December 23, 2016

Cecilia Muñoz
Director, Domestic Policy Council
The White House
1600 Pennsylvania Ave, NW
Washington, DC 20500

Dear Ms. Muñoz,

On behalf of the members of the Parity Implementation Coalition (PIC), we applaud the release of the White House Mental Health and Substance Use Disorder Parity Task Force's report. We thank the Administration for its commitment to enforcement and implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA).

We are writing in response to the request for comments on "Disclosures with Respect to MH/SUD Benefits" that was included in the "FAQs about Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation" released in conjunction with the Task Force's report on October 27, 2016.

The Parity Implementation Coalition is an alliance of addiction and mental health consumer and provider organizations. Members include the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, Depression and Bipolar Support Alliance, Hazelden Betty Ford Foundation, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, National Association of Addiction Treatment Providers, Residential Eating Disorders Consortium, The Watershed Addiction Treatment Programs, Inc. and Young People in Recovery. In an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders, many of these organizations have advocated for more than nineteen years in support of parity legislation and issuance of regulations. We are committed to the prompt and effective implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA).

Transparency is essential to ensure that plan participants and beneficiaries receive medically necessary health care coverage and access to equitable addiction and mental health treatment based on parity-compliant benefit plan design, medical management protocols, and other non-quantitative treatment limitations (NQTLs). Therefore, proper disclosure of information is especially important to plan participants and beneficiaries seeking mental health/substance use disorder (MH/SUD) treatment and recovery support services and the providers who help them. This is true whether a patient is trying to understand an adverse benefit determination or challenging what appears to be an unlawful NQTL utilized by a health plan, either as written, as applied or both.

One of the most common barriers reported by the patients and providers PIC members serve is the lack of disclosure by health plans on the development and application of NQTLs. Parity compliance testing cannot be performed on coverage limitations such as prescription drug formulary design, medical and administrative management techniques, including restrictions based on facility type or provider specialty, without this information. For example, in order to determine whether a plan is in compliance with the law, consumers and their providers, who often serve as authorized representatives for patients, may request medical management criteria and protocols, information on how these criteria and protocols are developed and applied (both as written and in operation), for both MH/SUD and medical/surgical benefits. We have been made aware of hundreds of such requests by authorized provider representatives that have gone unanswered.

To ensure documents and information are fully disclosed, consistent with MHPAEA's statute and implementing regulations, we recommend that the forms require the following documents and information to be supplied for review upon request.

NQTL Compliance: 5-Step Process

As we have communicated previously to the Departments, despite the April 20, 2016 release of Affordable Care Act Implementation FAQs Part 31, Q#9, and the June 1, 2016 issuance of Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance, the vast majority of plans are not disclosing any information on comparative medical/surgical analyses for a MH/SUD NQTL. Even when a very few plans list the factors that may have been used to develop an NQTL, to our knowledge no plan has identified the specific factor(s) the plan in fact relied upon, and no plan has identified the evidentiary standard that defines those factors. Nor has any plan disclosed an analysis or documentation as to how it developed and compared these factors and their defined standards between the medical/surgical and MH/SUD benefits in a specific classification to assure comparability. Further, no plan has disclosed information or documents as to how it monitors or otherwise tests the operational comparability of an NQTL and to assure no greater stringency in application to the MH/SUD benefit.

We applaud FAQs Part 31, Q#9, and based on our collective experience, we believe that additional guidance is needed to clarify for those obligated to disclose what is meant by "documentation" as used in Q#9 relating to each of the components of the NQTL test. Based on our experience with assisting patients and providers, **we recommend utilization of a 5-step parity compliant analysis and ensuring that template forms require the disclosure of key plan documents.** The 5-step process explained and illustrated below provides clear guidance on the type of information and documentation that is required to be disclosed.

These 5 steps are based on the MHPAEA Final Rules, related federal regulations, as well as previously issued FAQs and other sub-regulatory guidance. Please find attached as **Appendix A,** Crosswalk Comparing Q# 9 to the below 5-step process. We emphasize once again how no consumer, authorized representative or regulator can possibly know whether a plan is compliant with or in violation of the NQTL rule of the federal parity law based on the information that, to our knowledge, has been submitted by any plan to date.

Please note that the metrics used below are illustrative only and do not represent what any specific plan has, in fact, done.

Recommendation 1

5-Step Parity Compliance NQTL Analysis (template forms should ensure all of this information is disclosed to both plan members and their authorized representatives).

Step 1. Describe the NQTL and both the MH/SUD services and medical/surgical services to which it applies. (Any separate NQTL that applies only to MH/SUD benefits within any particular classification is in violation of MHPAEA).

Step 2. **Identify the factor(s) used in the development of the specific NQTL.**
A description of each of the factors that were in fact used to develop the specific NQTL, including the rationale for the relevancy of such factor(s) and the sources for ascertaining each of these factors: e.g., external research studies, internal claims analyses, internal quality standard studies, etc.

Illustrative examples of factors that could be used include:

- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Lack of clinical efficacy of treatment

Step 3. Identify the evidentiary standard(s) used to define such factor(s).
A description of the evidentiary standard(s) used to define each of these factors identified in Step 2.

Illustrative evidentiary standards that may define the factors listed above include:

- Two standard deviations above average utilization per episode of care (may define excessive utilization)
- Medical costs for certain services increased 10% or more per year for 2 years (may define recent medical cost escalation)
- Deviation from national generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews (may define lack of adherence to quality standards)
- 25% of patients stayed longer than the median length of stay for acute hospital episodes of care (may define high level of variation in length of stay)
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12 month period (may define high variability in cost per episode)
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12 month sample (may define lack of clinical efficacy)

Please note: The term "evidentiary standards" may also include any evidence a plan considers in developing its medical management techniques, such as recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials).

Step 4. Methods and Analyses used to establish comparability in the development of the NQTL.

A description of the methods and analyses used to determine that any factors used, evidentiary standards relied upon, and processes employed in developing the NQTL for MH/SUD services and medical/surgical services are comparable. The results of these analyses are to be included.

Illustrative methods and analyses to determine if factors, evidentiary standards, and processes are comparable include:

- Internal claims database analyses that showed key factors (which are each defined by specific evidentiary standards) were present in a comparable manner in both MH/SUD and medical/surgical class of benefits.
- Review of the published literature on rapidly increasing cost for services for both MH/SUD and medical/surgical conditions and determination that a key factor(s) was present with similar frequency in specific categories of both MH/SUD and medical/surgical services.
- Methodology and results for analyzing that all medical/surgical service categories that had a "high cost variability" (defined in the same manner for both medical and MH/SUD services) were subject to pre-authorization, as were all types of MH/SUD services that fit this definition
- Analyses that the processes for setting usual and customary provider rates for both MH/SUD and medical/surgical were the same, both as developed and applied, along with the results from these analyses.

Step 5. Testing and Reviews conducted to establish comparability and no more stringency in the application of this NQTL "in operation".

Documentation of any testing, audits or reviews and the results thereof that demonstrate that the processes employed "in operation" for MH/SUD benefits in each relevant classification of benefits are comparable to and applied no more stringently than the same processes employed "in operation" for medical/surgical benefits in the corresponding classification of benefits.

Illustrative documentation of methods and analyses to determine the comparability and equivalent stringency of processes used in NQTL application, in operation, include:

- Documentation that specific audits were performed with respect to the frequency of medical/surgical vs. MH/SUD reviews within the same classifications of benefits to assure that the NQTL is applied comparably and no more stringently.
- Audit results that physician to physician utilization reviews were similar in frequency and length of time for medical/surgical vs. MH/SUD within the same classifications of benefits to assure that the reviews were comparable and no more stringently applied in these respects.
- Audit results that demonstrate that frequency of reviews for the extension of initial determinations for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for MH/SUD benefits.

- Data from analyses to determine whether the out-of-pocket spending by members for inpatient SUD and MH services are similar to those for out-of-pocket spending for medical/surgical members in similar types of facilities.
- Results of compliance testing of network access standards that wait times for primary care office visits were the same as the wait times for psychiatric office visits.

Please note: There are many other processes that may be used in operation for any given NQTL, particularly those that involve medical management techniques, such as consultations with expert reviewers, clinical rationale used in approving or denying benefits, and the selection of information deemed reasonably necessary to make a medical necessity determination, etc. Plans must analyze every process employed in operation for comparability and equivalent stringency in application.

Recommendation 2

Financial Requirements

1. Provide a list of all financial requirements which apply to mental health and substance use disorder benefits for each of your health plans, e.g., deductibles, copayments, coinsurance, or out of pocket maximums. If there is a difference between plans, indicate which is applicable to each plan.

2. For each financial requirement listed above, provide all documentation which demonstrates that each financial requirement applies to "substantially all" or at least two-thirds of all the medical/surgical benefits within the same classification and is the "predominant" level or applies to more than half of the medical/surgical benefits in that classification based on plan costs.

3. Provide a list of all quantitative treatment limitations which apply to mental health and substance use disorder benefits for each of your health plans, e.g., including annual, episode, and lifetime day and visit limits. If there is a difference between plans, indicate which is applicable with each plan.

4. For each quantitative requirement list in above, provide all documentation which demonstrates that each quantitative requirement applies to "substantially all" or at least two-thirds of all the medical/surgical benefits within the same classification and is the "predominant" level or applies to more than half of the medical/surgical benefits in that classification based on plan costs.

Recommendation 3

Appeals and Denials

1. For dates of service provided in the 12 months prior to the date the data responsive to this request is collected, provide the total number of outpatient mental health claims submitted for CPT codes 99201-99205 and 99211-99215 (include both in and out-of-network claims).

2. For dates of service provided in the 12 months prior to the date the data responsive to this request is collected, provide the total number of outpatient mental health claims denied for CPT codes 99201-99205 and 99211-99215 (either on a prior authorization or retroactive

basis). Of these, please specify the number denied on a retroactive basis.

3. For dates of service provided in the 12 months prior to the date the data responsive to this request is collected, provide the total number of outpatient non-mental health claims submitted for CPT codes 99201-99205 and 99211-99215 (include both in and out-of-network claims).

4. For dates of service provided in the 12 months prior to the date the data responsive to this request is collected, provide the total number of outpatient non-mental health claims denied for CPT codes 99201-99205 and 99211-99215 (either on a prior authorization or retroactive basis). Of these, please specify the number denied on a retroactive basis.

5. For dates of service provided in the 12 months prior to the date the data responsive to this request is collected, provide the number of inpatient mental health claims submitted and the number denied (either on a prior authorization or retroactive basis). Of these, please specify the number denied on a retroactive basis.

6. For dates of service provided in the 12 months prior to the date the data responsive to this request is collected, provide the number of inpatient non-mental health claims submitted and the number denied (either on a prior authorization or retroactive basis). Of these, please specify the number denied on a retroactive basis.

7. Provide the number of internal appeals submitted in the prior year by (a) mental health and (b) non-mental health providers including the reason(s) for appeal and its final decision by the health plan (i.e. whether it was upheld or overturned).

8. Provide the number of final internal adverse benefit determinations in the prior year that were externally appealed and were submitted by (a) mental health and (b) non-mental health providers including the reason(s) for appeal and the final decision by the external appeal decision maker (i.e. whether it was upheld or overturned).

Conclusion

Thank you again for the opportunity to provide comments. We look forward to working with the Task Force and the Administration in any way we can to ensure the Mental Health Parity and Addiction Equity Act is fully implemented and enforced so consumers have access to the non-discriminatory mental health and substance use disorder treatment as promised to them under the law.

Sincerely,

Mark Covall
Parity Implementation Coalition Co-Chair

Beth Ann Middlebrook
Parity Implementation Coalition Co-Chair

FAQ 9 AND 5-STEP CROSSWALK
NQTL Compliance With MHPAEA

FAQ 9 (ACA Implementation FAQs Part 31, et al., April 20, 2016)	**5-STEPS**
1. A Summary Plan Description (SPD) from an ERISA plan, or similar information that may be provided by non-ERISA plans;	
2. The specific plan language regarding the imposition of the NQTL (such as preauthorization requirement);	1. Describe the NQTL and both the MH/SUD services and medical/surgical services to which it applies;
3. The specific underlying processes, strategies, evidentiary standards and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit;	2. Identify the factor(s) used in the development of the specific NQTL; 3. Identify the evidentiary standard(s) used to define such factor(s);
4. Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue; 6. Any analyses performed by the plan as to how the NQTL complies with MHPAEA.	4. Methods and Analyses used to establish comparability in the development of the NQTL;
5. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; 6. Any analyses performed by the plan as to how the NQTL complies with MHPAEA.	5. Testing and reviews conducted to establish comparability and no more stringency in the application of this NQTL "in operation."