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The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: CMS-2009-0040-0048

Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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General Comment

Attachments

CMS-2009-0040-DRAFT-0069.1: Samuel Knapp, Ed.D. Director of Professional Affairs



An affiliate of the
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Centers for Medicare and Medicaid Services
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Attention: CMS-4140, PO Box 8016
Baltimore, MD 21244-1850

RE: CMS-4140-IFC (Interim Final Rules Under the **Paul Wellstone** and **Pete Domenici** Mental Health Parity and Addiction Equity Act of 2008).

Dear Sir or Madam:

On behalf of the Pennsylvania Psychological Association, we are commenting on the Interim Final Rules under the Paul Wellstone and Pete **Domenici** Mental Health Parity and Addiction Equity Act of 2008. ***We urge the adoption of the current interim regulations.***

These interim final regulations address two important issues related to insurance discrimination against persons with mental illness or substance abuse problems that violate the Mental Health Parity law: the use of prior approvals to discourage utilization; and the lack of adequate access to services because of inadequate provider panels. Each of these issues will be discussed below, although the issues overlap.

Both of these issues are considered in the portion of the regulations dealing with nonquantitative treatment limitations. According to the regulations, "a nonquantitative treatment limitation is a limitation that is not expressed numerically, but otherwise limits the scope or duration of benefits for treatment" and includes a non-exhaustive list of treatment limitations that include "medical managed standards limiting or excluding benefits" (p. 5412). We will describe in detail below how the nonquantitative treatment limitations have been used to contravene the goals of parity. These have implications for the costs of parity which are also described below.

Prior Approval Requirements Not Applied to Physical Health Care

We urge the Department of Health and Human Services to retain the prohibition against nonquantitative treatment limitations as they pertain to medical management or prior authorizations. The regulations give an example dealing with prior approval (Example 2, (iii), p. 5426) which holds that a plan violates parity if it denies the entire payment of services based on lack of prior approval, whereas they would reduce the payment by 25% of what they would otherwise pay for the lack of prior approval for medical or surgical benefits.

Another example related to medical management is the requirement for authorizations (also called pre-certifications) for mental health or substance abuse care when similar prior authorizations are not required for physical health care. Authorizations for mental health treatment **limit** the ability of patients to access the services that they or their employer have paid for, and similar or comparable requirements are not required to access physical health care.

The authorizations for mental health services often include restrictions that do not apply in physical health care. These restrictions may **include** limiting the time period in which the service must be provided (sometimes within **very** narrow time frames), **specifying** the procedure codes that must be used, and placing such a large administrative burden on providers that they discourage psychologists **from** accepting patients with policies that have an authorization process. Below we present brief information on authorizations and then describe how they have been implemented with mental health care in a manner that is not done with physical health care.

Background on Authorizations

A survey conducted by the Pennsylvania Psychological Association in 2008 revealed widespread use of "authorizations" by health insurers. These authorizations permit beneficiaries to use their mental health benefits for a specified number of sessions (usually 8, but one insurer in Pennsylvania currently restricts the number of sessions to 5 and cases have been documented where they have authorized one 1, 2, or 3 sessions at a time). Payment is denied if the insurer does not have a copy of the authorization on record

Interviews with psychologists revealed that most psychologists have had never had an authorization denied because of medical necessity reasons. Several psychologists reported that they have received literally thousands of authorizations without one single denial. This is consistent with the report of one managed care company, Value Options, which reported less than 1% of authorizations were **denied**; however, they did not **specify** if they were denied for clinical purposes or for administrative purposes (Ledsky, 2000).

Authorizations May Put Arbitrary Restrictions on the Period of Time in Which the Service Must Be Provided

In contrast to ensuring medical necessity, often the authorizations place medically contraindicated restrictions on services. For example, a company may vary the length of the authorization from two months to a year. If the services cannot be delivered within the restricted

time period, then the providers have to resubmit authorizations, again resulting in unnecessary paperwork and the potential for a disruption in treatment. *We know of no plans which place similar limitations on access to physical health care.*

Authorizations May Restrict the Procedure Codes That May Be Used

Some authorizations restrict the type of service that can be offered. For example, an adolescent patient may receive authorizations for four sessions of individual therapy and four sessions of family therapy during a limited **time** period. If the psychologist were to deliver five sessions of individual therapy during this time period, then that psychologist could not collect payment for the 5th session of individual therapy. Of course, no mental health professional can always predict on the basis of one initial interview what the optimal *mix* of family and individual therapy sessions should be. *We question whether the prior authorizations for physical health problems put such restrictions on the procedure codes that can be used.*

Authorizations May Include Other Unique Requirements That Discourage Patient Care

One insurer requires psychologists to get outpatient authorizations for all inpatient consultations. Often these consultations were for neurological evaluations or competency to consent to treatment evaluations that required a quick turnaround. These authorizations are never denied, but they do delay implementation of a health care service in a setting where timeliness is very important. *Physicians do not have to get similar authorizations for inpatient services related to physical health.*

Another insurer reported that they required the psychologist to exhaust the 8 authorized sessions before she could apply for 8 more sessions, thus resulting in an **interruption** in treatment. This problem was eventually corrected, but it is yet another example of a process applied to mental health that was not applied to physical health.

Authorizations Place Such a Large Administrative Burden on Providers That They Discourage Utilization of Benefits

Authorizations may take anywhere **from** 5 to 15 minutes to complete, but the larger problem comes **from** the laxity of insurers in storing these authorizations. The provider's **administrative** time for authorizations includes both the time the secretarial or professional staff need to create the authorization, submit it, input it into the billing **software** program, and file a hard copy of the approval. The provider's administrative cost must also include time spent to correct the authorizations that get lost by the insurer, and time spent **talking** with patients about lost or delayed authorizations, or incorrect information on the authorizations. At least three steps are required to correct a clean authorization (where payment for an authorized service has been denied because of an error on the **part** of the insurer). The professional or clerical staff must double-check paperwork to ensure that the claims are indeed clean, call the insurer which then must search their records and update their systems, and then send the documentation to the

insurer. One group practice estimates that this takes 30 minutes per adjustment (assuming that the total cost of an hour of clerical staff is \$36 **[including** salary, benefits, work station costs, etc.], then it costs \$18 to "clean up" an authorization). Furthermore, providers need to assume some services will never get paid for because of authorization problems.¹

These cumulative burdens placed on mental health care, which are not placed on physical health care, have the impact of discouraging psychologists **from** treating patients with certain insurance policies.

Patient Access to Services

The interim regulations state that nonquantitative treatment limitations could include "standards for provider admission to participate in a network including reimbursement rates" (ii (D), p. 5436). This is an important element that needs to be retained in the regulations. Regrettably, some insurers and managed care companies offer rates so low that they effectively deprive beneficiaries of the opportunity to use the mental health benefits included in their health care plans because of the unwillingness of providers to accept such low reimbursement rates. For example, in Pennsylvania the rates for the Procedure Code 90806 under Medicare are \$90, but commercial insurers pay anywhere **from** \$105 to **\$50**. Access to health professionals is a factor influencing utilization. **Cully, Tolpin, Henderson, Jimenez, Kunick, & Peterson** (2008) looked at more than 410,000 VA patients and found that travel distance impacted the **likelihood** that individuals would attend psychotherapy.

Cost Implications

Page 5424 of your commentary discusses the cost implications associated with the increased utilization of mental health and substance abuse disorder benefits. Many of the points that you make in your discussion are valid; however, the discussion fails to address the fact that the nonquantitative medical management controls placed on behavioral health actually increase costs and waste huge amounts of money. ***We believe that your cost analysis should include ways that the elimination of unique and discriminatory medical management controls will increase the moneys spent on actual patient cure.***

¹Although a study by Wilk *et al.* (2008) did not deal with commercial policies covered by mental health parity, it nonetheless shows the impact of nonquantitative procedures on access to care. Wilk *et al.* (2008) studied implementation of Part D of Medicare for patients who had dual eligibility (for both Medicare and Medicaid) and found that, "in many cases, for every one hour of direct patient care there was one hour or more of administrative time for psychiatrists and their staff when certain drug plan policies applied" (p. 37). The increased administrative burden diverted psychiatric time away **from** direct patient care.

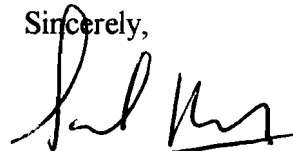
We have documentation that, for some insurers, at some points in time, almost **50%** of money allocated for outpatient mental health are spent on administrative purposes because of medical management procedures that are not applied to physical health. In **2005**, we reviewed the administrative costs for insurers in Southeastern Pennsylvania using a behavioral health carve out. The behavioral health provider reported that 80% of its revenue went toward direct services and the rest for administrative services and profits (although the definition of direct services is questionable, since they considered "case management" calls to be direct services, when we viewed them as a form of medical management). Also, we assume that the primary insurer had some administrative costs associated with its oversight of the behavioral health subcontractor. Nonetheless, even if we accept the **inflated 80% figure** to represent their direct services to patient and even if we assume NO administrative costs for the primary insurer, ***we find that only 52% of the money allotted for outpatient behavioral health actually gets spent on health care.*** This is derived by multiplying the **33%** of the moneys that group providers have to spend on administrative costs and multiplying it by the 80% of the money that the managed care company claims that it spends on behavioral health care.

If we exclude moneys spent on case management and spent by the primary insurer on their own administration and oversight of the carve-out company, and recognize that much professional time is spent in administrative tasks related to authorizations and other medical management procedures, we reach a figure ***where perhaps only 40% of the moneys allotted for outpatient behavioral health actually get spent on health care.*** The waste in administrative resources was so huge that, in those policies that required a **\$40** copay, the copay covers all of almost all of the cost of service and the health insurance premiums contribute nothing or almost nothing to the health care service.

We argue that parity in nonquantitative features will increase moneys spent on actual health care. Authorizations save money only to the extent that they deny payment for services based on administrative reasons, or discourage the utilization of medically necessary services. Also providers are more reluctant to accept patients who are represented by programs with authorizations, thus making it harder for patients to access their benefits.

Thank you for your consideration of our concerns.

Sincerely,

A handwritten signature in black ink, appearing to read 'Samuel Knapp', written over a horizontal line.

Samuel Knapp, Ed.D.

Director of Professional Affairs

References

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- Wilk, J., West, J., Rae, D., Rubio-Stipec, M., Chen, J., & Regier, D. (2008).** Medicare Part D prescription drug benefit and administrative burden in the care of dually eligible psychiatric patients. *Psychiatric Services*, 59, **34-39**.