to only these individuals. Much of the information referred to in these provisions is complex, proprietary (especially in the area of nonquantitative treatment limits), and voluminous; and disclosure of this information can be an enormous administrative burden when our members have multiple plan partners. Therefore, the document request should be targeted to the relevant information related to the individual's claim.

Thank you for your consideration of these suggested changes to the self-compliance tool. If you have any questions or would like to discuss any of these issues with ABHW, please contact me at (202) 449-7660 or greenberg@abhw.org.

Sincerely,

Pamela Greenberg

Pamela Greenberg, MPP
President and CEO

Cc:
Amy Turner