beacon
health options

July 24, 2020

Amber Rivers
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., NW, Suite N-5653
Washington, D.C. 20210

Re: Comments on Draft to Update U.S. Department of Labor's (DOL) 2020 Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Self-Compliance Tool

Submitted electronically via e-ohpsca-MHPAEA-SCT-2020@dol.gov

Dear Ms. Rivers:

Beacon Health Options (Beacon) welcomes the opportunity to submit comments and recommendations on the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) MHPAEA Self-Compliance Tool (Self-Compliance Tool).

Background

Beacon is one of the country's leading behavioral health management company. We work with a broad client base that includes employers, regional and specialty health plans, and federal, state, and local governments. Today, we serve approximately 37 million people across all 50 states. Notably, Beacon administers programs that serve Medicaid recipients and other public sector populations in 20 states and the District of Columbia. In addition, we manage services for 5.4 million military service members and their families. Beacon is also among the largest specialty payers for autism services in the country.

Beacon has taken significant steps to support implementation of MHPAEA. These efforts preceded MHPAEA final regulations, which were released in 2013, and continue today through working with employers, health plans, state Medicaid agencies, regulators, legislators, providers, behavioral health interest groups and advocates, and others to further parity compliance. At the same time, Beacon works to provide the right level of care for consumers in an affordable manner, a goal compatible with parity compliance and consistent with broader clinical practice.

In these comments, Beacon would like to discuss the need for refined guidance for non-quantitative treatment limitations (NQTLs), including reimbursement.

Specific Recommendations

Analysis of Medical Services for Behavioral Health Conditions (p. 6)

The Self-Compliance Tool proposes a new note regarding the definition for "mental health benefits," stating that, "if a plan defines autism spectrum disorder (ASD) as a mental health condition, it must treat benefits for ASD as mental health benefits."

Beacon, as an exclusive behavioral health payer, has encountered much confusion among stakeholders and regulators regarding whether MHPAEA applies to a medical/surgical (M/S) benefit for a behavioral health condition. The issues arise over a very specific set of circumstances, including speech and occupational therapy for Autism Spectrum Disorder, surgery for gender dysphoria, or nutritional counseling for eating disorders. Many of our clients have expressed concern that if speech therapy for Autism Spectrum Disorder is subject to MHPAEA and is unlimited in benefit, but speech therapy for a stroke is not subject to MHPAEA and may have a limited benefit, the resultant disparity may be viewed as discriminatory (not to mention confusing and hard to administer).

To resolve any confusion, we recommend that plans be allowed to use a reasonable method for defining such services as M/S or MH/SUD benefits. For example, that method could define the service based on whether the service is most commonly or frequently used for a M/S or MH/SUD condition, using the plan's annual claims experience to determine spend on the service in question. (Note: A plan may be able to define other reasonable methods.) We note that CMS previously addressed this issue – of defining benefits in the case of a treatment or service that is used to treat both M/S and MH/SUD conditions – in an FAQ issued in October 2017 regarding MHPAEA compliance for Medicaid and CHIP programs and plans.[1] We believe that guidance is instructive for all scenarios where a plan must assign a treatment/service to one category of benefits or the other for purposes of plan design and administration of plan terms and conditions, including financial requirements, QTLs and NQTLs.

For example, if the member's plan uses annual claims experience for physical therapy services and finds that 87% of claims for physical therapy have a M/S diagnosis and 13% have a MH/SUD diagnosis, the plan may then define physical therapy as a medical benefit for purpose of defining the applicable quantitative limits (e.g., annual visit limit) and financial requirements (e.g., copayment). If, however, the plan's claim experience showed that 48% of claims for physical therapy were for a M/S diagnosis and 52% were for a MH/SUD diagnosis, the plan would have to treat physical therapy as a mental health benefit.

Panels of Experts (pp. 12; 25)

Beacon supports the Self-Compliance Tool's proposed new examples discussing the use of panels of experts as evidentiary support to justify use of a particular NQTL. In general, many plans like Beacon use panels of medical experts to assess whether a particular utilization management protocol (such as prior authorization) should be applied to a particular service; these decisions are not based simply on one or two individual studies or quantifiable metrics. Beacon notes that differences do exist between behavioral health and physical health in order to ensure that the best quality, evidence-based care is being provided to consumers; while physical health has biomarkers to indicate a disease or condition, behavioral health diagnoses are not as clearly identified. One way to ensure the provision of excellent care is to focus on the above example and reliance on panels of experts to make clinical determinations. Such an approach is more reliable than an overly rigid or imprecise benefit/service crosswalk approach.

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[1] See https://www.medicaid.gov/federal-policy-guidance/downloads/faq101117.pdf ("A variety of LTSS benefits, such as personal care and respite care, could be defined as either MH/SUD or M/S (M/S), depending on the condition of the beneficiary being treated. For these benefits, the state may define the benefit as MH/SUD or M/S for the entire beneficiary population using a reasonable method, such as whether the service is most commonly or frequently provided due to a MH/SUD or M/S condition. For example, if more than 50% of spending on personal care is for beneficiaries who are receiving the service due to M/S conditions, the state may reasonably define personal care services as a M/S benefit for the purposes of the parity analysis.).

During the recent DOL-hosted listening session on parity, some stakeholders continue to argue for NQTLs to rely solely on quantifiable metrics to support an analysis. The "predominant" and "substantially all" tests that apply to financial requirements and quantitative treatment limitations do not apply to a health plan's NQTLs. The MHPAEA final regulations require the application of a different test because NQTLs are not mathematical in nature.[2] Many stakeholders continue to re-write the MHPAEA Final Rule to argue that a mathematical component should be the key component in any compliance analysis. Rather, the DOL should reiterate in the Self-Compliance tool that a compliant NQTL analysis can be solely based on a comparison of narrative or qualitative descriptions.

Reimbursement (pp. 23-23; 39-40)

For reimbursement rates, Beacon suggests that the Self-Compliance Tool be revised to show how factors used in determining provider reimbursement, when applied in a manner that is comparable to and no more stringent for MH/SUD as for M/S benefits, can result in different dollar amounts that are permissible under MHPAEA.

The Self-Compliance Tool fails to recognize that MH/SUD and M/S providers are generally subject to an identical process for setting in-network, contracted rates. The parties begin at the base rate, and via arms-length negotiations reach the final rate, meaning that market forces, and not the chosen base rate, determine whether providers receive higher rates. Providers are not required to join a plan's network, and do so only after a voluntary negotiation has been concluded. In general, the processes and standards used to negotiate M/S and MH/SUD rates are comparable, and applied no more stringently for MH/SUD benefits, in that they rely on free-market negotiations to arrive at the final result.

Plans and issuers may, per the MHPAEA Final Rule, consider a wide array of factors in determining provider reimbursement rates for both M/S services and MH/SUD services, such as: service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience and licensure of providers.[3] The NQTL provisions require that these or other factors be applied *comparably to* and no more stringently than those applied with respect to M/S services.

Beacon suggests the Self-Compliance Tool provide an additional example to demonstrate how a plan can be compliant with MHPAEA even though it utilizes a Medicare relative value unit ("RVU") for determining base rates for M/S providers and a different fee schedule for determining MH/SUD base rates, as long as the underlying process for selecting the fee schedule, including considerations and factors relied upon, is comparable, even if the MH/SUD base rates are lower in some respects than those for M/S providers. MHPAEA's NQTL rule allows for negotiations with providers and reliance on market factors to be used in provider contracting.

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[2] "These final regulations continue to provide different parity standards with respect to quantitative treatment limitations and NQTLs. . . ." 78 FR 68245.

[3] See 78 Fed. Reg. 68240, 68246. Notably, key research in this area has tended to support the factors used by the regulators, including the following: "The bargaining power will vary across provider types depending on the relative scarcity of the type of provider. For example, an issuer may have little negotiating power in setting the reimbursement rate for child psychiatrists because there are relatively few child psychiatrists in the market area, whereas the issuer may have negotiating power with other provider types that are in greater supply, such as social workers." *Changes in Individual and Small Group Behavioral Health Coverage Following the Enactment of Parity Requirements: Final Report* (January 2017), report of U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy.

The Self-Compliance Tool should emphasize a comparability analysis for both setting base rates for MH/SUD and M/S rate setting using the following analysis:

Medicare M/S Rate	Reimbursement Factors	Non-Medicare MH/SUD Rate
Yes	Usual and Customary Work	Yes
Yes	Supply and Demand	Yes
Yes	Geographic Location	Yes
Yes	Licensure and Training	Yes
Yes	Value, Effort and Efficiency of Service	Yes
Yes	Commitment to Value-Based Reimbursement Models	Yes

The above is not intended to be, and should not be interpreted to be, the entirety of a payer's analysis of provider reimbursement rates. The use of any particular base rate is only one factor in the overall processes, strategies, etc. that lead to provider reimbursement rates. Indeed, in both cases, these base rates serve *only* as a floor for contract negotiations for newly contracted providers. Both MH/SUD and M/S providers are subject to an identical process for setting in-network, contracted rates. The parties begin at the base rate, and via arms-length negotiations reach the final rate, meaning that market forces, and not the chosen base rate, determine whether providers receive higher rates. Notably M/S providers tend to be associated with larger provider groups that enjoy greater negotiating power because they control larger swaths of the market. As a result, they tend to negotiate larger rate increases over the base rates, whereas MH/SUD providers tend to be solo or small group practitioners who have less negotiating leverage. This is an inherent issue that can lead to reimbursement disparities; however, it is consummately a condition of the prevailing market forces, a condition that is expressly permitted by MHPAEA. The Self-Compliance Tool's apparent focus on a single factor in the provider-reimbursement process, without taking into consideration the other factors in this process (as well as the interaction between factors and how they may bare on provider reimbursement), appears to be entirely results driven which is inappropriate for NQTL analyses.

Coverage of Benefits (p. 10)

The Self-Compliance Tool proposes new guidance related to exclusions of benefits for MH/SUD conditions, stating that the coverage of prescription drugs for a particular condition may impact the ability of a plan to exclude other benefits. Beacon recommends that this example be removed or be further clarified/refined. MHPAEA does not mandate a scope of service or that any particular MH/SUD condition must be covered. Payers do not always know the reasons a provider prescribed a particular drug. Moreover, a drug may be prescribed for a co-morbidity that does not necessarily relate to an underlying

MH/SUD condition. For example, if a drug is prescribed for apraxia, which may be related to autism, and the plan does not cover autism, does that mean there is de facto coverage for autism? It would be extremely challenging from an operational perspective for plans and issuers to effectively police their coverage to ensure that no benefits are paid for any drug or other treatment or service for an excluded condition.

Additional Examples of NQTL noncompliance (pp. 28-29)

The Self-Compliance Tool proposes adding two problematic examples relating to drug testing and medical necessity to its "red flag" lists (pp. 28-29).

A proposed Warning Sign reads:

> 2. Denying all drug screening tests for those with SUD: A plan or issuer denies all claims for drug screening tests for participants and beneficiaries with a sole diagnosis of addiction because they are treated as not medically necessary. However, the plan or issuer covers drug screening tests when the diagnosis is a M/S condition.

With regard to drug testing, due to fraud and overuse of SUD testing (particularly in out-of-network facilities), many payers have medical necessity requirements before authorizations. Beacon is concerned that this example over-simplifies a complex NQTL analysis involving what services on M/S side that are subject to fraud, waste and abuse and the standard for denials of such services. Beacon recommends removal of this example.

Another Warning sign reads:

> 3. *Different medical necessity review requirements*: A plan or issuer imposes medical necessity review requirements on outpatient MH/SUD benefits after a certain number of visits, despite permitting a greater number of visits before requiring any such review for outpatient M/S care.

While Beacon has no concerns with the outpatient component of the example, it would be helpful to address a "green flag" version of the medical necessity concept that is more challenging. Beacon notes that while Diagnostic Related Group (DRG) reimbursement methodologies exist on the M/S side and serve to act as a treatment limitation for inpatient stays, DRGs do not exist as frequently for MH/SUD treatments. In such situations, it would be helpful for the Self-Compliance Tool to provide an example deeming that a plan's use of concurrent review is clinically appropriate and permissible for psychiatric hospitalizations, as long as general medical hospitalizations that are not reimbursed based on DRGs are also subject to concurrent review. Beacon remains committed to offering innovated value-based payment arrangements as well as DRGs, but thus far, many providers and facilities remain resistant to such efforts.

Wit v United Health Care case (p. 33)

The Self-Compliance Tool proposes a cite to the *Wit v. United Behavioral Health* decision to illustrate the point that parity compliance is often inter-related with other regulatory compliance issues. Beacon objects to the *Wit* case being set forth as an example of noncompliance, given that this decision has not been entered as a final judgment, is currently being appealed, sets forth sweeping new requirements that have not been adopted by any other district, and as a district court decision is not binding on any other district nation-wide. Beacon respectfully requests that EBSA not address active

litigation through the Parity Self-Compliance Tool, especially with regard to points of law that are not specific to parity.

Provider Directories (p. 26)

The Self-Compliance Tool proposes new language discussing parameters around the requirement that ERISA-covered plans must provide accurate provider directories to members. While supportable in concept, the issue of provider directories is not a MHPAEA issue (nor an NQTL) and should not be part of the analysis. Beacon requests removal of this discussion/reference.

National Association of Insurance Commissioners' (NAIC's) Data Collection Tool (p. 35)

The Self-Compliance tool inserts new language indicating that stakeholders may want to use the current NAIC Data Collection Tool, which includes a NQTL Chart, to assist in assuring MHPAEA compliance. Beacon supports and endorses use of the flexible NQTL Data Collection Tool/template adopted previously by the NAIC. The existing NAIC Data Collection Tool aligns with MHPAEA and is clear and easy to read which can aid examiners in conducting efficient and productive NQTL examinations. Notably, it is our understanding that the NAIC Data Collection Tool (sometimes referred to as "Table 5") has been used by the CMS to ensure a consistent and uniform approach in parity enforcement efforts of NQTLs. We encourage DOL to formalize the proposed recommendation that health plans rely on the existing NAIC template and to continue to engage the NAIC and state officials to ensure alignment moving forward.

NQTL "step-wise" analytical framework

Lastly, Beacon remains concerned with the Self-Compliance Tool's promotion of a step-wise framework for analyzing NQTLs. The granular direction of the NQTL guidance is confusing and burdensome, which does not serve to improve consumers' behavioral health treatment and access. Specifically, the information set forth in the Self-Compliance Tool could require plans to produce or review large quantities of technical information, such as comparative effectiveness studies, clinical trials, professional protocols, published research studies, thresholds for evidentiary standards, such as "two standard deviation higher in total cost than the average cost per episode 20 percent of the time in a 12-month period", and internal claims database analyses, among other examples. Beacon is concerned that this level of detail in the Self-Compliance Tool goes far beyond what is required in the law, which specifies "any processes, strategies, evidentiary standards, or other factors" used in applying NQTLs. Indeed, MHPAEA and its related regulations do not define the terms "processes, strategies, evidentiary standards, or other factors." The Self-Compliance Tool should explicitly allow plans flexibility under the regulations as to how these terms may be defined and applied under a particular plan design and/or operational procedure. These terms may have specified definitions, or plans may choose to treat these terms as synonyms under the law.

Conclusion

Beacon thanks the Department of Labor for this opportunity to provide our comments on the Self-Compliance Tool. Beacon will continue to implement innovative programs that improve access to quality,

affordable, and evidence-based behavioral health care. We will also continue to work with policymakers in removing barriers to further innovations and improvements for those individuals with MH/SUD conditions. Should you have any questions, please feel free to contact me at daniel.risku@beaconhealthoptions.com or 617-747-1255.

Sincerely,

Daniel M. Risku
Executive Vice President & General Counsel
Beacon Health Options