

Date: June 22, 2018

To: The United States Departments of Health and Human Services, Labor, and Treasury

From: Tim Clement

RE: FAQ 39 and the Revised Draft MHPAEA Disclosure Template

Hello, my name is Tim Clement and I want to make clear that I am commenting only on behalf of myself and NOT on behalf of either the American Psychiatric Association or The Kennedy Forum.

Below I have addressed two topics that were subject to public comment after their release on April 23, 2018. The first is a proposed additional question and answer that could be added to FAQ 39. The second is my commentary and proposed edits to the Revised Draft MHPAEA Disclosure Template.

I realize that it may be infeasible, or maybe even impermissible, for the Departments to add a new Q to the proposed FAQs, but I would like them to consider adding the one I have written below. And, if this cannot be added to FAQ 39, I would like the Departments to consider releasing it in a future guidance. The reason I have added an entirely new Q is that I have become concerned over recent months in conversations with state regulators along with plans and issuers that there is a lack of attention being paid to the in operation component of MHPAEA. The Department of Labor addressed this quite boldly (literally) on page 17 its Self-Compliance Tool.

That being said, I do not think plans and issuers have much clarity about what constitutes processes, in operation. I find this a bit disconcerting in that of the four terms “processes, strategies, evidentiary standards, or other factors”, processes would seem to be the easiest to grasp intellectually. Nonetheless, I do not think there is much if any oversight by plans and issuers of how they are applying certain things in operation during utilization review that would seem to be “processes” under the plain English definition of the word. The proposed Q below identifies a number of processes that may occur during utilization review. All of these processes were copied and pasted directly from the utilization management manuals of several major health insurance companies. Obviously, there are other processes that take place, and certainly, not all or even many of these processes take place during any given review.

Proposed Additional Q

QX: My health plan denied my continued inpatient stay at a residential treatment facility for substance use disorder treatment after performing concurrent review. My health plan asserted that it performs concurrent review every 72 hours for both inpatient, in-network MH/SUD treatment and for inpatient, in-network medical surgical treatment and that the reviewers apply the same utilization management criteria and screening scripts from an identical utilization manual for both MH/SUD and medical/surgical reviews. Is this permissible under MHPAEA?

It depends. There are additional processes applied in operation during the MH/SUD review that must be examined to determine if they are comparable to and applied no more stringently than the same processes applied during a medical/surgical review. Those processes include, but are not limited to, peer clinical review, telephonic consultations with attending providers, consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary

to make a medical necessity determination, adherence to utilization management criteria and criteria hierarchy, professional judgment used in lieu of utilization management criteria, actions taken when incomplete information is received from attending providers, utilization review decision timeliness, requests of patient medical records, process for sharing all clinical and demographic information on individual patients among various clinical and administrative departments, among others.

The health plan cannot assure that it is in compliance with MHPAEA unless it has performed analyses of how these in operation processes are applied to MH/SUD reviews in the inpatient in-network classification compared to how they are applied to medical/surgical reviews, in the inpatient, in-network classification.

Comments and Edits for Draft MHPAEA Disclosure Template

I was very pleased with the step-wise approach to nonquantitative treatment limitation (NQTL) analysis adopted in Section F of the Department of Labor's Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act. I would like to see the disclosure steps on pages two and three of the Disclosure Template align more closely with the steps in the Self-Compliance Tool. While both sets of steps are very similar, the steps in the Self-Compliance Tool are somewhat clearer and better adhere to the language in the NQTL paragraph (c)(4) of the MHPAEA final rules (26 CFR 54.9812-1; 29 CFR 2590.712; 45 CFR 146.136). Below is my demonstration of how I would amend the steps of the disclosure guide and some comments explaining my rationale:

1. Provide the specific plan language regarding the limitation and identify all of the medical/surgical and mental health and substance use disorder benefits to which it applies in the relevant benefit classification;

2. Identify the factors used in the ~~design~~development of the limitation (examples of factors include, but are not limited to, excessive utilization, recent medical cost escalation, high variability in cost for each episode of care, and safety and effectiveness of treatment);

3. Identify the sources (including and process, strategies, or evidentiary standards) used to ~~define~~evaluate the factors. Examples include, but are not limited to, the following:

- Excessive utilization as defined by two standard deviations above average utilization per episode of care;
- Recent medical cost escalation as defined by medical costs for certain services increasing 10% or more per year for 2 years;
- High variability in cost per episode of care as defined by episodes of outpatient care being 2 standard deviations higher in total costs than the average cost per episode 20% or more of the time in a 12-month period; and
- Safety and efficacy of treatment modality as defined by 2 random clinical trials required to establish a treatment is not experimental or investigational; and

~~4. Identify the methods and analysis used in the development of the limitation; and~~

I think while there is nothing wrong with this step, in a vacuum, I don't believe that it adds any value to the overall examination and could lead to the disclosure of information that is not useful. Additionally, there is no specification within the NQTL paragraph (c)(4) of the final regulations regarding the terms "methods" and "analysis", nor is there any mention of these terms in the disclosure paragraphs (d)(1), (d)(2), and (d)(3). I worry that health plans and issuers will struggle to understand what exactly they are supposed to be demonstrating about these terms because there are no statutory or regulatory stipulations governing those terms as they pertain to the actual imposition of an NQTL, either as written or in operation.

I do understand that the term "methods" appears in 42 U.S.C. 300gg-26(a)(7)(B) and (C) several times, but it is not used in a context that places any requirements on a health plan or issuer. The term is used once in (B)(i), and once in each of (C), (C)(i), (C)(ii), (C)(vii), (C)(viii), and (C)(ix). However, each time the term is used in these subclauses, it is in the context of examples of "methods" the Departments should provide in subregulatory guidance related to the design and application of NQTLs. While I may seem to be belaboring a minor semantical point, I do think it is important. There are clear requirements in the Code of Federal Regulations for health plans and issuers regarding the terms processes, strategies, evidentiary standards, and factors. There are no requirements or specifications for health plans and issuers regarding the terms "methods" and "analysis". If I worked for a plan or issuer and was tasked with completing this step of the disclosure process, I would probably just ignore this step because there is no legal obligation regarding "methods" and "analysis" that plans and issuers must satisfy in paragraphs (c)(4), (d)(1), (d)(2), (d)(3) or in any other part of the statute or regulations.

45. Provide any evidence and documentation to establish that any processes, strategies, or evidentiary standards used in applying the limitation are comparable to and no more stringently applied to MH/SUD benefits, and medical/surgical benefits both is applied no more stringently, as written and in operation, ~~to mental health and substance use disorder benefits than to medical and surgical benefits.~~

My edits to this step are designed to make it align with step four of the Self-Compliance Tool, and also to make it comport with NQTL paragraph (c)(4) of the final regulations. The way it is currently constructed does not comport with paragraph (c)(4)(i) in that it asks for documentation that "the limitation is applied no more stringently as written and in operation". However, paragraph (c)(4)(i) does not require that the limitation as a whole be applied no more stringently, but rather that the "...processes, strategies, evidentiary standards, or other factors used in applying.." the NQTL are comparable and applied no more stringently. The Departments made note of this in the preamble to the final regulations on 78 FR 68245 and 78 FR 68246 by stating that "Disparate results alone do not mean that the NQTLs in use do not comply with these requirements" and "Again, disparate results alone do not mean that the NQTLs in use fail to comply with these requirements". Similarly to my comments to the previous step, it may seem as if I am being pedantic regarding semantics, but I think it is critically important that any guidance maintain strict fidelity to statutory and regulatory requirements. If I worked for a plan or issuer and was responsible for completing this step, I would object to the request that I should provide evidence and documentation that the limitation is applied no more stringently because that is not legally obligated.

In sum, my edits and comments for steps four and five are written with the intention that beneficiaries receive useful information when they make disclosure requests. I fear that if these tweaks are not

incorporated, clever attorneys for plans and issuers will seize on the inconsistencies with the actual legal requirements of MHPAEA and its implementing regulations and provide information that would ultimately prove useless or poisonous to a plaintiff in a legal proceeding, thereby potentially scuttling his case. Or, the plan or issuer will object entirely to disclosing anything because the last step goes beyond what is actually required by the law.