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July 24, 2020

Office of Health Plan Standards and Compliance Assistance
Amber Rivers, Office Director
200 Constitution Ave NW
Suite N-5653
Washington, DC 20210

Re: Proposed 2020 MHPAEA Self-Compliance Tool

Dear Director Rivers:

Magellan Healthcare (Magellan) appreciates the opportunity to comment on the Department of Labor (DOL) proposed revisions to the Mental Health Parity and Addiction Equity Act (MHPAEA) Self-Compliance Tool. Magellan is committed to ensuring access to high quality and fully integrated mental health and substance use disorder (SUD) benefits.

Magellan is a leader in managing the fastest growing, most complex areas of healthcare, including individuals with special healthcare needs, complete pharmacy benefits, and other specialty areas of healthcare. We connect behavioral, physical, pharmacy, and social needs with high-impact, evidence-based clinical and community support programs to ensure the care and services provided to our members are individualized, coordinated, fully integrated, and cost effective.

As a specialty managed care company with our roots in behavioral health, we are deeply committed to working with our customer health plans on continuing compliance with mental health parity. Our perspective on parity is informed by extensive experience providing a tailored spectrum of behavioral health services and employee assistance programs for health plans, employers and various military and government agencies and public healthcare programs, including active-duty service members and their families, state Medicaid programs and individuals dually eligible for Medicare and Medicaid.

We contract with more than 77,000 credentialed behavioral health providers nationwide and provide behavioral healthcare services to approximately 1.8 million public-sector members through a range of innovative state programs, including the nation's first Medicaid specialty health plan for adults living with serious mental illness.

Background

Magellan and other behavioral health-focused health plans have paved the way to demonstrate how managed care can increase access to behavioral health treatment that not only works but is integrated. Magellan has 50 years of experience taking new, innovative ideas to their maximum potential, beginning with behavioral healthcare.

In 2008, the MHPAEA changed the landscape of mental health parity and SUD coverage in the United States. MHPAEA led to significant improvements in mental health and SUD coverage over the past decade. While MHPAEA and its predecessor, the Mental Health Parity Act of 1996, as well as the Affordable Care Act of 2010, have done much to advance the mental health and SUD coverage landscape, further opportunities remain to improve access to high-quality and value-based mental health and SUD services and treatments.

Magellan's Comments

Magellan appreciates the Department's efforts to provide tools to help plans ensure compliance with the MHPAEA. This is an important tool that is used by state regulators in addition to plans to obtain additional clarity in interpreting the regulatory parity requirements. While many of these revisions are needed to provide guidance to facilitate compliance, we have concerns with the implications of some of these proposals as discussed below.

SECTION B. COVERAGE IN ALL CLASSIFICATIONS: Classifying Benefits

Proposed Revision: Page 11

NOTE: If a plan covers room and board for inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, both of which the plan classifies as inpatient care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction based on facility type - a treatment limitation - only on MH/SUD benefits and therefore violates MHPAEA.¹ The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment.

Comments

In nearly every inpatient situation, whether medical/surgical or for MH/SUD, prior authorization is critical to ensure the coordination of care and medical necessity for treatment. In all cases, ensuring that a beneficiary is receiving the most appropriate care in the most appropriate setting is a priority.

This note creates the potential for confusion because the point it attempts to clarify (application of the NQTL test to restrictions based on facility type) is unrelated to the section it is located (requirement to apply consistent criteria to the classification of benefits).

In addition, the comparison between two specific provider types is not appropriate. It fails to acknowledge that plans and issuers may provide coverage for some residential treatment provider types but not others. Furthermore, it fails to acknowledge that plans and issuers retain the flexibility to define covered benefits, and to apply reasonable factors to determine which treatments and services are covered under a given benefit.

As drafted, the note fails to recognize the specific facility type or types where an exclusion may be applied. As a result, it creates a false impression that where a benefit for residential MH/SUD treatment exists means that all residential MH/SUD facility types must be covered.

Recommendation

Magellan recommends that if the note is retained, it be moved to Section F or Appendix I and reframed as an illustration of the NQTL analysis.

Medication Assisted Treatment (MAT) is subject to MHPAEA

Magellan is a national leader in serving individuals with Opioid Use Disorder (OUD) and other SUDs. Our experience includes a wide variety of activities, programs and tools for health plans, Medicaid managed care organizations, employers, labor unions, state Medicaid programs, and military and government agencies designed to support long-term recovery and resiliency.

SECTION D. FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

Proposed Revision: Page 18

ILLUSTRATION: Plan Z requires copayments for out-patient, in-network MH/SUD benefits. In order to determine if the plan meets the parity requirements: 1. STEP ONE: Determine if the particular type of financial requirement applies to substantially all (that is, 2/3 of) medical /surgical benefits in the relevant classification. Based on its prior claims experience, Plan Z expects \$1 million in medical/surgical benefits to be paid in the outpatient, in-network classification and \$700,000 of those benefits are expected to be subject to copayments. Because the amount of medical/surgical benefits expected to be subject to a copayment, which is

\$700,000, is at least 2/3 of the \$1 million total medical/surgical benefits expected to be paid, a copayment can be applied to outpatient, in-network MH/SUD benefits. 2. STEP TWO: Determine what level of the financial requirement is predominant (that is, the level that applies to more than half the medical/surgical benefits subject to the financial requirement in the relevant classification). In the outpatient, in-network classification where \$1 million in medical/surgical benefits is expected to be paid, \$700,000 of those benefits are expected to be subject to copayments. Out of the \$700,000, Plan Z expects that 25% will be subject to a \$15 copayment and 75% will be subject to a \$30 copayment. Since 75% is more than half, the \$30 copayment is the predominant level. CONCLUSION: Plan Z cannot impose a copayment on MH/SUD benefits in this classification that is higher than \$30.

Warning Sign: If a plan or issuer applies a specialist copayment requirement for all MH/SUD benefits within a classification, but applies a specialist copayment only for certain medical/surgical benefits within a classification, this may be indicative of noncompliance and warrant further review.

Comments

Under the existing rule, the “warning sign” proposed on pages 18-19 is permissible. Currently, it is common and accepted practice for visits to specialty providers to require higher copayments for a visit given the complexity associated with many areas of healthcare. For example, the medical/surgical outpatient classifications include primary care physicians (PCPs) and specialists. A comparable scenario does not exist for MH/SUD classifications. In fact, every MH/SUD provider could be viewed as a specialist and therefore subject to a specialist copay or cost share so long as the substantially all and predominant test from the rule and noted in the illustration are met. A prior FAQ from the DOL issued May 12, 2012 specifically notes that the specialist copay is permissible to apply to all MH/SUD benefits within the classification if this test is met.

Q7: Can my plan impose a higher “specialist” financial requirement with respect to mental health and substance use disorder benefits?

A7: A plan may not create sub-classifications for generalists and specialists to determine separate predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. However, if the predominant level of a type of financial requirement that applies to substantially all medical/surgical benefits in a classification is the one charged for a medical/surgical specialist, then that “specialist” financial requirement can be applied for all mental health or substance use disorder benefits within that classification. On the other hand, if the predominant level of a type of financial requirement that applies to substantially all medical/surgical benefits in a classification is the one charged for a medical/surgical generalist, then the financial requirement charged for all mental

health or substance use disorder benefits within that classification cannot be higher than the “generalist” financial requirement for medical/surgical benefits.

The revision in this section presupposes that a MH/SUD provider is not a specialist, and therefore changes both the intent and scope of the underlying rule.

Recommendation

Magellan recommends that DOL strike this revision because it is inconsistent with the rule and with prior guidance from DOL.

SECTION F. NONQUANTITATIVE TREATMENT LIMITATIONS

Proposed Revision: Page 22

NOTE – To comply with MHPAEA, a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network providers for both medical/surgical and MH/SUD benefits. For example, if reimbursement rates for medical/surgical benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule. Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, and market need or availability (demand) must be applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits.

NOTE - Plans and issuers may attempt to address shortages in medical/surgical specialist providers and to ensure reasonable patient wait times for appointments by adjusting provider admission standards through increased reimbursement rates and by developing a process for accelerating enrollment in their networks to improve network adequacy. To comply with the requirements of MHPAEA, plans and issuers must take measures that are comparable and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers, even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan’s network See FAQs Part 39, Q6 and Q7, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resourcecenter/faqs/aca-part-39-final.pdf>.

Warning Signs: The following plan provisions related to provider reimbursements may be indicative of noncompliance and warrant further review:

1. Inequitable reimbursement rates established via a comparison to Medicare: A plan or issuer generally pays at or around Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for

medical/surgical benefits. For assistance comparing a plan or coverage's reimbursement schedule to Medicare, see the **TOOL FOR COMPARING PLAN REIMBURSEMENT RATES TO MEDICARE** in Appendix II.

Comments

Magellan appreciates the intent to provide more clarity and guidance to ensure compliance with the MHPAEA.

The tool assumes that the party responsible for compliance has visibility to the contracted health plan rates and the underlying methodologies used to determine those rates. Historically, many plans have been reluctant to share this information. If the health plan will not disclose their rates or their rate methodology, then a self-insured employer plan should not be held accountable for this.

The language in the final rule regarding reimbursement rates notes, in the illustrated list of NQTLs, that the NQTL is “[standard] for provider admission to participate in a network, including reimbursement rates.¹” The focus was intended on ensuring network adequacy for members. Parity is a patient protection law, and rates for network providers are not relevant to members beyond ensuring that the rates are sufficient to contract with a network that meets any state, federal or accreditation standard for network adequacy.

The proposed revisions suggest Medicare is an appropriate benchmark to use in comparing rates for *all* plans, regardless of whether Medicare rates are used in compiling rates for any given provider network. Plans may use other rate tools such as FairHealth or Medicaid rates in addition to other factors in the market when determining rates. The revisions also do not contemplate areas where rates may rightly vary, but are not necessarily an indication of non-compliance.

Rate development processes are multifaceted. It is unlikely that a plan will maintain the same rate for all providers, even for those plans contemplating Medicare rates. Several market factors must be considered (e.g., cost of living, supply and demand, etc.). Furthermore, not all providers in the same classification will necessarily receive the same rates, this chart does not account for that situation.

Disparate results are not indicative of a parity compliance issue in reviewing rates. Rates could vary for comparable and no more stringent reasons (e.g. a shortage of a medical/surgical provider type could lead to higher rates for those types of providers and therefore a higher payment to that provider type). A plan may also pay higher rates to a behavioral health provider where there is a shortage of a MH/SUD provider type. This is comparable and no more stringent regardless of what the end rates are.

¹ 29 C.F.R. § 2590.712 (c)(4)(ii)

In addition, assessing rate development in detail presents challenges due to the proprietary and confidential nature of rate setting for plans. Particularly in those situations where the MH/SUD benefits are provided by a different entity than that which provides the medical/surgical benefits.

For example, for self-insured employer group health plans that contract with different vendors for each service type, the employer plan is responsible for parity compliance. However, obtaining detailed information from the medical/surgical vendor in order to compare rate development methodologies with those of the MH/SUD vendor presents significant barriers due in part to the proprietary nature of that information. If the intention is to require a detailed review of rate methodology at a granular level, other potential impacts should be considered. In particular, where a plan seeks to comply with this requirement, but is unable to obtain the necessary information to determine compliance due to their inability to obtain corresponding detailed information from the medical/surgical vendor.

In addition, MH/SUD vendors would potentially need to create different rates for the same MH/SUD provider where rate review occurs at a more detailed level and the vendor provides services to multiple plans in the state. As a result, this increases administrative burden on the MH/SUD benefit provider as well as the practitioners contracted with the MH/SUD organization which then need to track the various rates for each plan administered by the MH/SUD plan.

Furthermore, many plans may have capitation in place for inpatient providers under the medical/surgical benefit or value-based reimbursement arrangements, but not have instituted such arrangements on the MH/SUD side for a variety of reasons, including lack of diagnosis related groups for behavioral services, creating another situation where it is difficult to compare and align rate setting.

Recommendation

We suggest that DOL remove this language and the accompanying chart in Appendix 2.

In the alternative, DOL should clarify that the example is appropriate for review of plans that create rates based on Medicare reimbursement only and that rates do not need to be developed using a methodology that is based off Medicare rates.

Conclusion

Magellan strives to ensure the right person receives the right services, at the right time. We appreciate the DOL's efforts to improve mental health care and ensure compliance with the MHPAEA. We look forward to engagement on these and other issues to help advance the goal of achieving mental health parity.

As DOL considers our comments, Magellan would be glad to answer questions. Please contact Brian Coyne, vice president of federal affairs, at (804) 548-0248 or bcoyne@magellanhealth.com; or, Kristina Arnoux, vice president of government affairs and public policy, at (401) 480-8034 or arnouxk@magellanhealth.com.

Thank you for the opportunity to share our experience and recommendations on this important issue.

Sincerely,



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