From: Lim, Sabina
To: EBSA MHPAEA Request for Comments
Subject: Mount Sinai Health System--Comment on Technical Release for MHPAEA Proposed Rule
Date: Wednesday, October 4, 2023 1:09:28 PM
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2024 MHPAEA Proposed Rule Comment Mount Sinai final-TR.pdf

Hello,

Please see attached formal comment submitted on behalf of the Mount Sinai Health System re: the Technical Release for the Proposed Rule on Requirements Related to the Mental Health and Addiction Equity Act. Thank you for your consideration of our comment.

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October 4, 2023

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N–5653
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
Attention: 1210–AC11

Dear Sir/Madam,

I am writing on behalf of the Mount Sinai Health System to comment on the "Proposed Relevant Data Requirements for Non-Quantitative Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurers Subject to the Mental Health Parity and Addiction Equity Act". We want to first thank and applaud the Department of Labor, the Department of Treasury, and the Department of Health and Human Services for this major revision of the Rule. We believe that this will significantly strengthen the Mental Health Parity and Addiction Equity Act (MHPAEA). The Mount Sinai Health System (MSHS) is an integrated health care system comprised of eight hospitals, over 400 ambulatory practices, and over 7,200 physicians, as well as the Icahn School of Medicine at Mount Sinai and the Phillips School of Nursing at Mount Sinai. MSHS is one of the largest providers of both mental health and addiction services in the northeast and likely in the nation, with over 5,700 inpatient mental health/substance use disorder (MH/SUD) discharges, over 13,600 emergency psychiatric visits, and over 727,000 outpatient MH/SUD visits in 2022. Moreover, we have a robust and diverse continuum of MH/SUD services across all levels of care.

We have made major investments in MH/SUD care over the years, culminating in what we believe is a transformational new model of care that provides a robust and integrated continuum of mental health, substance use disorder and physical health services in a single location, our new Mount Sinai-Behavioral Health Center (MSBHC). This new center provides inpatient, crisis, intensive outpatient, and integrated outpatient clinic-based mental health, substance use disorder, and primary care in a "one-stop-

shop" model. Not only does MSBHC have all these services under one roof, but all the MSBHC programs are functionally integrated with each other to provide simpler and streamlined pathways to access new and continued care for our patients. We have made this and other investments, despite the issues that the MHPAEA is trying to address, because we have long believed that mental health and substance use disorder treatment is a basic and integral part of health care. However, in order to sustain these investments, and for other providers to replicate or create similar investments, we must make drastic changes to how we are paid, and part of this focus must include a major, substantive analysis of insurance plans' MH/SUD policies and day-to-day practices. We therefore appreciate the opportunity to comment on the Proposed Rule, and we respectfully submit the following for your consideration in the Final Rule.

Comments on general framework and key global concepts of the Proposed Rule

- **NQTLs and Network Adequacy:** We strongly support the Proposed Rule's emphasis on implementation procedures of Non-Quantitative Treatment Limits (NQTLs) by insurance plans. Although the original MHPAEA and its updates were major achievements, **much of the disparities that exist between MH/SUD and medical/surgical benefits coverage lie in the day-to-day utilization review and claims processing operational practices and procedures** used by many health insurance plans, across all payer types. We also support the emphasis on network adequacy measures and compliance. However, the lack of true network adequacy is more a consequence of the base policies and daily practices and processes (written and unwritten) employed by many plans. **Therefore, we strongly recommend that the major focus should be on how exactly NQTLs are operationalized, with a similar emphasis on definitional and implementation-based compliance assessments in other areas regulated by the MHPAEA (i.e., quantitative limits).**

- **MH/SUD vs. Medical/Surgical Classifications:** We agree overall that the comparison between MH/SUD and medical/surgical benefits should occur at the six classification levels outlined (inpatient, in network and out of network; outpatient, in network and out of network; emergency care; and prescription drugs). However, we must point out the following:

    - Many MH/SUD services do not fall clearly into any of these classification schemes. The Proposed Rule already notes crisis services such as Mobile Crisis Teams as one such service. However there are other types of crisis services, and the reasons for using such services are much more closely aligned with reasons for emergency care (especially because without

these crisis services, the only appropriate clinical level of care is typically emergency services, not office-based or community-based outpatient services). **We therefore strongly recommend classification of mental health crisis services under Emergency Care for NQTL and Quantitative Treatment Limitations (QTL) comparative analyses.**

Furthermore, MH/SUD crisis services in general are typically not covered by Medicare or commercial plans (state Medicaid plans often do cover some or many such services). A parallel service in medical/surgical care is Urgent Care, which is usually covered by most payers.

Relatedly, we posit respectfully that part of the issue is that the question cannot always be "How does MH/SUD fall into the existing medical/surgical classification/ framework?" **True parity would also ask, "How can we create additional classifications/expand the medical/surgical framework to better incorporate MH/SUD services and to create a complete health care framework". For example, a new classification of "Urgent/Crisis Care" could encompass both medical/surgical urgent care and MH/SUD crisis services.**

- We strongly encourage HHS/CMS to evaluate Medicare coverage of **hospital-based psychiatric observation beds, which falls under crisis services**. While Medicare covers hospital-based medical observation beds, it does not cover psychiatric observation beds. New York, for example, covers this benefit under Medicaid, and is a critical part of the crisis continuum. Commercial and other non-governmental plans also typically do not cover psychiatric observation beds. The lack of coverage of psychiatric observation beds by Medicare and commercial plans is in and of itself a disparity. At the end of the submission, we provide further recommendations on other types of disparities that are not currently fully covered by the MHPAEA.

- Some MH/SUD services fall into the outpatient classification, but are fundamentally different from most medical/surgical outpatient services. These are typically outpatient programs that require frequent recurrent visits, such as Partial Hospitalization Programs (PHP), Intensive Outpatient Programs (IOP), and Opioid Treatment Programs (OTP). **We strongly recommend that the appropriate NQTL comparative analysis should be with medical/surgical services with similar recurrent visit structures, such as dialysis and**

chemotherapy. We do not recommend that recurrent medical ancillary services such as laboratory services are an appropriate comparison classification.

Moreover, we recommend specifically that the appropriate counterpart for PHP's and IOP's is chemotherapy, while dialysis should be used for OTP's. This is because PHP, IOP and chemotherapy all represent time-limited course/episode of treatment, while OTP's and dialysis are generally used for extended periods of time or even a lifetime.

- **Claims Processing/Payment/Denial Data Submission by Payers:** We strongly urge that **payment and denials data submitted by payers should be as specific as possible.** For example, denials data should be not just all denials, but should include **denials by type** (i.e., medical necessity, no authorization, timely filing, credentialing, informational, etc.) and that plans should explain **how each denial type is defined and examples**. This is because **under-reimbursement of MH/SUD providers is not just due to medical necessity or utilization review policies and procedures, but rather technical problems in MH/SUD claims processing**. Rather, our experience is that the more rampant issue affecting payment of services are these technical claims processing issues. The following is a partial list of common and/or recurrent issues that have occurred over the years to illustrate. **This requires tremendous internal attention and resources, and usually takes months or even years for plans to correct, especially because the fault was not with the provider, but rather in their claims processing setup and logic.**

    - "No authorization" denials when authorizations were actually obtained
    - "Credentialing" denials: for example, when a plan thought that Evaluation and Management (E&M) claims from outpatient MH/SUD clinics had to be submitted under a primary care provider NPI - simply because they were E&Ms (this was fixed after a year, and then started recurring again).
    - Recurrent "Need More Information" Denials, which ultimately get paid, but plans never reach out to provider to obtain the additional information needed. This potentially could be an end-run to prompt payment laws.
    - Plans not loading correct rate codes or revenue codes, or using incorrect facility addresses

- We must note a general comment regarding the fundamental principle of the MHPAEA - namely that MH/SUD benefits must not be more restrictive than medical/surgical benefits in policy and

implementation. It is possible that plans may make their medical/surgical QTL and NQTL processes, strategies and evidentiary standards to be more restrictive (rather than making the corollaries for MH/SUD benefits less restrictive). **We urge the Departments to put in measures within to safeguard against this possibility.**

- We also strongly encourage the Departments to prioritize enforcement of violations. As noted in the July 2023 MHPAEA Comparative Analysis Report to Congress, many plans did not even provide sufficient information in their comparative analyses despite multiple notices. This Proposed Rule provides significant granular clarification, and moreover, it has now been **15 years that MHPAEA has been in effect. We expect and hope that robust and prompt enforcement of violations occur in light of the time that plans have had to come into compliance and these major clarifications.**

Section IIA2: Comments on Meaning of Terms

We concur with the proposed clarifying definitions, particularly re: "predominant" and "variation". We also recommend further clarifications regarding "mental health" and "substance abuse" disorders (page 51565). Some plans will deny claims for mental health services when the primary diagnosis is a "Substance-Induced Psychotic Disorder", despite it being classified under the DSM V-TR under Schizophrenia Spectrum and Other Psychotic Disorders, and not under Substance Related and Addictive Disorders. In ICD-10, this diagnosis falls under F10-F19 "Mental and Behavioral Disorders due to Psychoactive Substance Use", and the specific code is based on the substance involved. This issue exists for bipolar, depressive and anxiety disorders induced by substances, despite the fact that these all fall under primary bipolar, depressive, and anxiety disorders, and not as a primary substance use disorder. **A clarifying statement could be for example, that when there is a discrepancy between the ICD-10 and DSM V-TR major diagnostic classification of a particular diagnosis, that the payer follows the DSM V-TR diagnostic category classification.**

N.B. The more fundamental issue here is that there are issues even within MH/SUD services where "mental health" vs "substance use" diagnoses are separated out and there are differing clinical and payment regulations between mental health and substance use disorder treatment, with certain diagnoses qualifying only as mental health treatment or substance use treatment. This artificial separation does not recognize the tremendous co-morbidity between these sets of diagnoses,

and effectively creates a bifurcation of care even within MH/SUD, which in and of itself is a parity issue within MH/SUD.

Section II3a: Comments on a. Requirement That NQTLs be No More Restrictive for Mental Health and Substance Use Disorder Benefits

Page 51570 notes requests comments on whether there should be a similar MH/SUD NQTL restriction such as the prohibition on prior authorization for any minimum length of stay after childbirth. **We strongly recommend a prohibition on prior authorization/notification of any kind when patients are admitted for involuntary psychiatric hospitalization and in accordance with state laws.** Most states have very strict clinically based legal criteria for involuntary psychiatric hospitalization. It is therefore moot if an authorization is required by an insurance plan representative for hospitalization, when a patient has been deemed to meet legal criteria for involuntary admission for an emergency psychiatric condition. Medical necessity is by default included as criteria for voluntary psychiatric hospitalization.

Section II3c and Section II3g: Comments on Illustrative, Non-Exhaustive List of NQTLs and Examples of NQTLs

We respectfully submit the following additional examples of NQTL's for inclusion, with context and rationale included, based on real-life occurrences:

- More Restrictive In-Network Prior Authorization Processes in Operation:

  - **"Notification" vs. Authorization Example 1**: A patient with schizophrenia is seen in a hospital emergency room and requires admission for an acute psychotic episode. The plan requires **full prior authorization** for inpatient psychiatric hospitalization, despite the fact that the patient was evaluated emergently and is admitted directly from the emergency room (this is despite state law that clearly states that prior authorization is not permissible if a patient has an "emergency condition"). Another patient who has a heart attack is also seen in the emergency room and requires admission to a cardiac inpatient unit. The plan only requires **phone or electronic notification** for this cardiac admission, despite the fact that **both are emergency conditions requiring emergency admission. In this case, "Notification" vs "Prior Authorization" processes are not par between MH/SUD and medical/surgical inpatient because the process and evidentiary standard (i.e., no evidentiary standard required in a notification) are in and of themselves different.**

- **"Notification" vs. Authorization Example 2: "Notifications" may be a parity issue for a different reason.** Some plans may institute "Notification" rather than "Prior Authorization" for inpatient or outpatient MH/SUD services, perhaps similar to that required for medical/surgical admission. If however, a "Notification" is inadvertently not done or allegedly not received, the plan routinely denies coverage for MH/SUD admission but not for a medical/surgical admission. **A "Notification" then is simply semantics and its ultimate purpose is authorization. We strongly recommend explicit definitions of what constitutes prior authorization in actual practice, regardless of what it is called by the plan.**

- **IOP vs. Chemotherapy example:** Plans typically authorize chemotherapy treatment in the form of time or by units of treatment (units are units of chemotherapeutic agent). Our experience is that with either form, approximately **3 months of authorization** are given for chemotherapy (very generally, 1 chemotherapy cycle can be for 2-6 weeks), For IOPs, however, the same plan requires prior authorization but authorizes only 5-10 days of treatment, and then a mandatory peer-to-peer review. For an IOP, 5-10 days generally mean only **2-3 weeks of treatment**, since most patients come to IOP for 2 or 3 days a week, typically for 2-3 months. These get more frequent thereafter. **This is an example of differential approved coverage units even if prior authorization is required for both MH/SUD and medical/surgical outpatient service, and differential concurrent review processes.**

- <u>More Restrictive Out of Network Prior Authorization Processes</u>:
  - Plans sometimes **require a lengthy search of in-network facilities, in possible violation of required time and distance limits, when a patient is in an emergency room of an out-of-network facility and requires inpatient psychiatric hospitalization.** An example scenario would be that the plan routinely requires the facility to call in-network facilities for availability well beyond reasonable geographic limits (including out of state). In addition, while they require on average calling five in-network facilities for psychiatric hospitalizations, they only require on average two for medical/surgical hospitalizations. We have had instances in the past where one plan required us to call over 15 in-network facilities.

- <u>More Restrictive Technical Claims Processing for MH/SUD Services</u>:
  - Many payment denials for MH/SUD services do not necessarily arise of out of plan policy or medical necessity criteria and processes, but rather are deeply embedded in the technical setup and processing of MH/SUD claims, as discussed earlier in this comment. Many plans carve-out MH/SUD claims

processing within their own company, or through an external vendor. **Part of evaluating parity should be whether the plan has comparable internal claims testing processes and auditing programs between medical/surgical and MH/SUD claims.**

Section II3f: Comments on Effect of Final Determination of Noncompliance

We strongly concur with the Proposed Rule's explicit focus on compliance with MHPAEA occurs both in policy and in operation, both written and unwritten. We recommend however, that unwritten operational procedures may represent a significant portion of non-compliance, and the plans themselves may not acknowledge unwritten procedures in their submissions. **We recommend clarification by the Departments re: how third-party (i.e., via plan members and/or providers) validation/reports of unwritten operational procedures could be incorporated into assessment of compliance beyond reliance on filed complaints. This includes not only in the Final Determination phase, but as early as possible in the entire compliance process (i.e., starting with comparative analyses).** Complaints often only represent the most egregious examples.

Comments on additional parity issues not specifically addressed in the Proposed Rule

- Basic payment methodology for MH/SUD services is in and of itself a parity issue**. The basic reimbursement methodology for most health care services does not adequately take into account the unique service delivery model of MH/SUD services**. The following are some concrete examples for why this is so:

  - Unlike other medical practices, psychiatric and some addiction services **do not have "physician extenders"** who can provide the kinds of services provided by medical physician assistants, nurse practitioners, or registered nurses. This is because the very **nature of the work of treatment for MH/SUD involves a one-to-one work between the provider and the patient,** and the provider cannot "delegate" pieces of individual psychotherapy and treatment. The majority of the work must be done by the single provider—in a limited amount of time.

  - Counseling or psychotherapy visits cannot be completed in 15 minutes by default of the nature of the treatment. While physical health practices can incorporate as many four patients per hour per

provider, therapists can only accommodate realistically at most two per hour. **A payment system that fundamentally is time-based does not permit a financially sustainable outpatient MH/SUD practice.**

- **The current payment system primarily recognizes physical procedures, which require equipment as worthy of higher reimbursement.** The system must concretely recognize that the "equipment" used in MH/SUD care is the provider's mind and relationship to the patient, and that the tools to improve health are not just those that are tangible. On the MH/SUD provider's end, there must be better use of standardized screening, diagnostic and progress evaluation instruments. Many such instruments exist and need wider adoption, and should be included as part of the "operational integration".

We respectfully remind the Departments that Medicare uses a wholly different payment methodology for inpatient psychiatric services. Medicare uses the Inpatient Psychiatric Facility Prospective Payment System (IPF-PPS), which is based on a gradually declining per diem base rate. This is contrary to the general Inpatient Prospective Payment System (IPPS), which is a DRG-based case rate for the hospitalization. The **IPF-PPS is in and of itself a form of reimbursement parity** enacted by HHS decades ago. It recognizes that a case rate for inpatient psychiatric care does not take into account the kind of treatment and time for recovery from illness that occurs with psychiatric illnesses, as compared to physical illnesses (and therefore, underpays for inpatient psychiatric care versus medical/surgical care). **We strongly urge HHS to concretely incorporate reimbursement parity concepts within MHPAEA, and evaluate a potential modified payment methodology for outpatient MH/SUD services. This does not have to be a complete overhaul of the current outpatient payment system. It could include, for example, adjusted rates for psychiatry Evaluation and Management codes; or per-patient or per-practice MH/SUD case management fee to address the existing unfunded case management that MH/SUD providers have always done as a basic part of care.**

The 2023 Consolidations Appropriations Act also included a mandate for HHS to formally collect data to better evaluate the costs of inpatient psychiatric care, because even with the IPF-PPS, inpatient psychiatric services still are paid at below direct cost of care. We eagerly await the Proposed Rule on this process, and **we strongly encourage HHS to conduct a similar cost evaluation for outpatient MH/SUD services. This step could also inform potential revisions to outpatient payment methodology.** Relatedly, non-Medicare plans often do not use a per diem inpatient payment methodology and instead use a case rate. **We believe that another way to ensure parity is to require all plans falling under the**

auspices of the MHPAEA utilize a per diem payment methodology for inpatient psychiatric services, regardless of payer.

Thank you for your consideration of these comments. Please do not hesitate to contact me at Sabina.lim@mssm.edu with any questions.

Sincerely,

Sabina Lim, MD MPH