Mental Health Parity Workshop

Elena Lynett, VP and Senior Health Compliance Consultant

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DOL Subregulatory Guidance & Report to Congress
Federal Reports and Tools


- DOL published an updated 2020 MHPAEA Self-Compliance Tool [https://www.dol.gov/agencies/ebsa/at-a-glance](https://www.dol.gov/agencies/ebsa/at-a-glance)
The Report emphasizes the Departments’ continued focus on ensuring access to MH/SUD benefits and compliance with MHPAEA.

The Departments provided examples of the changes their investigations resulted in, including:

- The elimination of exclusions for applied behavioral therapy to treat autism
- The removal of exclusions for medication-assisted treatment for opioid use disorder
- The elimination of certain impermissible nutrition counseling exclusions that were applied more restrictively to MH conditions than to medical/surgical conditions
- The correction of restrictive claims processes related to urine drug testing for SUD
- The removal of blanket prior authorization requirements on outpatient MH and SUD benefits
- The correction of impermissible exclusions and limitations related to residential treatment
DOL MHPAEA Report to Congress

- DOL issued 156 letters requesting comparative analyses for 216 NQTLs
- The Centers for Medicare & Medicaid Services (CMS) issued 15 letters
- The Departments stated that none of the comparative analyses received by the Departments contained sufficient information upon initial receipt.
- The Departments call for Congressional action to enhance MHPAEA and MH/SUD enforcement. Specifically, the Departments request:
  - Civil monetary penalties
  - Direct enforcement authority with respect to third-party benefit administrators
  - Extension of flexibilities that allow for expanded access to telehealth
  - Amendments to MHPAEA to promote uniformity and objectivity in defining MH and SUD benefits
EBSA and CMS investigated MHPAEA violations in these categories:

- Annual dollar limits
- Aggregate lifetime dollar limits
- Benefits in all classifications described in the MHPAEA final regulations
- Financial requirements (i.e., deductibles, copayments, coinsurance or out-of-pocket maximums)
- Quantitative treatment limitations (QTLs) and NQTLs
- Cumulative financial requirements and QTLs
The Departments clarify that a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards or other factors related to NQTLs is insufficient to fulfill the new comparative analysis requirement.
The Departments point to the DOL’s **MHPAEA Self-Compliance Tool** as a source of guidance related to requirements for NQTLs, including a process for analyzing whether a particular NQTL meets those requirements.
Tips to Avoid as Insufficient Comparative Analysis

The FAQs provide examples of reasons why the Departments might conclude that documentation of comparative analyses of NQTLs is insufficiently specific and detailed.

- Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis
- Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations
- Identification of processes, strategies, sources and factors without the required or clear and detailed comparative analysis
Tips to Avoid as Insufficient Comparative Analysis

- Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application

- Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason
In addition, the Departments clarify that plan sponsors should be prepared to make available documents that support the analysis and conclusions of their NQTL comparative analyses.

For example, they note:

If comparative analyses reference studies, testing, claims data, reports, or other considerations in defining or applying factors (such as meeting minutes or reports showing how those considerations were applied), then the plan or issuer should be prepared to provide copies of all those items.
Enforcement Priorities

- The FAQs do not provide an exhaustive list of NQTLs regarding which the Departments may request the comparative analysis and reinforce the need to perform and document comparative analyses for all NQTLs imposed.

- In the near term, the DOL indicates that it expects to focus its enforcement efforts on:
  - Prior authorization requirements
  - Concurrent review requirements
  - Standards for provider admission to participate in a network (including reimbursement rates)
  - Out-of-network reimbursement rates
More Guidance on the Horizon

Congress directs the departments to issue guidance to include:

- Clarifying information and illustrative examples of methods that group health plans may use for disclosing information
- Illustrative examples of methods that plans may use to provide any participants, beneficiaries, contracting providers, or authorized representative, as applicable, with documents containing information that plans are required to disclose
More Guidance on the Horizon

Congress directs the departments to issue guidance to include:

- Information that illustrates the comparative nature of the requirements
- Guidance regarding the process and timeline to file complaints of regarding a plan being in violation MHPAEA.
Audits: A Closer Look
Autism Coverage Compliance Challenged

(i) The specific Plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(iii) The evidentiary standards used for the factors identified in paragraph (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.
(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical (Med/Surg) benefits in the benefits classification.

(v) The specific findings and conclusions reached by the Plan, including any results of the comparative analyses that indicate that the Plan or coverage is or is not in compliance with MHPAEA
Audits Probing Autism

**Autism Coverage Compliance Challenged**

- More restrictive prior authorization under the plan’s written terms required revision
- Misleading plan language regarding comprehensive assessment prerequisite to prior authorization flagged
- Potentially restrictive treatment plan reviews questioned
- Expectation of significant improvement required for ongoing coverage approval reviewed
Audits Probing Autism

**Autism Coverage Compliance Challenged**

- ABA exclusion questions
- Comparative analysis supporting ABA exclusion requested
- Limits or restrictions related to ABA coverage present risk; Plans can expect requests for comparative analysis information related to any limits or restrictions that may apply to ABA therapy
More Audit Examples

**MHPAEA enforcement requests:**

- Claims information to support specialist rate charged for mental health office visits
- Claims reports to support an assertion that benefits were not denied under a certain plan provision
- Exclusion for residential treatment for MH/SUD challenged
- Exclusions or limitation on nutritional counseling, including for treatment of eating disorders being challenged
Audit Probing Nutrition Counseling

Claims Denial

Details Requested:

### Health Claims Data Attributes:

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan ID</td>
<td>Unique identifier for enrollment in the Plan.</td>
</tr>
<tr>
<td>Coverage Option ID</td>
<td>Unique identifier for enrollment in a coverage option.</td>
</tr>
<tr>
<td>Member ID</td>
<td>Unique identifier for each policy holder.</td>
</tr>
<tr>
<td>Patient ID</td>
<td>Unique identifier for the patient/individual incurring the claim.</td>
</tr>
<tr>
<td>Patient Birthdate</td>
<td>Birthdate of the patient.</td>
</tr>
<tr>
<td>Patient Sex</td>
<td>Sex of the patient.</td>
</tr>
<tr>
<td>Unique claim number</td>
<td>Unique identifier for a claim within the claims systems.</td>
</tr>
<tr>
<td>Unique line number</td>
<td>Unique identifier for a line of service within the claim.</td>
</tr>
<tr>
<td>Service start date</td>
<td>Beginning date of service.</td>
</tr>
<tr>
<td>Service end date</td>
<td>End date of service.</td>
</tr>
<tr>
<td>Received date</td>
<td>Date the payer received the claim.</td>
</tr>
<tr>
<td>Processed date</td>
<td>Date the payer adjudicated the claim.</td>
</tr>
<tr>
<td>Paid date</td>
<td>Date the claim was paid.</td>
</tr>
<tr>
<td>Diagnosis Code (primary, secondary, tertiary)</td>
<td>What the patient is diagnosed with at the visit (include all codes present for each claim).</td>
</tr>
<tr>
<td>Diagnosis Code description</td>
<td>Description of each listed diagnosis code.</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Code representing the procedure provided to the patient during the visit, <strong>including all modifiers</strong>.</td>
</tr>
<tr>
<td>Procedure Code description</td>
<td>Description of the procedure provided to the patient during the visit.</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Category of provider services (e.g. surgical, behavioral, preventive, emergency, specialist, etc.).</td>
</tr>
<tr>
<td>Place of Service Code</td>
<td>The type of location or entity where the services were rendered.</td>
</tr>
<tr>
<td>Inpatient/Outpatient Indicator</td>
<td>Claim classification as inpatient or outpatient.</td>
</tr>
<tr>
<td>Provider Network Status</td>
<td>Provider is in-network or out-of-network.</td>
</tr>
<tr>
<td>Pricing schedule</td>
<td>Indicate the pricing schedule that was used to price the claim, if out of network (e.g. based on % of Medicare)</td>
</tr>
</tbody>
</table>
Plan Sponsors Considerations
What can plans do now?

• Develop an approach to good faith compliance with the statute.
  – Determine a plan to begin to collect and document relevant information. This will most commonly include coordination with benefit administrators (both medical and pharmacy) to help review the plan’s NQTL compliance as written and in operation.
  – Plan sponsors should anticipate that some compliance issues may be identified and need to be resolved.

• Watch for forthcoming guidance.
  – This may include additional FAQs, regulatory guidance, updates to the DOL self-compliance tool, and/or other clarifying information that may be published by the Departments.
What can plans do now?

- Ensure outdated plans terms are eliminated in writing and operation.
- Incorporate benefit improvements, including updating medical management practices according to current industry standards.
- Assess the compliance capabilities of existing administrators. Are your plan administrators providing information in a format consistent with DOL’s approach?
- Probe compliance support capabilities in the selection process. Identify the new service provider and begin compliance efforts as part of the implementation process.
Requests and Complaints

A participant, beneficiary or enrollee (or their authorized representative) or a state regulator, may request an NQTL comparative analysis.

The Departments note that in the instance of a specific complaint, they may request information related to the NQTL in question, such as the comparative analysis related to prior authorization. However, the Departments remind plan sponsors that, under the amendments to MHPAEA, the DOL or HHS may also request NQTL comparative analyses in any instance deemed appropriate.
What can plans do now?

Plans that receive participant complaints should work diligently to resolve those complaints.

– Complaints may trigger a request for the NQTL comparative analysis

– Complaints may trigger a comprehensive Federal audit for parity compliance OR a comprehensive audit for health plan compliance with applicable Federal law under ERISA or the Public Health Service Act, including compliance with the ACA and other applicable laws
Thank You!

Elena Lynett
VP, Senior Consultant
Compliance-Health, National Compliance
elynett@segalco.com