



Public Comment to FAQ, Part 34

Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38

There is an increasing need for equitable treatment access to address the urgent opioid epidemic and reduce the deleterious effects of complex chronic medical diseases co-occurring with mental health disorders. The Paul Wellstone and Pete Domenici Mental Health Parity & Addiction Equity Act of 2008 (MHPAEA) is essential, not only to the health of the individual, but to the health of the nation as well. The added protections given by the Affordable Care Act (ACA) and the 21st Century Cures Act (Cure Act) allow opportunities to refine the implementation of MHPAEA.

SAE thanks the Departments of Labor, Health and Human Services (collectively, hereby, recognized as the Departments) for the opportunity to respond to the June 16 FAQ, as allowed by the Cures Act, Part 38. Our Parity Compliance team is pleased to offer guidance from our direct experience supporting various states' ability to assess and monitor Managed Care Organizations' and their behavioral health vendors' compliance to MHPAEA. We firmly believe and have witnessed the spirit in which MHPAEA was written can be honored with:

1. clearly defined and structured market conduct requirements and standards,
2. required and publicly available attestations to policy and practice Parity standards,
3. periodic examinations, oversight of marketplace violations and complimentary governance roles with joint leadership from members of the Departments; and
4. audit control mechanisms for marketplace violations that provide evidence of noncompliance trends, particularly with non-quantitative treatment limitation (NQTL) responses toward specific clinical sub-groups and across high-cost classifications to also identify potential of service billing fraud.

In response to the FAQ request by the Departments on model forms, SAE would like to provide the following considerations:

- A. *Model forms to be used by participants and their representatives to request information with respect to various NQTLs for the health plan product.*

Model forms should be available that allow participants to view and compare medical/surgical (M/S) and Mental Health (MH) and Substance Use Disorder (SUD) benefit design across the health plan product for:

- preauthorization and pre-service notification requirements;
- treatment progress and treatment attempt requirements per classification/category driven by expected step-therapy/fail-first protocols;
- expected criteria of types of measurable and substantial improvement within termed/expected approved days for covered services;

- written treatment plan expected requirements within classification for covered services;
- published standards for classifying benefits for covered services for both M/S, MH and SUD;
- geographical limitations for MH or SUD with comparable allowance for M/S for out-of-network benefits; and
- licensure requirements of MH and SUD facilities with comparable guidelines of M/S.

B. *Model forms for specific information about medical necessity criteria.*

Psychiatric criteria, based on clinical symptomology and functional ability, should be incorporated into a clear guidance for the determination of “treatment necessity” versus “medical necessity” per level of care/classification. Given that MHPAEA endeavored to address equitable and fair access to MH and SUD treatment, treatment necessity determinations should be inclusive of psychiatric evaluation and criteria. They should not be solely based on a standard of medical criteria or a set of medical criteria established individually by each MCO. The use of medical criteria for mental health treatment is not singularly congruent to the treatment needs and necessity that evolve and center on psychiatric, emotional and functional impairments. It is essential that the psychiatric clinical criteria for treatment necessity is formally structured; therefore, clinical knowledge on symptomology, functioning and impairments must be incorporated into treatment necessity determinations. This will be explicitly relevant in the below response for eating disorder treatment, as well as for ensuring treatment interventions across classifications of treatment to nationally address opioid addiction.

C. *Model forms for states to determine compliance with the NQTL standards.*

Model forms should be available for states to identify the structure of processes, strategies and evidentiary requirements that treatment authorizations will be determined upon. The model forms should request information categorized by classification of covered services for the following:

- types of like services per classification recognized as comparable across M/S and MH and SUD with clinical criteria for treatment determinations and management standards;
- procedures and processes for pre-authorizations, concurrent reviews, denials, appeals, and reverse determination standards;
- provider network reimbursement rates and expected credentialing requirements for classification of services;
- possible limits to scope or duration of benefits linked to treatment process or progress per classification of services; and
- processes and procedures for communication of treatment requests, authorizations, appeals, determinations, network benefits, and out-of-network approvals.

D. *Steps the Departments can take to improve scope and quality of disclosures.*

The collaborative work of the Departments is essential for enforcing the requirements of MHPAEA across the marketplace and different health plan products. Identifying possible violations across product lines can be made clearer with shared aggregated data to map compliancy standards and highlight trends of outliers performing against known policy

changes. Likewise, procedures for filing and investigating complaints should be similar across the Departments to:

- map process efficacies to maintain a quality improvement practice for structured data reporting;
- identify trends across the marketplace and among products by the same MCO or their behavioral health vendor; and
- identify specific authorization and treatment determination processes by clinical populations with known access barriers.

The authority of the Departments in defining and interpreting MHPAEA is especially important and powerful. SAE & Associates recognize that states have varying legislative requirements for governance, interpretation, and the implementation of MHPAEA. As such, a federal guidance by the Departments will enlighten states that may be struggling with the definition of “mental illness” and “substance disorder” treatment. While there are states that are well advanced in defining and monitoring mental illness and substance disorder Parity requirements of covered services, there are some states that are struggling with the implementation of the Parity legislation across health plan products. Clear and specific guidance with defined parameters and required structured data reporting will provide a national framework that can be monitored for progress and refined to continuously improve upon the implementation and monitoring of MHPAEA. Additionally, transparent collaborative roles between the Departments, at the federal level, will model for the state-level departments the possible functions across their departments that can be crafted to improve communication and task sharing.

E. Specific steps to improve state market conduct examinations and/or federal oversight.

Through our direct experience working with state-governing entities, SAE has witnessed the needed oversight, monitoring, and resolutions on Actions of Decision (AOD) for MHPAEA marketplace violations. The role of the Departments is essential in the implementation, monitoring and enforcement of MHPAEA. Our team recommends structured data reporting that will allow the mapping of policy changes to particular QTLs and NQTLs, as well as financial requirements (FR) emphasized in the Final Rule from Medicaid/CHIP. Without structured data requirements, the tracking, mapping, and identification of trends incongruent with policy requirements will be difficult to examine over the course of time and cohort clinical groups. Additionally, reviews and audits that are not dependent on survey response are essential to examine the processes, procedures, and organizational culture change needed to make a shift in policy and practice in regards to MHPAEA. A direct review would also examine the data capture mechanisms for required QTLs, NQTLs, and FRs to ensure uncorrupted data practices.

Lastly, post AOD for marketplace violations should include sustainability measures over time to ensure course corrections to ‘right size’ approved authorizations are not in practice.

We thank the Departments for the clarification that recognizes coverage for eating disorder benefits must be consistent with the requirements of MHPAEA. Coupled with our Parity compliance experience, our direct clinical experience, and clinical research on Parity violations for varying clinical cohort groups, we understand the vulnerabilities that enrollees may face with covered services for eating disorder treatment. Eating disorder treatment requires a uniquely blended cross-disciplinary approach, particularly at critical points of care.

- There are supportive therapy components that should be defined and identified under the appropriate covered services per classification. Data request and examination ensure access for those therapy components, and policy for those indicated classifications should be implemented. With potentially multiple service modalities needed during one course of an eating disorder treatment, an FR study and an aggregate lifetime and annual dollar limit study could clarify if access to the array of supportive therapy components are QTLs that are MHPAEA-compliant.

Eating disorder treatments also vary greatly: anorexia nervosa treatment is different than treatment for bulimia nervosa disorder. Although both will need nutrition counseling as part of the covered services, determination for treatment necessity will have different criteria thresholds per classification of covered services.

- Guidance on the clinical criteria for the specific disorder cohort with preauthorization requirements, treatment determination processes and the aforementioned NQTLs must be examined for compliance.
- Health plan determination practices that are aversive and negatively impact required measurable and substantial improvements that must be reported within termed/expected approved days need to be identified. These NQTLs are barriers to treatment engagement and treatment access. Clinically evidence-based practices (EBPs) should be identified as part of NQTLs that involve review of measurable treatment gains and treatment planning.

SAE thanks the Departments for the release of the FAQ and for the opportunity to respond in detail regarding the implementation and monitoring of MHPAEA. Driven to work toward true access to care and with deep appreciation for mental health and substance treatment Parity, we understand the important leadership role the Departments have, as well as the role each state entity has in governing at the state level. It is with direct experience analyzing and monitoring Parity compliance that our Parity Compliance team summarized the above recommendations. It is also with our extensive clinical experience and knowledge of policy to practice that we believe MHPAEA can ensure equitable treatment access to address the urgent opioid epidemic, as well as reduce the financial, social and emotional cost of complex chronic diseases co-occurring with mental health disorders. We believe the spirit in which MHPAEA was written can be applied to transform and care for the urgent health needs of all individuals in this nation.