UPMC | University of Pittsburgh Medical Center

Western Psychiatric Institute and Clinic

May 28, 2009

3811 O'Hara Street
Pittsburgh, PA 15213

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U. S. Department of Labor
200 Constitution Boulevard
Washington, DC 20210

Re: Mental Health Parity and Addiction Equity Act Comments

To All It May Concern:

Western Psychiatric Institute and Clinic of the University of Pittsburgh Medical Center appreciates the opportunity to respond to the Request for Information (RFI) regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (PHPAEA) published on the Federal Register on April 28, 2009.

With the passage of this law, the legislative body of the United States intended to provide benefits for mental illness and substance use disorders equal to those provided for other chronic and persistent medical problems. The efforts put forth to achieve this, and the outcome itself, directly challenged the long-standing difference, discrepancy and discrimination in the realm of behavioral health benefits, which resulted both from benefit design, the management of those benefits, or both.

Our focus now turns to the development of the regulations, which will serve to further ensure that the implementation of parity meets both the intention and the spirit of the law. Without adequate rules, given the areas of latitude in the law itself, there exists great opportunity for employers and insurers to insert more, new or different restrictions, which will result in negative, unintended consequence to individuals, families and providers. Mindful of these concerns, we offer the following the following responses to RFI in the specific areas identified:

- **Financial Requirements and Treatment Limitations**

  Currently, limitations to access and/or application of behavioral health benefits (benefits for mental health and/or substance use disorders) result from practices not specifically addressed in the law in the following ways:

  1) Inconsistent diagnostic limitations and/or conditions of treatment:

The law permits the use of exclusions based upon diagnosis, but in some instances exclusions may include the childhood version of a disorder that is otherwise covered once the age of adult has been reached, e.g., overanxious disorder in children is not covered, but anxiety disorder in an adult, is.

With some carriers, diagnostic limitations are imposed on the basis of the symptom(s). Symptoms of a disorder may include behaviors, especially in childhood disorders. If there is an exclusion clause on the policy which states that conditions related to behavior are not covered, this has resulted in the determination that a particular disorder is not covered, even when those behaviors are recognized as associated with relatively more common (and treatable) diagnoses in children, e.g., overanxious disorders, attention deficit disorders, oppositional disorders, etc.

Differences in coverage may also occur because the payer has determined that the disorder is biologically rather than non-biologically based, or other specific clauses exist which preclude access to the benefit, e.g., the condition was self-imposed, in which case results a denial of benefits for any psychiatric care following a suicide attempt.

A treatment episode may not be covered at all with an exemption clause which states that the condition must be amenable to "short-term, acute intervention". The analogy would be to provide an intervention during a heart attack, but to preclude access to on-going cardiac care and rehabilitation.

2) Use of Medical Necessity Criteria that is too general and narrowly applied.

The application of medical necessity criteria used by each payer AND the process by which decisions of medical necessity are made are vastly different than the process used for medical benefits.

Often medical necessity criteria (MNC) does not take into consideration manifestations of need relative to the age of the individual and are not specific to certain psychiatric disorders, e.g., eating disorders, obsessive compulsive disorder, etc. In such occurrence, symptoms can be seriously debilitating and require intensive intervention and though necessary by all practice standards, may not be covered because they are not seen as posing imminent danger and/or require treatment over the long term.

The medical necessity criteria in content impose a set of circumstances that by themselves, limit access to care in that they: a) Vary one company from another,

yet tend to be oversimplified into lethality, i.e., 'danger to self or others' especially when evaluating the necessity of more intensive levels of care; b) Often fail to measure lethality or dangerousness of psychiatric symptoms outside specific and immediate threats to the safety of others, or imminent suicidal threat; c) Are not diagnostic specific, so the needs of someone with an eating disorder, a major depression, or a combination of aging and depression will be evaluated against the same medical necessity criteria; and d) Do not take into consideration the need for continuation of services in order to sustain gains and improvement of condition.

In addition, there is a wide variance in the interpretation of the criteria across payers, and in some cases, within the same payer by different reviewers. And all too often in the cases of specialized needs, the reviewer rendering the denial may not be of equal degree, competence or experience as the professional recommending the treatment services. Access to a specialized second opinion after an initial denial is made, all too often, not made available.

Unlike the process on the medical side whereby the primary care physician or attending physician make the determinations relative to level of care, scope of care, services, etc., in behavioral health, the attending/recommending psychiatrist or eligible mental health practitioner must subject their assessment and recommendations to review by the insurer or designee before payment will be authorized.

The determination of "medically necessary" or "not medically necessary", places different financial requirements on the subscriber, dependent and/or provider. If a condition is not covered, or if the level of care being requested by the attending physician (psychiatrist) is determined to not meet medical necessity, the provider must still provide the services deemed to be 'medically necessary" and cannot deny treatment based upon the absence of authorization for payment. This puts the subscriber, and in some cases, the provider at risk for the payment.

3) Limited covered services and scope of coverage

There can be significant limitations in the area of covered services in behavioral health, where there are many more levels of care for treatment and services (accepted as effective treatment modalities) than exist in the medical world yet many commercial payers only cover inpatient and traditional outpatient services.

The result is the absence of coverage for levels of care such as partial hospitalization, intensive outpatient programs, community based services, case

management services, etc. which precludes ready access to the needed, and often less expensive yet effective services, and /or pushes the cost of service to either the subscriber or dependent, or to the public system if eligible.

4) Varying benefit levels

There are varying and differing coverage levels within classes of benefits for behavioral health, i.e., when comparing drug and alcohol to mental health benefits and/or in comparison to physical health benefits

There may be varying coverage levels, or no coverage at all, if the condition is deemed 'pre-existing'.

5) The determination of a "treatment episode"

Subscribers or dependents may incur a number of required co-payments/coinsurance requirements as they move from one level of care to another, e.g., from a medical hospital following a suicide attempt or the reverse, must be temporarily admitted to a medical unit following the development of a medical complication. In cases where transfer to a medical facility or unit from a psychiatric facility is required for diagnostic testing - even when the progression of care is all related to the same "condition" or follows the same 'precipitating event', payment requirements can apply.

6) Limited provider networks, with even more limited access to sub-specialty providers and care.

- **Terms or Provisions**

In order to facilitate compliance and equity, the following would be helpful:

1) Define/clarify a behavioral symptom of a behavioral health condition and preclude the ability to exclude coverage under the rubric of the term 'behavior'; additionally require consistent interpretation of covered conditions across the life span

2) Set forth provisions for development of medical necessity criteria which are disorder specific; eliminates 'fail first' (which requires that a person try services at a lower level of care, or less expensive level of care and fail, before being allowed to access the recommended, higher level of care); and which provides for a determination of dangerousness AND debilitation caused by the symptoms.

3) Require elimination of independent payer determinations of categories like 'biological or non-biological' or 'self-induced' as a means of limiting access to existing benefits

4) Reference a national standard for medical necessity criteria which should serve as the minimum for all payers

5) Eliminate 'pre-existing' exclusion

6) Define 'treatment episode' to include contiguous step down from one level of care, or step up, for the same condition or episode of care

7) Define whether services will come under the category of 'specialist' or primary care where co-payments, co-insurance, and deductibles apply

8) Clarify which level of care transitions are subject to additional co-payment/coinsurance and under what conditions

9) Provide for an inclusive, rather than restrictive network, which includes access to subspecialty care

10) Eliminate the ability to deny access to benefits with exception clauses that are intended to artificially restrict access to coverage

11) Make clear the requirements for managed plans, such as PPO, POS, and HMO, and the requirements for indemnity or unmanaged plans to the extent to which they still exist

12) Require that the insurers provide reviewers with credentials and expertise equal to those of the requesting provider

- **Medical Necessity Determinations and Notifications**

  The access to medical necessity criteria varies widely. Many payers will give the provider access to medical necessity criteria, others do not; even when they indicate they do, and even in instances where the protocol for requesting a copy has been followed. Subscribers have even less success with access to that information.

  When available, the information may be given to the network provider on paper, electronically, or on-line. (This is payer / Behavioral Health Managed Care Organization (BHMCO or MCO) specific)

Medical necessity criteria, as the basis of determinations of access to coverage for all subscribers and dependents, should be made readily and easily available on-line for those who have access-capability, and for those who do not, then in alternative version.

The criteria need to be based on research and scientific literature and best practice where available, with allowance for prevailing practice standards where best practices do not yet exist. Time frames must be established for disclosure of medical necessity criteria, along with clear requirement that appeal and oversight mechanisms must exist.

Providers and subscribers/beneficiaries should have access to the criteria without cost, and health plans should be required to provide someone to review and explain the medical necessity criteria to subscribers and/or dependents who require such.

- **Reasons for any denial under the plan (or coverage) of reimbursement or payment**

  While there are certain protections in Pennsylvania provided by Act 68 regarding managed care performance, including notifications of denials, the provision of information regarding specific medical necessity determinations is plan-specific, and varies both in the manner given, and in the amount of information provided; furthermore, the process and the information will vary based upon the level of care.

  In acute levels of care, e.g., inpatient or partial hospital if covered, generally the review and determination are made in real-time and communicated verbally most often; though this is not always the case. In the case of less acute levels of care, e.g, outpatient, requests for authorization are often made via a treatment plan or authorization request – either on paper or on line – and the determination of medical necessity comes by letter or electronic notification.

  In Pennsylvania, a copy of the denial letter is also sent to the subscriber, though this has raised some interesting questions regarding potential violation of privacy when the person seeking care is not the subscriber, but adult dependent; these letters must also include information regarding any appeal rights.

  Generally, information regarding the denial is vague, and not specific. While variable in language, they appear to be universally 'sparse', i.e., a denial may simply state that the service is deemed to be not medically necessary 'based upon the information provided'.

- **Out of Network Coverage**

  Out of Network (OON) coverage varies greatly plan to plan. Some do not provide any OON at all even when the medical benefit does; some may provide it but for only certain kinds of services or levels of care; others may provide it to all levels of care covered, but with varying financial requirements to the subscriber.

  Dependent upon the specific insurer and plan, e.g., HMO, enhanced HMO, PPO, etc. practice, the financial implications to the subscriber can be sizeable. Furthermore, this may make it extremely difficult, if not impossible, to go out of network to a provider who has expertise in a specific disorder, e.g., early childhood disorders, disorders more common with the aged, eating disorder, obsessive compulsive disorder, specific mood disorder, etc. even when the network does not have the expertise required.

- **Increased Cost Exemption**

  The cost-exemption issue needs further guidance/clarification specifically in regards to the "employer eligibility" for exemption and in the manner in which such exemptions will be reported, tracked and the information made further available.

  The law currently states that if costs to a plan are increased more than 2% in the first plan year related to compliance with the law and 1% thereafter, that such plan may request a cost exemption for the following year. The movement of plans into and out of, and potentially back into, exemption has the makings of chaos for both the subscriber and the provider.

  The process for application, and the conditions of eligibility for application, must be made explicit and clear. Furthermore, the financial formula, determination and algorithm must be specific and careful to consider the difference between real cost increases, versus those that may be the result of inflation or higher penetration rates as the demands for services go up (particularly in the current stressful, economic environment) and access is improved. Increased lengths of stay, or increased use of service, that derives directly from compliance with the law must be clearly differentiated from other kinds of cost increases.

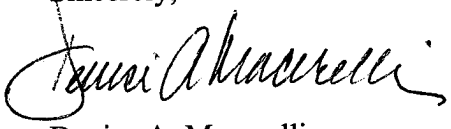
  Model notices would be very helpful. Additionally, serious consideration must be given to the development and management of a real time mechanism, such as a registry or a required public posting on the insurer's website, whereby both subscribers and providers could quickly view the cost exemption status of any employer/insurer.

The ability to have this information in real-time is critical, so that those seeking service and those providing the service will not be at risk for financial losses related to the services sought and rendered.

Delays in access to accurate information in this regard will likely, in many instances, preclude the ability to pursue other payment mechanisms or financial assistance for the subscriber/dependent. The results to the subscriber, and to the provider system, would be devastating if notifications and status are not properly managed.

In closing, we appreciate that the rule making related to parity is an intense and critically important undertaking. It is our hope that the comments and detail we have provided you will be helpful in this effort. Thank you again for the opportunity to comment. And please, do not hesitate to contact us directly should there be any questions, or wish for more information.

Sincerely,



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cc: Claudia Roth, Ph. D., President and CEO