PARITY ENFORCEMENT PROJECT

A Joint Collaboration between the
American Psychiatric Association
and
New York State Psychiatric Association

Presented by Seth P. Stein, Esq. and Rachel A. Fernbach, Esq.
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Overview/Goals

- Provide a new approach and new tools to fight back against discriminatory practices by health plans
- Identify and challenge existing parity violations, particularly in the context of disparate utilization review of behavioral health benefits
- Packet of form letters and instructional materials to be used by psychiatrists and/or patients

Potential Uses

- Reductions in the frequency of covered or reimbursed visits
- Pre-payment medical record reviews
- Requests for peer interviews
- Requirements for outpatient treatment reports
- Imposition of prior authorization requirements on behavioral health treatment
- Imposition of numerical visit limits
- Notification that behavioral health treatment will no longer be covered by the health plan

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

- Current or potential participants, beneficiaries, and contracting providers may request copies of medical necessity criteria with respect to mental health or substance use disorder (MH/SUD) benefits only
- Participants and beneficiaries may be provided with the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits

Employee Retirement Income Security Act (ERISA)

- Plan participants and beneficiaries and their authorized representatives have the right to request copies of “instruments under which the plan is established or operated”
- Must be furnished within 30 days

Two Approaches/Tracks

- General Inquiry Letter
  - In advance of any adverse action
  - Request access to plan documents
  - Under either MHPAEA or ERISA

- Letter Following an Adverse Action
  - Denial of benefits, reduction in covered services or other adverse action
  - Request that the plan provide a written reason for denial taking into account patient's particular medical circumstances

Five Form Letters

All posted on NYSPA website in word format

- Authorized Representative Designation
- Document Request Letter under both ERISA and MHPAEA
- MHPAEA Only Document Request Letter – Plan Participant
- MHPAEA Only Document Request Letter – Current or Potential Contracting Provider
- Authorized Representative Request for Written Reason for Denial

Authorized Representative Designation

- Patients may use this form letter to designate their psychiatrist or other third party as an authorized representative to:
  - request access to certain plan documents
  - pursue a benefit claim by requesting written notification of reason for denial
  - pursue appeal of an adverse benefit determination

Authorized Representative Form Letter

TO: [Health Plan or Plan Administrator]

FROM: [Patient Name]
[Patient Address]
[Insurance ID Number]

Regulations promulgated under the Mental Health Parity and Addiction Equity Act (MHPAEA) (29 C.F.R. § 2590.712(d)(1)-(2)) and ERISA (29 C.F.R. § 2560.503-1) permit health plan participants and beneficiaries to designate an authorized representative to: (i) request access to certain plan documents; (ii) pursue a benefit claim or (iii) pursue appeal of an adverse benefit determination.

As a participant or beneficiary in United Health Care and/or United Behavioral Health, I hereby designate _____ as my Authorized Representative for the purposes of requesting information or assisting me in further accessing the mental health or substance use disorder benefits available to me under my health plan.

This designation shall automatically terminate upon termination of the treatment relationship, unless earlier terminated by me in writing.

General Inquiry Letters

- ERISA and MHPAEA Document Request (1 form letter)
- MHPAEA Only Document Request (2 form letters)
- May be requested at any time – no need to wait for submission of a claim or adverse benefit determination
- Examples of triggering events: request for medical records, request for peer interview, patient thinking about switching to a new plan

Document Requests Under ERISA and MHPAEA

- Copies of all instruments under which a health plan is established or operated
- Broader access – can request access to plan documents for both medical/surgical and MH/SUD benefits
- Plan required to respond within 30 days
- Request may be sent by patient or by provider (if so authorized)

Documents that may be requested under ERISA

- Non-quantitative treatment limitations and medical necessity criteria that apply to health benefits – for both medical/surgical and MH/SUD benefits (reminder: MHPAEA request limited to MH/SUD benefits)
- Processes, strategies, evidentiary standards and other factors used in applying non-quantitative treatment limitations and/or medical necessity criteria to health benefits
- Studies, schedules or similar documents containing information and data that serve as the basis for determining health benefits
- Compliance analyses for each of the non-quantitative treatment limitations that apply and documentation used in plan formation, including compliance analyses required by MHPAEA.

Document Requests under MHPAEA Only

- Request for copy of medical necessity criteria used by the plan to make determinations regarding MH/SUD benefits only
- Request focuses on criteria for a particular illness or condition, based upon the patient's current diagnosis or diagnoses
- Should be used ONLY for plans that are not subject to ERISA, including
  - Individual plans (now covered under MHPAEA)
  - ACA Exchange plans
- Regulations do not provide for specific response deadline

Document Requests Under MHPAEA Only

- Two form letters:
- Plan Participant – includes current or potential plan participants – may be sent by individual currently evaluating a plan
- Provider – includes current or potential providers – may be used even if you are not a participating provider in the patient's health plan

MHPAEA Document Request – Plan Participant

"I hereby request a copy of the medical necessity criteria used by _____[health plan] to make determinations regarding mental health and substance use disorder benefits available under the plan for the treatment of _____ [diagnosis or diagnoses]. In addition, please provide any information you have regarding the processes, strategies, evidentiary standards, and other factors used by the plan in applying the medical necessity criteria to mental health and substance use disorder benefits available under the plan."

MHPAEA Document Request – Provider

"I am a current or potential contracting provider with _____ [health plan]. I am currently treating an individual with _____[diagnosis or diagnoses] and I hereby request a copy of the medical necessity criteria used by _____[health plan] to make determinations regarding mental health and substance use disorder benefits available under the plan for the treatment of _____ [diagnosis or diagnoses]. In addition, please provide any information you have regarding the processes, strategies, evidentiary standards, and other factors used by the plan in applying the medical necessity criteria to mental health and substance use disorder benefits available under the plan."

Following An Adverse Action

- Something “bad” has happened
- This letter should be sent immediately following the adverse action
- Can be sent as part of or in addition to appeal request letter
- This form letter intended to be sent by provider acting as authorized representative
- Failure of plan to provide complete and prompt responses to these requests is a possible violation of law and will serve as a basis for complaints to federal and state regulatory authorities

Reason for Denial Request Letter

- Authorized Representative requests written notification of the reason or reasons for denial of reimbursement or payment for mental health or substance use disorder services rendered to patient
- "As required by law, the notice of denial must include the specific reason for the denial and the relevant denial code, including the meaning of the denial code and a description of the standards used in denying the claim, with a reference to the specific plan provisions relied upon. For denials based on medical necessity determinations, the plan must provide an explanation of the scientific or clinical judgment used to make the decision, applying the terms of the plan to the specific medical circumstances in question."

Next Steps

- Form letters have been posted in the Members-Only section of NYSPA website with instructions for use
- We also plan to post contact information for plans doing business in New York
- We are interested in compiling and reviewing responses to these requests (with patient identities redacted) to
  - Identify benefits determinations that lack clinical support
  - Detect patterns of discrimination
- We plan to work collaboratively with the APA and to share information collected
- Project not limited to New York State and can be extended nationally