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Ms. Cecilia Muñoz, Chair
Mental Health and Substance Use Disorder Parity Task Force
c/o Domestic Policy Council
The White House
1600 Pennsylvania Ave. NW
Washington, DC 20500

Submitted electronically via parity@hhs.gov

Dear Ms. Muñoz:

On behalf of America's Health Insurance Plans (AHIP), I am writing to address issues surrounding mental health and substance use disorder parity.

AHIP is the national association representing health insurance plans. Our members provide health and supplemental benefits to the American people through employer-sponsored coverage, the individual insurance market, and public programs. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

In this letter, we highlight our industry's commitment to parity and to meeting the needs of patients with mental health and substance use disorders. We also address some of the challenges associated with treating patients with mental health and substance use disorders, most notably the national shortage of clinicians who are qualified to treat patients with behavioral disorders, and we offer recommendations for the Task Force. Additionally, we offer comments on guidance the Administration has issued addressing: (1) whether insurers can rely on data for their entire book of business in testing whether a plan passes the "substantially all" and "predominant" level testing required under federal law for testing financial requirements and quantitative treatment limitations; and (2) disclosure obligations under federal law for medical necessity determinations with respect to mental health and substance use disorder benefits.

Health Plans Promote Access to Quality, Affordable Behavioral Health Care

Our members support the protections established by the federal Mental Health Parity Act (MHPA), and as amended by the Mental Health Parity and Addiction Equity Act (MHPAEA), as well as state requirements. Health plans have worked diligently to ensure compliance with parity

requirements – involving clinical and administrative personnel across both medical and behavioral departments to promote understanding and implementation of parity rules. A 2013 report prepared for the Department of Health and Human Services found that "…employers and health plans have made substantial changes to their plan designs in order to comply with MHPAEA…"[1]

Beyond parity, our members have been leaders in pioneering innovative programs focused on ensuring that patients have affordable access to high-quality, evidence-based treatments. We recently conducted a series of interviews with some of our member plans to document the range of creative and comprehensive approaches to meeting the needs of patients with mental health and substance use disorders. Our issue brief, *Ensuring Access to Quality Behavioral Health Care*, describes a number of these plan-specific initiatives.[2] The following are key components of these programs:

First, these programs rely on ***proactive identification and outreach***. Because of the oftentimes close link between physical and behavioral health, health plan medical care managers working with patients with chronic medical conditions screen for behavioral health concerns and, if any potential issues are identified, they work with the plan's behavioral health care managers to help these patients navigate the system and coordinate ongoing care. This process runs parallel to the processes used to assist patients with chronic medical conditions.

Second, these programs are founded on ***quality, evidence-based care***. Using nationally-recognized external sources supplemented with internally-utilized evidence-based criteria, health plans develop clinical guidelines for behavioral health conditions in the same way they do for medical conditions. As with medical conditions, recognized quality metrics are used to track and improve behavioral health care quality.

Third, just as with medical conditions, ***coordination and integration*** are essential to securing follow-up care, managing medications, and identifying community support resources. Some plans have created behavioral health home models; others have embedded behavioral health clinicians in primary care practices or trained primary care physicians to identify behavioral health conditions in their patients. These approaches are consistent with and integral to health

[1] Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Prepared for the Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. November 2013.
[2] Ensuring Access to Quality Behavioral Health Care: Health Plan Examples, AHIP, May 2016, https://www.ahip.org/ensuring-access-to-quality-behavioral-health-care/.

plans' overall efforts to implement delivery system reforms that improve value and outcomes for patients.

Fourth, health plan programs strive to provide ***timely access*** to behavioral health care. In addition to meeting state and federal network adequacy requirements, health plans actively recruit behavioral health clinicians, monitor the availability of appointments, help members get appointments when needed, and many plans are also using telemedicine to augment network capacity.

Workforce Shortages and Other Challenges Undermine Access

It is important to note that challenges exist in all of these areas. For example, federal rules limit the sharing of substance use information among clinicians, affecting coordination and integration of care. A lack of behavioral health outcomes measures makes it difficult to effectively track quality and measure improvement. And the uniqueness of behavioral health conditions can sometimes make a direct crosswalk with medical conditions difficult. However, one of the most significant challenges is the widespread shortage of appropriately licensed behavioral clinicians, particularly psychiatrists and psychologists who specialize in caring for children and adolescents. This shortage of behavioral health clinicians is an issue that must be addressed separately from MHPAEA as it spills over into reduced hours of operation for many behavioral health facilities and more limited behavioral health community resources. The reduced capacity of the behavioral health workforce, paired with the scarcity of community support options, is an area needing community-based solutions that could greatly improve plans' ability to provide timely access to behavioral health care.

Further exacerbating the workforce shortage is the number of behavioral health clinicians who refuse to participate in health plan networks, resulting in patients having to pay out-of-pocket for behavioral health treatment or forgo treatment altogether.[3] Our members continue to actively recruit behavioral health clinicians for their provider networks. We also recognize the importance of timely and accurate information in health plan provider directories to assist consumers in accessing care. In April 2016, AHIP kicked off a six-month intensive pilot to explore joint health plan-provider solutions to making provider directories more accurate and up-to-date.[4]

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[3] Bishop, Tara F et al. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care. *JAMA Psychiatry*. 2014;71(2):176-181. Accessed on June 24, 2016 at http://archpsyc.jamanetwork.com/article.aspx?articleid=1785174.

[4] Provider Directory Pilot: Program Overview and FAQ, AHIP, https://www.ahip.org/wp-content/uploads/2016/03/Provider-Directory-FAQ-1.pdf.

Another challenge to improved access and consumer awareness relates to the multiple jurisdictions and perspectives on the laws and regulations applicable to mental health and substance use disorder treatment. The overlap of jurisdiction is one area that has caused confusion for consumers as well as health care entities in determining what law or regulation governs. For example, states may have regulations that meet the federal standards and add state requirements, as long as they do not conflict with or prevent the application of federal standards, but some of that guidance or interpretation about the application of federal parity requirements, or whether federal regulators retain the "final say" in interpreting laws, regulations, or sub-regulatory guidance may not be clear to all parties. And situations where several requirements that may apply (e.g., HIPAA, the federal "Part 2" confidentiality regulations, a state law that is more stringent than federal requirements) create complexity as well. We believe that expanding the ability of consumers and stakeholders to share examples of these types of challenges, with information and scenarios shared with the Mental Health Parity Task Force and other state and federal regulators in public events can promote a better understanding of the legal requirements and how they apply in a variety of real-life contexts.

Information Lacking on Quality of Behavioral Health Facilities

Another significant challenge is the lack of readily available information on the quality of behavioral health facilities, including data on patient outcomes to help consumers make decisions. According to a 2012 HHS report, there are 256 private psychiatric hospitals, 1,292 non-federal hospitals with separate psychiatric facilities, and 672 other facilities with adult residential treatment capacity.[5] Yet, in contrast to medical and surgical facilities where there are well documented quality measures and well established certification/accreditation programs, there is little information on the quality of psychiatric facilities or patient outcomes.

Despite recent efforts, quality measurement for even the more common behavioral health conditions is less well developed than for comparable general medical conditions.[6] Measurement and reporting of quality data on inpatient stays through Hospital Compare, for example, have led to significant improvements in quality and patient safety.[7] Additionally, the American Heart Association, the American Diabetes Association and the American Cancer Society have collaborated to promote the use of evidence-based treatment guidelines, performance measurement tools, and quality improvement strategies. These collaborations have

[5] Behavioral Health, United States, 2012, U.S. Department of Health and Human Services, http://media.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf
[6] Institute of Medicine: Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC, National Academies Press, 2006.
[7] https://blog.cms.gov/2016/05/25/cms-continues-progress-toward-a-safer-health-care-system-through-integrated-efforts-to-improve-patient-safety-and-reduce-hospital-readmissions/

resulted in programs for stroke, arterial fibrillation, heart attack, and resuscitation that allow facilities to measure performance based on nationally recognized quality measures. Such an effort is lacking in behavioral health, even for the most common conditions such as anxiety disorders, bipolar disorder, dementia, schizophrenia, and substance use and addiction. Further study is needed with respect to treatment guidelines for behavioral health and the evidence basis for quantitative and non-quantitative limits.

To date, the National Quality Forum (NQF) has identified more than 700 health quality measures overall, but only 30 are directly linked to behavioral health care. Most behavioral health quality measures are clinical process of care measures; only a few, such as depression remission, are outcome measures. The absence of a broadly accepted set of key evidence-based quality and outcome measures for behavioral health impedes the identification of effective clinicians and facilities. While the reporting of quality measures by inpatient psychiatric facilities through Hospital Compare is a step in the right direction, more needs to be done to make such quality information more robust and accessible.

A recent study[8] determined that the collection and use of functional outcome measures present new opportunities for behavioral health care. Broad outcome measures facilitate practice innovations that lead to quality improvement, increase incentives for coordination with other parts of the health and social service system, and provide a basis for comparisons of facilities and clinicians.

The lack of widespread adoption of validated, evidence-based quality standards and certification/measures for behavioral health facilities, particularly inpatient or 24-hour residential care facilities, adds to the difficulty of identifying for consumers and payers which facilities may provide services that will be most effective and reinforces the need for tools and strategies to ensure the safety and appropriateness of treatments. The current landscape of facilities is such that there is a great deal of ambiguity and wide variation in residential treatment facilities.[9] As a result, loose definitions (e.g., residential facilities may include group homes, spas, etc.), an undefined scope of service, lack of evidence supporting effectiveness, and often very long duration treatment options that can isolate the patient from family support and involvement in treatment plans create challenges for improved outcomes, continuity and coordination of care, and patient satisfaction.[10]

[8] Measuring Performance in Psychiatry: A Call to Action, Psychiatric Services 66:8, August 2015.
[9] Marketing Residential Treatment Programs for Eating Disorders: A Call for Transparency 67:6, March 2016.
[10] *Ibid.*

Certification and accreditation organizations that complement state licensure and certification standards are developing programs for behavioral health residential treatment facilities, including:

- Joint Commission - https://www.jointcommission.org/accreditation/behavioral_health_care.aspx
- Commission on Accreditation of Rehabilitation Facilities - http://www.carf.org/Programs/
- Council on Accreditation – http://coanet.org/about/behavioral-health-roadmap/
- National Integrated Accreditation Healthcare Organization - http://www.achc.org/programs/behavioral-health

The Joint Commission introduced its program in the 1970s and it has evolved over time; as of 2016 they have accredited more than 2,200 behavioral health organizations. The Council on Accreditation released its program in 2012 and has accredited 700 behavioral health organizations. The Commission on Accreditation of Rehabilitation Facilities (CARF) expanded to include mental health programs in the mid-1990s, including community mental health programs, and substance use treatment programs. However, these programs are not widely adopted and many in the field are not yet aware of them.

Additional resources devoted to the development of quality standards and the addition of required certification/accreditation, coupled with evidence-based behavioral health quality measures – particularly outcome measures – are needed to capitalize on the opportunity to identify best practices, quality clinicians and facilities, and drive quality improvement.

Tri-Agency FAQ[11] on "Book of Business" Testing (Q8)

We appreciate the work that the Administration has undertaken over the past eight years in implementing the MHPA/MHPAEA. Health insurance plans have modified their products and state filings, which can include benefit and plan designs, to incorporate the MHPA/MHPAEA "tests." Based on a common understanding of how to measure parity under these tests, plans have designed co-payments and benefits and moved forward in making their required state filings, designing marketing materials, and having an actuarially-sound basis for their premiums.

Frequently Asked Question Number 8 (Q8), published by the Administration in April 2016, addresses whether insurers can rely on data for their entire book of business in testing whether a

[11] Tri-Agency FAQ# 31 question number 8. https://www.dol.gov/ebsa/faqs/faq-aca31.html

plan passes the "substantially all" and "predominant" level testing required under the MHPAEA for testing financial requirements and quantitative treatment limitations. After noting that the MHPAEA regulations permit "any reasonable method" to be used to determine the dollar amount of all plan payments for the substantially all/predominant analysis, the agencies determined in Q8 that "book of business" testing is not a "reasonable method" for those purposes.

The FAQ goes on to recognize each self-insured plan separately and then suggests that each insured group plan offered on an experience-rated basis should be evaluated on a plan-level basis. This fails to recognize that many "large" groups may have fewer than the number of enrollees needed for actuarial credibility for the "reasonable" analysis that Q8 purports to propose. The underlying regulation calls for a demonstration of parity in each of the categories listed, including inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; pharmacy. Because of this, each category should have enough utilization to be credible. This could mean, for example, that thousands of members may be necessary to ensure credibility. Book of business level data is almost always going to be more credible. Use of plan level data would not lead to sufficient volume for all but the very largest of groups leading to testing results that are driven by statistical variation rather than being an indication of a plan with a design that is not in parity. This would seem to be contrary to the intent of the law.

In addition, this FAQ would apply the same plan test standard for insured small group and individual market plans. Recognizing that there may be insufficient data to calculate the substantially all and predominant tests at the plan level, Q8 does allow an issuer to use data at the product level to inform its projections of expected spending in the benefit classification at issue (provided that the issuer can demonstrate the validity of the projection method). However, while product level data allow for a larger data set over which to aggregate, it may not be sufficient to allow for actuarial credibility if enrollment in a product is insufficient.

Additionally, this guidance for the individual and small group markets is inconsistent with how plans are required to rate those products: since plans must rate products based on the experience of the total individual risk pool, and the total small group risk pool. Determining financial quantitative requirements and non-quantitative treatment limitations on a different basis –at each separate plan level, introduces significant inconsistencies that complicate managing premiums.

As drafted, this FAQ creates significant structural change to prior guidance on "reasonable approaches" to determine financial quantitative requirements and non-quantitative treatment limitations. Testing at the plan level can create distortions due to outliers and variance that can skew the data and produce an inaccurate picture of plan spending when a single year is reviewed.

Such a plan level review would harm consumers especially if variation causes significant swings from year-to-year in deductibles and copays as a result of a single year's experience.

There are additional areas of concern. Even under the testing guidance prior to this FAQ, there have been issues with regard to the testing approach. The testing methodology may result in the same benefit design having different parity testing results when employed in the individual, small group, fully insured large group, and self-funded group markets because of the different populations. Under the FAQ guidance, a plan by plan approach may cause a standard Exchange plan design in the individual market to meet parity testing for one issuer but not meet it for another issuer based on the enrolled population. The agencies may also wish to consider whether alternative methods should be considered that are consistent with the spirit of the parity law, including safe harbors that carve out from testing cost sharing for mental health services that have the lowest level of cost sharing, so as to prevent the counter-intuitive result of requiring deductibles to be increased so as reach parity with medical services/visits.

Another issue raised by this FAQ is the administrative challenge posed by a plan level analysis. A single carrier may have thousands of large group plans (in addition to its many small group and individual market plans) which would require very time consuming plan level analysis – and would have little utility given the distortions presented by the lack of credibility.

Finally, this FAQ does not provide any type of relief in terms of being applied on a prospective basis, and hence, without more clarity, this FAQ could expose prior-year testing results to audit challenges, if such testing was done on a "book of business" basis. For these reasons, we are recommending that Q8 be retracted or revisited which is a consensus recommendation by the industry developed by AHIP, the Blue Cross and Blue Shield Association and the Association for Behavioral Health and Wellness.

If not retracted, we recommend that the FAQ be revised to read as shown below (with the red text representing new language):

> **Q: When performing "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations under MHPAEA, may a plan or issuer base the analysis on an issuers entire overall book of business for the year?**
>
> No. Basing the analysis on an issuer's entire overall book of business expected to be paid for the year or book of business in a specific region or State is not a reasonable method to determine the dollar amount of all plan payments under MHPAEA. While each unique plan of benefits would ideally be tested against the data specific to that plan, an employer/group health plan or issuer may aggregate data to the necessary level, which may be line of

business, market segment, entity, or product, to assure sufficient data to make projections, based on the standards of actuarial analysis of credibility.[12] To the extent group health plan-specific data is available, each self-insured group health plan must use such data in making their projections. For large fully-insured group health plans, for which the premiums are determined on an experience-rated basis, the issuer should generally have group health plan-specific data to make projections. If the large, fully-insured plan does not have sufficient group health plan-specific data to make projections, data from other similarly-structured group health plans with similar demographics can be utilized for the analysis.

For insured small group and individual market plans, the health insurance issuer should use data at the "plan" level (as opposed to the "product") to perform the substantially all and predominant analyses, as such terms are defined in 45 CFR 144.103.[13] If an issuer does not have sufficient data at calculate the substantially all and predominant tests at the plan level, it can use data at the product level or aggregate data consistent with the ACA's single risk pool requirements to inform its projections of expected spending in the benefit classification at issue (provided that the issuer can demonstrate the validity of the projection method based on the ~~best available data~~ standards of actuarial credibility[14]).

Q. How will the Departments enforce compliance with the "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations under MHPAEA?

The Departments recognize that there has been some uncertainty about prior requirements relating to the relevant level of aggregation to determine the dollar amount of all plan payments for purposes of conducting the "substantially all" and "predominant tests" under MHPAEA. With regard to enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the MHPAEA regulations in analyzing whether enforcement action is appropriate under these tests.

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[12] Standards of actuarial analysis that provide for the recommended basis are outlined in the Actuarial Standard of Practice No. 25 (ASOP #25) Developed by the Actuarial Standards Board (http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop025_143.pdf).

[13] 45 CFR 14404.103 states "product means a discrete package of health insurance coverage benefits that a health insurance issuer offers using a particular product network type within a service area, and "plan" means, with respect to an issuer and a product, the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and servicer area."

[14] Op cit. ASOP #25.

Tri-Agency FAQ[15] on Disclosure and Non-Quantitative Treatment Limits (Q9)

The Administration has issued FAQ guidance pertaining to disclosure obligations under the MHPAEA for medical necessity determinations with respect to mental health and substance use disorder benefits. Health plans have been meeting those obligations under the MHPAEA standard for the past 18 months, and will continue to assure they provide the necessary disclosure to consumers and clinicians when there are requests or appeals.

While we recognize that the intent of the additional guidance is to build on existing disclosure requirements, we are concerned that the changes will not result in the availability of meaningful, consumer friendly information. The disclosures required by FAQ 9 are intended for consumers to provide documentation to help them understand what services may not be covered and associated reasons, however in its current form easy to understand information to assist consumers is not available. Heath plans are developing communications on mental health services that are consumer friendly, and we recommend that the guidance focus on developing in layman's terms general information on processes and tools plans use to make medical policy decisions, such as:

- Description of process
- Who is involved
- How decisions are made
- Define medical management tools (prior authorization, concurrent review, etc.)

In addition, we recognize that questions have been raised as to the use of non-quantitative treatment limits (NQTLs) for mental health and substance use and the variation of such limits when applied to medical and surgical benefits; and it is important to understand where and when health plans apply such limits and the challenges pertaining to mental health and substance use disorder services. Health plans, employer-sponsored plans, and government-sponsored health care programs have long utilized medical necessity review for medical and surgical procedures to ensure that patients are receiving optimal care based on well-established evidence of efficacy and safety, while providing benefits to the individual patient. NQTLs are permitted with regard to mental health and substance use provided that the "processes, strategies, evidentiary standards and other factors" used in applying the NQTL are comparable to medical/surgical benefits and not more stringent.

Medical necessity review is generally done when there is a lack of or conflicting evidence supporting a particular therapy or drug, safety concerns especially for specific populations, questions pertaining to a therapy's effectiveness for a specific population, licensure

[15] Tri-Agency FAQ# 31 question number 9. https://www.dol.gov/ebsa/faqs/faq-aca31.html

requirements, and questions regarding benefit design. As the preceding discussion about measuring quality makes abundantly clear, there is less information on the quality of behavioral-related outcomes, more gaps in evidence, and therefore may be more safety and effectiveness concerns than with respect to medical/surgical care where there are well documented and evidence based quality measures. Health plans use nationally recognized care criteria for all therapies – medical, surgical, mental health or substance use – such as Milliman Level of Care Criteria, or American Society of Addiction Medicine (ASAM) criteria for chemical dependency, the input of a plan's pharmacy and therapeutics committee composed of specialty clinicians for specific medical protocols, and consideration of the latest medical evidence based on the highest standards of care. Such review is used for a range of medical and surgical services, such as non-routine outpatient services with wide variation in cost and/or utilization within a clinician's practice utilizing peer-peer comparisons, outpatient surgical procedures to ensure safety in the non-hospital setting, advanced radiology or imaging, and infusion therapy, to name a few. Such review is also applied to mental health and substance use therapies where too often evidence for a particular service or condition is lacking or has conflicting results, safety concerns have been reported, and/or such services are delivered by unqualified clinicians, practicing outside their licensed scope of practice.

Prior authorization is an important tool in medical necessity review for both medical/surgical and behavioral health conditions. As medical evidence traditionally links efficacy of drugs and services to a specific population or subpopulation, it is important that the prescribed therapy is safe and effective for the patient's specific condition, provides the greatest value, and is a covered benefit. Particularly with respect to services prone to overuse or misuse, prior authorization can be used to ensure that care takes place in the most appropriate setting and at the most appropriate frequency. Prior authorization can also be used to make sure that drugs and devices are not being used for clinical indications other than those approved by the FDA. Often off-label drug use requires the prescriber to confirm the use for which the off-label drug was prescribed and the rationale for its use over other recommended drugs for that condition. Such action helps ensure the patient is not placed at risk and allows for monitoring of the drug's use. In addition, prior authorization can help ensure that prescribing access to select medications is limited to specific physician specialists, such as those that have a high level of expertise in prescribing and monitoring treatment. In fact, prior authorization is a tool used and/or endorsed by many state Medicaid programs with respect to the prescribing of the addiction recovery drug Suboxone (buprenorphine-naloxone) as a way to reduce the risk of misuse, further addiction and diversion of the medication. As an additional example, given the FDA's black box warning regarding the use of anti-depressants in the pediatric population and the increased risk of suicidal thinking, prior authorization can also help ensure that an appropriate psychiatric evaluation has

been conducted by a provider certified in pediatric mental health. In sum, prior authorization offers the clinician the opportunity to provide the medical rationale for the service and ensure that it will be provided by a clinician practicing within his or her licensed scope of practice.

Step therapy may also be used for prescription drugs used to treat both medical and behavioral conditions. Step therapy involves prescribing a recognized safe and cost-effective drug before approval of a more complex, costlier or riskier drug or drug combination. For example, there is limited evidence on the safety and efficacy of using two or more antipsychotic medications concurrently, yet the prescribing of multiple antipsychotic drugs occurs in as much as 35 percent of outpatients and 50 percent of inpatients. The professional society of psychiatrists advises clinicians that use of multiple antipsychotic medications concurrently not be tried until at least three attempts using a single antipsychotic medication have failed. [16] Health plan step therapy policies can help reinforce this professional society recommendation.

In addition, certain medical or surgical services are frequently only covered if performed at a recognized and contracted Center of Excellence (COE). These facilities have a proven record of offering high quality care with minimal to no complications and utilize experienced qualified clinicians. Centers of Excellence are often used for solid organ transplants, some cancer therapies, especially pediatric cancer, bariatric surgery, etc. Unfortunately, most mental health and substance use facilities lack standard quality requirements, as previously discussed, thus limiting the use of COE for these services. In addition, needed services exceed the current capacity for residential treatment centers, inpatient psychiatric centers, and clinics.

Medical necessity review, prior authorization, step therapy, and Centers of Excellence are traditional tools used by health plans across their medical and surgical benefits and are applied similarly to mental health and substance use. The individual needs and risk factors associated with each patient are considered during the review and as such a simple checklist is not feasible. Such tools help to improve patient access to the most effective and beneficial therapies, improve patient outcomes, and reduce overall health care costs.

While the unique nature of behavioral health conditions can preclude a direct comparison of the medical necessity criteria for these conditions to the criteria for medical and surgical conditions, disclosure of those services requiring medical necessity review and/or prior authorization as well

[16] http://www.choosingwisely.org/clinician-lists/american-psychiatric-association-routine-prescription-of-two-or-more-concurrent-antipsychotics/

as any medical documentation required is available to clinicians, either through health plans' websites or other methods of communication, as part of their medical policies, clinical utilization management guidelines, and pre-certification requirements – and is directed to the clinician as the prescribing authority. Specific instructions are included with respect to the process and forms to be completed to expedite approval. It is important to note that in all cases, review is expedited for emergencies.

Insurers understand the importance of disclosing information to consumers, even when it can be challenging, as they may not be able to address the specific requirements for services requiring review before approval, such as licensing requirements, safety issues or confirmation of specific medical needs that prohibit the use of other therapies. In addition, areas such as participation in networks and reimbursement are based on the geographic availability and supply of clinicians, state licensure and negotiations between the payer and the provider.

In regard to clinicians licensed and skilled in managing mental health and substance use disorders, the number of clinicians in a specific geographic area may be limited, many clinicians choose not to contract with commercial payers, and their office hours are often limited thereby creating additional access problems for patients. As the plan of care is discussed between the clinician and the patient, payers focus their efforts on ensuring that clinicians are aware of medical necessity review, use of preferred facilities, pharmacy limitations, and other pre-certification requirements.

Conclusion

Promoting parity between medical and behavioral health conditions is an ongoing, enterprise-wide endeavor to which health plans are strongly committed. Essential to the successful implementation of parity is health plans' ability to use reasonable medical management to promote appropriate, safe, evidence-based care. Additionally, because a "one-size-fits-all" approach is particularly misplaced in the area of behavioral health, there must be sufficient flexibility in implementing regulatory guidance to allow for continued innovation and customization to address specific needs and ample opportunities for public input. Unlike much of medical and surgical care where treatments are focused on objective signs of dysfunction and improvements can be measured by objective tests, treatment of many behavioral health conditions involves often extensive periods of time to address symptoms that may be subjective with treatments that may not be standardized. Being able to conduct reviews for ongoing treatment allows health plans to ensure that members are receiving safe and appropriate, evidence-based treatments from qualified providers.

Lastly, we encourage federal regulators to either provide guidance for states that review compliance with benefits and parity, or provide more information and expand awareness of federal jurisdiction and state roles, so we can achieve the goal of consistent interpretations across oversight agencies, provide a level of regulatory certainty, minimize variation in interpretations, and help consumers understand when and which federal and/or state laws apply to their individual health needs and health care services.

Our members recognize that behavioral health conditions, particularly with their often close relationship to chronic medical conditions, have a significant impact on individuals, families, our society, and our economy. Access to evidence-based services, coordination with primary medical care, and assistance with finding community support services to meet basic needs such as housing, transportation and job training all contribute to the overall well-being of individuals with behavioral health conditions. For these reasons, our members will continue to implement innovative programs that improve access to quality, affordable, evidence-based care and work with policymakers to remove barriers to further innovations and improvements in meeting the needs of those with behavioral health conditions.

Thank you for considering our perspectives on these important issues. We stand ready to provide further information as the Task Force continues its deliberations.

Sincerely,

Carmella Bocchino
Executive Vice President

Julie Miller
General Counsel