AMERICAN PSYCHIATRIC ASSOCIATION

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Washington, D.C. 20024

July 24, 2020

Dear United States Department of Labor, Employee Benefits Security Administration:

On behalf of the American Psychiatric Association (APA), the medical specialty society representing over 38,800 physicians who specialize in the treatment of mental illnesses, including substance use disorders, we thank you for considering our comments in response to The Department of Labor's Proposed Updates to 2020 MHPAEA Self-Compliance Tool.[1] We commend the DOL for providing this additional guidance to help group health plans' sponsors and administrators, group and individual market health insurance issuers, State regulators, and other stakeholders determine whether a group health plan or health insurance issuer is in compliance with MHPAEA and its implementing regulations.

The APA supports the Department's inclusion of the stepwise protocol in the original Self Compliance Tool and its maintaining that format in this second updated tool. Since promulgating the stepwise protocol in its original tool in 2018, many states have adopted a similar stepwise approach for analyzing NQTL compliance, through both legislative and regulatory approaches.

The APA understands that comments are only requested for text in the tool that is highlighted in yellow. The APA has restricted our comments to those sections of text and has included comments on some, but not all highlighted sections.

Definitions on page 6

The APA commends the Department for providing further clarification regarding how MH/SUD benefits are to be defined. **APA recommends that the Department add further clarity by stating that any benefit that is used for treatment of both MH/SUD conditions and medical/surgical conditions shall be considered an MH/SUD benefit when used for the treatment of an MH/SUD condition and, as such, subject to all the financial requirement and treatment limitation rules**. For example, occupational therapy is often used for treatment of medical/surgical conditions and for the treatment of mental health conditions, such as schizophrenia, bipolar disorder, and autism. When occupational therapy is used for the treatment of MH/SUD conditions, a plan or issuer must not impose any quantitative treatment limitations (QTLs) without demonstrating it passes the QTL substantially all test in the applicable classification or sub-classification of benefits.

[1] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/compliance-assistance-guide-appendix-a-mhpaea-proposed-updates.pdf#:~:text=The%20MHPAEA%20Self-Compliance%20Tool%20is%20published%20by%20the,in%20compliance%20with%20MHPAEA%20and%20its%20implementing%20regulations.

The APA understands that plans and issuers routinely impose a 20-visit annual limit to occupational, physical, and speech therapy, but a plain reading of the statutory and regulatory text makes it clear that it is impermissible to impose this limitation to occupational therapy or speech therapy when it is used for the treatment of an MH/SUD condition if the requirements of the substantially all test are not met.

Nonquantitative Treatment Limitations (NQTLs) page 22.

Reimbursement Rates

The first note on page 22, regarding reimbursement rate setting, should be modified. Often, plans and issuers will indicate that their process took into account the factors listed by the Department, such as the nature of the service, provider type, market dynamics, and market need or availability (demand), among others, like quality measures and treatment outcome measures.

However, in order to apply these factors comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits, the plan or issuer must use the same factors and in the same fashion for MH/SUD benefits versus medical/surgical benefits. For example, if the plan or issuer uses the factors of market dynamics and demand to inform medical/surgical reimbursement rates, but uses quality measures and treatment outcome measures to inform MH/SUD reimbursement rates, that is a non-comparable consideration and application of factors. Additionally, even if the same factors are considered, the plan or issuer must consider them in a comparable fashion, and, importantly, the plan or issuer must use the information gleaned from considering the factors in a comparable and no more stringent fashion for setting MH/SUD reimbursement rates versus medical/surgical reimbursement rates.

For instance, if a plan or issuer considers a market dynamic factor such as provider availability/scarcity for both MH/SUD and medical/surgical rate setting, how it determines availability/scarcity must be comparable and applied no more stringently, and, how the findings then affect the reimbursement rate setting must be comparable and applied no more stringently. There are many ways in which a plan or issuer could determine provider availability/scarcity, and numerous ways that this could then affect reimbursement rate setting. There is no right way to do this, and this is true for many other factors that may come into play during reimbursement rate setting. However, everything related to the process of selecting, considering, evaluating, and then applying a factor to reimbursement rate setting must be comparable and applied no more stringently.

The APA recommends that the Department add to the end of this note more text indicating to plans and issuers that everything involved in the process of selecting, considering, evaluating, and applying the factors that inform reimbursement rate setting must be comparable to and applied no more stringently for MH/SUD benefits versus medical/surgical benefits.

Network Adequacy

The APA commends the Department for emphasizing in its second note on page 22 that plans and issuers must respond to provider shortages in their MH/SUD networks in a way that is comparable and applied no more stringently to how they do so for provider shortages in their medical/surgical networks. **The APA recommends the DOL make two additions to this note:**

1. In order to meet this standard, the process by which plans and issuers identify provider shortages must be comparable and applied nor more stringently.

2. The process by which plans and issuers respond to MH/SUD provider shortages must be comparable and applied no more stringently to the process by which they respond to medical/surgical provider shortages of similar scarcity.

Regarding the warning signs about reimbursement rates on page 23, **the APA suggests that the Department could add an additional warning sign that aligns with the example mentioned in our comment above regarding the first note on page 22 in which a plan uses the factors of market dynamics and demand to inform medical/surgical reimbursement rate setting but uses factors of quality measures and treatment outcome measures to inform MH/SUD reimbursement rate setting.**

Stepwise Process

The APA recommends modifying two notes regarding the stepwise process: 1. the note on page 25—specifically, the example listed about cost and safety concerns informing the imposition of prior authorization on electroconvulsive therapy (ECT); and 2. the note about "high cost" on page 26, which we suggest be incorporated into the note on page 25, along with the additional modifications described below. The APA is aware that plans and issuers frequently impose prior authorization on ECT and justify this with reasoning in line with what is suggested in this example.

The APA strongly recommends that the Department enhance this example by noting that plans and issuers must define the parameters of "high cost" and "legitimate safety concerns" for ECT in a way that is comparable and applied no more stringently to how the parameters for those terms are defined for medical/surgical benefits in the same classification of benefits.

From working with our members and also with state regulators, the APA has found that plans and issuers frequently cite these terms as reasons for imposing prior authorization on ECT but are unable to supply any sort of definitional benchmarks that meaningfully describe either term, let alone demonstrate that they are defined comparably and no more stringently than how they are for medical/surgical benefits.

One of the core goals of MHPAEA was to eliminate arbitrary treatment limitations applied to MH/SUD benefits that are more restrictive than those in place for medical/surgical benefits. If plans and issuers cannot even define what parameters are in place for considering an MH/SUD benefit "high cost" and posing "legitimate safety concerns", this demonstrates that the arbitrary and restrictive limitations MHPAEA aims to eliminate may still be in place.

The APA appreciates the guidance provided by the Department on page 26 about "high cost", but believes that an even more fundamental expectation should be set when it comes to defining "high cost" (and "legitimate safety concerns", for that matter). This does not mean APA is suggesting that the actual dollar amount for what constitutes high cost must be the same for ECT versus a medical/surgical benefit. Rather, the foundational approach to ascertaining what constitutes "high cost" must be comparable and applied no more stringently.

The APA recommends enhancing the new bullet point added in the "compliance tips" box on page 28 by adding: "This includes monitoring how first-level utilization reviewers make determinations whether to send authorization requests to second-level reviewers and also monitoring how second-level physician reviewers adhere to medical necessity and level of care criteria, including the physicians' use of discretion."

This is important because experience with our members and state regulators has shown that these in-operation processes for MH/SUD authorizations are often more stringently applied than they are for medical/surgical authorizations. This is especially true in the inpatient classifications of benefits and for intermediate levels of care, such as partial hospitalization and intensive outpatient programs that fall either into the outpatient classifications or the outpatient, other sub-classifications of benefits (when sub-classifications are used).

The APA has seen that first-level reviewers send MH/SUD authorization requests to second-level physician reviewers far more frequently than what occurs for medical/surgical authorization requests. Additionally, MH/SUD second-level physician reviewers often apply their own professional discretion or judgment in lieu of the plan or issuer's medical necessity and level of care criteria more frequently, and more arbitrarily, than medical/surgical second-level physician reviewers. Again, these are the types of arbitrary and discriminatory practices that MHPAEA is designed to prevent. Alternatively, if the Department prefers addressing this elsewhere than the bullet point in the "compliance tips" box on page 28, the APA suggests that it could be added to the "warning signs" examples on page 28 and page 29.

Establishing an Internal MHPAEA Compliance Plan

The APA applauds the Department for adding this new Section H to the tool. As the Department notes, and the APA is well aware, plans and issuers are not explicitly statutorily required to establish a compliance plan. However, it is clear that a plan or issuer is unlikely to be in compliance with the dense and multi-faceted requirements of MHPAEA if it does not have an internal compliance plan.

The APA appreciates the guidance supplied in this Section H, but suggests that it be supplemented.

As the Department and many other commenters are probably aware, several state legislatures have passed MHPAEA-compliance reporting requirements since 2018. More are expected to pass similar legislation in subsequent sessions. Additionally, a number of state regulators have implemented very similar MHPAEA-compliance reporting requirements during that same time span without legislation passing. By our count, no fewer than 20 states have already done this over the last two years through either legislative or regulatory means.

The APA suggests that Section H include guidance to plans and issuers, particularly as it relates to issuers subject to state jurisdiction, that any internal compliance plan should be able to collect and analyze information in the comparative format that is required by state law or by state regulators, when applicable.

This is important guidance for issuers because they may create additional administrative burden for themselves and state regulators if they are developing means for performing comparative analyses that are not in line with what is required by a state. The APA does not suggest that there is a single "right" way to do this, just that there are a substantial and growing number of states that use very specific approaches to compliance reporting. Issuers' internal compliance plans should be responsive to what is required statutorily or through regulatory means.

Appendix I: Additional Illustrations

The APA has concerns regarding the new illustration 6 on pages 37 and 38 regarding imposition of prior authorization for physical therapy and psychological testing. The illustration states that for physical

therapy, the number of sessions authorized is tailored to the medical/surgical condition treated, consistent with the hypothetical "Jones and Smith Guidelines". For psychological testing, the number of hours authorized are tailored to the age of the client and type of evaluation required and are determined on the "basis of the average number of hours for evaluation conducted nationally for the last 3 years."

We are concerned that for physical therapy, the evidentiary standards upon which the hypothetical plan is relying are published guidelines, whereas for psychological testing, the evidentiary standards are an analysis of historical averages. These appear to be different, and most likely, non-comparable evidentiary standards. Published guidelines are customarily informed by experts and clinical leaders in a given field. Historical averages are merely statistical artifacts that are not necessarily informed by any type of sound clinical rationale. A historical average could theoretically have resulted from clinicians and payers relying upon sound clinical guidelines and research, which then led to the subsequent average time. Or, a historical average could be the result of factors that had nothing to do with clinical guidelines and medically sound practice. That is the whole point.

Clinical guidelines are carefully crafted protocols steeped in expert clinical knowledge. Historical averages are merely mathematical outcomes that may not have any correlation to clinical knowledge and best practices. Using Jones and Smith Guidelines means that the number of sessions approved for physical therapy are anchored to (hypothetical) clinical expertise. Using national averages for the last 3 years means that the hours approved for psychological testing are not inherently moored to clinical expertise. The APA's interpretation is that this would be non-comparable and possibly more stringent application of evidentiary standards.

The APA appreciates that the Department may have been trying to illustrate an instance where a plan uses evidentiary standards that may be comparable but not identical. **However, we suggest using a different evidentiary standard for physical therapy to do so. The APA recommends that the Department change the Jones and Smith Guidelines evidentiary standard to an evidentiary standard of data being analyzed that informed number of visits approved for physical therapy.**

Thank you for the opportunity to comment on the proposed 2020 MHPAEA Self-Compliance Tool. The APA looks forward to your consideration of these comments.

Sincerely,

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