



June 7, 2017

The Honorable Chris Christie
Chair, President's Commission on Combating Drug Addiction and the Opioid Crisis
Eisenhower Executive Office Building
1650 Pennsylvania Ave NW
Washington, DC 20502

Dear Governor Christie,

On behalf of the members of the Parity Implementation Coalition (PIC), thank you for the opportunity to provide input into the Commission's development of recommendations to address the opioid misuse and overdose epidemic.

The Parity Implementation Coalition is an alliance of addiction and mental health consumer and provider organizations. Members include the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, Depression and Bipolar Support Alliance, Hazelden Betty Ford Foundation, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, National Association of Addiction Treatment Providers, and Young People in Recovery. In an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders, many of these organizations have advocated for more than nineteen years in support of parity legislation and issuance of regulations. We are committed to the prompt and effective implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)

Please find below recommendations based on our experience over the last 7 years in working with consumers, providers and health plans with respect to implementation of the law.

Transparency and Disclosure

- Transparency is essential to ensure that plan participants and beneficiaries receive medically necessary health care coverage and access to equitable addiction and mental health treatment based on parity-compliant benefit plan design, medical management protocols, and other non-quantitative treatment limitations (NQTs).
- Proper disclosure of information is especially important to plan participants and beneficiaries seeking mental health/substance use disorder (MH/SUD) treatment and recovery support services and the providers who help them. This is true whether a patient is trying to understand an adverse benefit determination or challenging what appears to be an unlawful NQTL utilized by a health plan, either as written, as applied or both.
- One of the most common barriers reported by the patients and providers PIC members serve is the lack of disclosure by health plans on the development and application of NQTs.

- Parity compliance testing cannot be performed on coverage limitations such as prescription drug formulary design, medical and administrative management techniques, including restrictions based on facility type or provider specialty, without this information.
- For example, to determine whether a plan is in compliance with the law, consumers and their providers, who often serve as authorized representatives for patients, may request medical management criteria and protocols, information on how these criteria and protocols are developed and applied (both as written and in operation), for both MH/SUD and medical/surgical benefits.
- We have been made aware of hundreds of such requests by authorized provider representatives that have gone unanswered.
- We emphasize once again how no consumer, authorized representative or regulator can possibly know whether a plan is compliant with or in violation of the NQTL rule of the federal parity law based on the information that, to our knowledge, has not been submitted by any plan to date.

Transparency and Disclosure Recommendations

- The Commission should recommend that the Departments of Health and Human Services and Labor develop additional guidance to clarify what is meant by “documentation” as used in sub-regulatory guidance relating to each of the components of the NQTL test.
- To ensure documents and information are fully disclosed, consistent with MHPAEA’s statute and implementing regulations, the Commission should recommend that federal and state agencies develop forms to include the following documents and information to be supplied for review upon request.
 - Based on our experience with assisting patients, we recommend utilization of a 5-step parity compliant analysis and state and federal regulators issue template forms that require the disclosure of key plan documents. The 5-step process explained and illustrated below provides clear guidance on the type of information and documentation that is required to be disclosed.
 - These 5 steps are based on the MHPAEA Final Rules, related federal regulations, as well as previously issued sub-regulatory guidance.
- Parity regulatory guidance required under the *21st Century Cures Act* on non-quantitative treatment limitations and other issues should be issued as soon as possible, but no later than the statutory deadline of December 2017.

Coverage of Addiction and Mental Health Treatment

The Commission's report should recommend that addiction and mental health treatment benefits continue to be available to Americans enrolled in the individual, small and large group markets as well as Medicaid plans, and that these benefits are compliant with MHPAEA.

For example, Medicaid expansion has been associated with an 18.3 percent reduction in unmet need for addiction treatment services among low-income adults. Any reduction to the Medicaid expansion or fundamental change to Medicaid's financing structure to cap spending on health care services will certainly reduce access to evidence-based treatments and reverse much or all progress made on the opioid crisis last year. Moreover, the loss of Medicaid-covered mental health and substance use disorder services for adults would result in more family disruption and out-of-home placements for children, significant trauma which has its own long-term health effects and a further burden on a child welfare system that is struggling to meet the current demand for foster home capacity.

Coverage of Addiction and Mental Health Treatment Recommendation

- As Congress considers legislation to reform the health care system, Sections 112 and 136 of the *American Health Care Act* as passed by the House should not apply to requirements for coverage of mental health and addiction treatment coverage.

Conclusion

Thank you again for the opportunity to provide comments. We look forward to working with the Commission and the Administration in any way we can to ensure the Mental Health Parity and Addiction Equity Act is fully implemented and enforced so consumers have access to the non-discriminatory mental health and substance use disorder treatment as promised to them under the law.

Sincerely,



Mark Covall
Co-Chair
Parity Implementation Coalition



Marvin Ventrell
Co-Chair
Parity Implementation Coalition

NQTL Compliance: 5-Step Process

5-Step Parity Compliance NQTL Analysis (template forms should be developed by federal and state regulators to ensure all of this information is disclosed to both plan members and their authorized representatives).

Step 1. Describe the NQTL and both the MH/SUD services and medical/surgical services to which it applies. (Any separate NQTL that applies only to MH/SUD benefits within any particular classification is in violation of MHPAEA).

Step 2. Identify the factor(s) used in the development of the specific NQTL.

A description of each of the factors that were in fact used to develop the specific NQTL, including the rationale for the relevancy of such factor(s) and the sources for ascertaining each of these factors: e.g., external research studies, internal claims analyses, internal quality standard studies, etc.

Illustrative examples of factors that could be used include:

- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Lack of clinical efficacy of treatment

Step 3. Identify the evidentiary standard(s) used to define such factor(s).

A description of the evidentiary standard(s) used to define each of these factors identified in Step 2.

Illustrative evidentiary standards that may define the factors listed above include:

- Two standard deviations above average utilization per episode of care (may define excessive utilization)
- Medical costs for certain services increased 10% or more per year for 2 years (may define recent medical cost escalation)
- Deviation from national generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews (may define lack of adherence to quality standards)
- 25% of patients stayed longer than the median length of stay for acute hospital episodes of care (may define high level of variation in length of stay)

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- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12 month period (may define high variability in cost per episode)
 - More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12 month sample (may define lack of clinical efficacy)

Please note: The term “evidentiary standards” may also include any evidence a plan considers in developing its medical management techniques, such as recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials).

Step 4. Methods and Analyses used to establish comparability in the development of the NQTL.

A description of the methods and analyses used to determine that any factors used, evidentiary standards relied upon, and processes employed in developing the NQTL for MH/SUD services and medical/surgical services are comparable. The results of these analyses are to be included.

Illustrative methods and analyses to determine if factors, evidentiary standards, and processes are comparable include:

- Internal claims database analyses that showed key factors (which are each defined by specific evidentiary standards) were present in a comparable manner in both MH/SUD and medical/surgical class of benefits.
- Review of the published literature on rapidly increasing cost for services for both MH/SUD and medical/surgical conditions and determination that a key factor(s) was present with similar frequency in specific categories of both MH/SUD and medical/surgical services.
- Methodology and results for analyzing that all medical/surgical service categories that had a “high cost variability” (defined in the same manner for both medical and MH/SUD services) were subject to pre-authorization, as were all types of MH/SUD services that fit this definition
- Analyses that the processes for setting usual and customary provider rates for both MH/SUD and medical/surgical were the same, both as developed and applied, along with the results from these analyses.

Step 5. Testing and Reviews conducted to establish comparability and no more stringency in the application of this NQTL “in operation”.

Documentation of any testing, audits or reviews and the results thereof that demonstrate that the processes employed “in operation” for MH/SUD benefits in each

relevant classification of benefits are comparable to and applied no more stringently than the same processes employed “in operation” for medical/surgical benefits in the corresponding classification of benefits.

Illustrative documentation of methods and analyses to determine the comparability and equivalent stringency of processes used in NQTL application, in operation, include:

- Documentation that specific audits were performed with respect to the frequency of medical/surgical vs. MH/SUD reviews within the same classifications of benefits to assure that the NQTL is applied comparably and no more stringently.
- Audit results that physician to physician utilization reviews were similar in frequency and length of time for medical/surgical vs. MH/SUD within the same classifications of benefits to assure that the reviews were comparable and no more stringently applied in these respects.
- Audit results that demonstrate that frequency of reviews for the extension of initial determinations for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for MH/SUD benefits.
- Data from analyses to determine whether the out-of-pocket spending by members for inpatient SUD and MH services are similar to those for out-of-pocket spending for medical/surgical members in similar types of facilities.
- Results of compliance testing of network access standards that wait times for primary care office visits were the same as the wait times for psychiatric office visits.

Please note: There are many other processes that may be used in operation for any given NQTL, particularly those that involve medical management techniques, such as consultations with expert reviewers, clinical rationale used in approving or denying benefits, and the selection of information deemed reasonably necessary to make a medical necessity determination, etc. Plans must analyze every process employed in operation for comparability and equivalent stringency in application.