October 9, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Lisa M. Gomez
Assistant Secretary for Employee Benefits Security
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

The Honorable Danny Werfel
Commissioner
Internal Revenue Service
1111 Constitution Avenue NW
Washington, DC 20224

Submitted via www.regulations.gov

RE: Requirements Related to the Mental Health Parity and Addiction Equity Act (CMS-9902-P).

Dear Administrator Brooks-LaSure, Assistant Secretary Gomez and Commissioner Werfel:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to submit comments in response to the additional guidance on the implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA). ACHP and its member companies prioritize mental health parity and enhanced access to mental health services. We strongly support proposals to reinforce the intended objective of MHPAEA to guarantee that health plans provide access to mental health and substance use disorder (SUD) benefits *without* imposing greater restrictions than those applied to medical/surgical benefits. We are committed to partnering with your Departments to overcome challenges that may prevent the goals of MHPAEA from being realized.

ACHP represents the nation's top-performing, nonprofit health plans that provide high-quality coverage and care to tens of millions of Americans in nearly 40 states, and D.C. Our member companies serve diverse populations across all lines of business and, as such, are committed to ensuring that consumers have access to quality and reliable mental health services that is on par with medical and surgical services.

While ACHP is strongly supportive of providing access to mental health and SUD benefits, the proposed rule does not provide clarity for provisions that impact parity compliance. Rather, it creates an entirely new regulatory schema, filled with ambiguities and enhanced documentation requirements that impede health plan efforts to be compliant and ensure parity in services offered. We offer the following recommendations to promote mental health parity and compliance among health plans:

- Streamlining the new requirements for NQTLs to reduce administrative burden, while ensuring the clarity of its benefit for consumers.
- Eliminating uncertainty, promoting consistency and avoiding waste by providing an exhaustive list of NQTLs.
- Reconsidering the necessity of the "special rule" for networks, considering potential implications for integrated delivery systems.
- Including telehealth in network adequacy standards and data collection requirements.
- Simplifying the six-step NQTL comparative analysis process by providing a complete list of NQTLs, delineating steps and distinguishing between components to reduce complexity and confusion.
- Accommodating integrated care models to ensure they can continue providing value-based health care.
- Reforming penalties for discoveries of noncompliance to reflect the nature of the violation.
- Modifying the applicability date for group health plans to plan years beginning on or after January 1, 2026, or two years following the publication date of the final rule, whichever is later.

Non-Quantitative Treatment Limitations (NQTLs)

ACHP urges the Departments to streamline the new requirements for NQTLs to reduce administrative burden and resource-intensive requirements. The proposed rule would increase operational requirements to demonstrate compliance with parity, creating significant operational challenges. The new requirements in the proposed rule will be time- and resource-intensive, without a clear benefit to health plan members.

For example, some health plans maintain a list upwards of 80 NQTLs. The proposed rule adds new quantitative analysis and data evaluation requirements for each NQTL, in addition to the six-part comparative analysis currently required under the Consolidated Appropriations Act of 2021. The rule's proposal to require that NQTLs be "no more restrictive" as applied to mental health/SUD benefits than to medical/surgical benefits, itself requires its own three-part subtest that will involve extensive data pulls and evaluations from multiple parts of a health plan's organization.

The "no more restrictive" requirement attempts to apply the analysis of Quantitative Treatment Limits (QTLs) to NQTLs. It is unclear to us whether this quantitative analysis is possible with many NQTLs given their non-quantitative nature. Health plans cannot run this type of analysis with NQTLs governing network composition.

Predominant/Substantially All Test

We seek clarity on how the "substantially all" test would be calculated in different benefit categories and with different types of NQTLs that are not attached to specific data points (particularly non-binary NQTLs and network composition standards). Greater clarity is further needed on what is meant by "predominant variation" in the "no more restrictive rule." While some NQTLs clearly have variation, others (e.g., prior authorization, medical necessity) do not. We have significant concerns on the importation of the "predominant/substantially all" test from the realm of financial requirements to the realm of NQTLs.

1. The new two-thirds threshold for applying any NQTL in a classification is a radical change that will make many aspects of managed care of behavioral health services virtually impossible, including NQTLs designed to improve the quality of care and protect consumers. Two clear examples: prescription drugs and continued stay reviews of inpatient services. For prescription drugs, it is likely that many plans/issuers do not apply *any* utilization management technique to two-thirds of medical or surgical drugs, which would mean that *no* utilization management techniques would be permitted for MH/SUD drugs. For continued stay reviews, these play a very different role in behavioral health treatment than in physical health treatment.

For medical/surgical admissions, continued stay review primarily serves a quality of care and care management function; Diagnosis Related Group-based billing means that the facility is at financial risk for extended stays, which means that utilization management is not a primary goal. For MH/SUD treatment, however, clinical best practices focus on ensuring patients are in the least restrictive setting that meets their needs, and continued

stay reviews are how plans ensure that consumers are appropriately stepped down to less restrictive levels of care when it is appropriate and safe.

The ability to review patient progress and deny continued payment is an important safeguard against providers "warehousing" consumers in inappropriately restrictive settings, which was significantly more common before managed care.

2. The new tests punish carriers that are trying to reduce their reliance on utilization management techniques for medical/surgical services. Recent developments suggest that insurance carriers are reducing their reliance on prior authorization as a utilization management technique where appropriate and feasible. However, this rule *disincentivizes* that approach. If a plan is considering dropping a surgical prior authorization requirement, and this would drop their use of prior authorization from 67% to 66% in a classification, the plan will likely not make that change if it puts their ability to require authorization for MH/SUD services at risk.

3. The application of this rule to NQTLs can be confusing, as the numerical nature of the limitations lends itself to a hard-and-fast mathematical rule. That is typically not the case with many NQTLs. For example, most plans have exclusions for experimental or investigational services. Per the guidance from the Departments, that exclusion would be considered an NQTL.

4. The "predominant" part of the test is confusing as it requires identifying "variations" of an NQTL. The only "variation" of a NQTL identified thus far has been different day intervals for concurrent reviews of inpatient care (i.e., review at 1 day vs. 3 days vs. 5 days); we are not aware of any other examples. Furthermore, what makes this a particularly troubling example is that the "substantially all/predominant" test in this context would mandate a *minimum interval* between continued stay reviews, which would be actively detrimental to patients who should be discharged more quickly to less restrictive levels of care.

The proposed rule also imposes a proactive requirement to start collecting extensive amounts of often ill-defined data. This is a change from the existing six-step comparative analysis that requires health plans to evaluate the data they had. NQTLs are not always attached to data points such as claims, member grievances or provider contracting rates. As such, we are unclear how health plans would be able to pull and track every one of their NQTLs from their databases.

Meaning of Terms

ACHP urges the Departments to provide an exhaustive list of NQTLs to eliminate uncertainty, promote consistency and avoid waste. Identifying an exhaustive list of NQTLs would direct activity to the areas of greatest concern regarding parity and would promote consistency across the industry. We urge the Departments to be descriptive when identifying an exhaustive list of NQTLs required for comparative analyses. Any ambiguity in this space is a detriment to achieving parity for plans eager to be in compliance.

Additionally, we request the Departments include what types of operational analyses would be expected of plans to perform. For example, some analyses are more difficult to quantify than others (e.g., analyzing networks versus analyzing formularies). Eliminating ambiguity regarding the types of analyses required of plans would be beneficial to ensure plans can maintain and achieve compliance for parity.

There are critical terms in the proposed rule that are vaguely defined or undefined. For example, the definition of mental health benefits includes all "conditions" and not just disorders. "Conditions," in the Diagnostic and Statistical Manual of Mental Disorders is a broad category that includes problems (e.g., relational conflict, religious or spiritual problems and poverty) that are not currently covered by all health plans. Additionally, the definitions of mental health/SUD and medical/surgical benefits leave ambiguity regarding the management of benefits that cross over multiple categories (e.g., speech therapy, occupational therapy, X-Rays).

ACHP requests the Departments create clear definitions for "material differences," "meaningful benefits" and "factors and evidentiary standards." The proposed rule states that "material differences" in outcome data will be a "strong indicator" of noncompliance. Plans are required to take reasonable action as necessary to address any "material differences" in data. The proposed rule ***does not*** clearly define what is meant by "material differences." We request further clarity as to what that would entail. Additionally, the proposed rule does not provide any guidance on what would be considered "reasonable action."

We are further unclear what is meant by "meaningful benefits" in the requirement that a health plan, which provides any mental health or substance use benefits in any classification of benefits, must provide meaningful benefits for that mental health or substance use disorder in every classification in which medical surgical benefits are provided.

We request clarification of the difference between "factors" and "evidentiary standards." It is unclear how a health plan demonstrates that a factor or evidentiary standard is unbiased. The prohibition on health plans from relying upon any factor or evidentiary standard if the

information, evidence, sources, or standards on which the factor or evidentiary standard is based "discriminates against" mental health/SUD benefits as compared to medical or surgical benefits is unclear.

Special Rule for NQTLs Related to Network Composition

ACHP requests the "special rule" for networks be rescinded. The data requirements for evaluating networks and the special rule for networks fail to account for important distinctions between mental health and medical/surgical networks. This rule may inadvertently penalize integrated delivery systems that have specifically created increased mental health access through supplemental, contracted networks.

The rule also does not address other important distinctions between mental health/SUD and medical/surgical networks. For example, mental health professionals are more often practicing via telehealth and across state lines. The rule does not include telehealth in its network adequacy data requirements. Further, medical/surgical benefits are more likely to be in integrated groups and value-based payment models, which may skew reimbursement data.

ACHP recommends the inclusion of telehealth in the proposed rules' network adequacy standards and data collection requirements. As the Departments acknowledge, telehealth has become a vital means of providing health care, particularly mental health care. Telehealth needs to be incorporated into the proposed rules' network adequacy standards and data collection requirements, as the metrics around time and distance are much less relevant when most mental health care is delivered virtually.

Required Use of Outcomes Data

ACHP proposes to allow plans to examine their own NQTLs, rather than imposing substantially increasing data collection and reporting requirements. ACHP supports data collection and interpretation in an objective manner to provide a meaningful representation regarding the design and application of NQTLs. NQTL design may be causal, correlative or unrelated. Understanding of root causes for any disparity requires appropriate analysis and interpretation of data, as well as iterative data collection and studies. In the proposed rule, the Departments appear to request data to serve a particular purpose, which suggests a bias against NQTLs prior to collection or interpretation of data. If finalized, this proposal could potentially obfuscate data interpretation.

We understand the Departments' wanting to look at outcomes data to ensure consumers are getting access to care. However, the Departments need some metrics by which to determine that MHPAEA enforcement efforts are working. Requiring data for *all* NQTLs is simply unworkable. Specifically, within (c)(4)(iv), there should be an exception to the required use of outcomes data for NQTLs that are inherently non-measurable.

Requirement to Provide Comparative Analyses and Notices to the Department and Other Individuals and Entities

ACHP requests that the Departments clarify the six-step NQTL comparative analysis process and consider the operational feasibility required to achieve compliance. To accomplish this, we recommend the Departments provide a complete list of NQTLs and delineate how many NQTL comparative analyses plans must conduct. The definitions should also clearly distinguish between each component of the analysis (e.g., factors, evidentiary standards, process and strategies). Further, we recommend that the final rule limit each step of the analyses to a particular component, such as:

- **Step 1:** identify the NQTL.
- **Step 2:** Describe the factors or reason for the NQTL being applied.
- **Step 3:** Describe the evidentiary standards relied upon.
- **Step 4:** Show the written process and strategy.
- **Step 5:** Show the in-operation process and strategy.
- **Step 6:** Describe the conclusion.

As currently proposed, the rule creates confusion by merging definitions and creating additional complications. For example, Step 1 requires plans to confirm the "substantially all" test has been completed, including consideration of the dominant variation. We are unclear whether this can be operationalized with all NQTLs. Step 1 also requires plans to provide all policies, guidelines, provider contracts or any other document where the NQTL "appears or is described," which is operationally infeasible and should be more limited.

The rule defines "factors" broadly — the definition subsumes "processes" and "strategies" – and it is unclear what distinguishes the current Steps 2 and 3. These steps also require plans to provide detailed descriptions of each factor, including evidence and sources relied upon, with data and relevant citations, which will be challenging to operationalize.

Additionally, Step 4 would create operational challenges due to its breadth. It requires plans to consider the factors identified and described above, but with quantitative data and any other relevant analyses. This includes any records that other factors were considered and not applied, plus any policy or procedure, checklists, manuals, forms and other documentation used to design the NQTL that will show whether a plan is meeting the threshold.

Finally, if the relevant Department makes a final determination that the health plan is not in compliance, the rule proposes that **within 7 calendar days** of the receipt of the final determination of noncompliance the health plan must provide a standalone notice to ***all*** participants and beneficiaries enrolled in the plan or coverage that the health plan is not in compliance with the requirements of these proposed rules. It would be operationally infeasible to comply with this rule.

This proposal is wholly misleading. If a violation is found, it is most likely to be that the plan does not have sufficient *documentation* to *prove* that it is *not* violating MHPAEA. Neither beneficiaries nor news organizations will read far enough past the initial notice to see the nuances of why the Departments determined the plan's documentation to be inadequate. **We request that the penalties for a finding of noncompliance be significantly reformed to better reflect the nature of the violation found**.

<u>Considerations for Integrated Delivery Systems and Value-Based Payment Arrangements</u>

ACHP requests the Departments evaluate the potential negative impact on integrated and value-based payment models of care. As currently proposed, the rule does not recognize integrated care and value-based payment models in its NQTL and network data requirements. If changes are not made, the proposed rule could inadvertently undermine integrated delivery and value-based payment models.

Integrated delivery systems are designed to provide value-based health care through both self-contained delivery systems where providers operate within the same organization, allowing care to be delivered with very few NQTLs, and contracted networks of community providers ensuring adequate access. Just as the existing MHPAEA regulations recognize that tiered networks warrant similar but separate analysis for QTLs, **ACHP requests that the Departments revise the proposed regulations to provide integrated health plans the option to conduct similar but separate analysis for NQTLs of (1) their integrated care delivery models and (2) their community contracted networks.**

Distinct care delivery models warrant separate comparative NQTL analyses. There are similar concerns with the application of these rules to value-based payment programs. To afford plans with ample time for proper implementation, **the Departments should consider modifying the applicability date for group health plans to plan years beginning on or after January 1, 2026, or two years following the publication date of the final rule, whichever option affords the most time.**

Conclusion

ACHP appreciates the opportunity to comment and provide recommendations on these critical mental health policies to ensure the well-being of consumers and further the goals of mental health parity. ACHP welcomes additional opportunities to engage with the Administration to ensure our commitment to advancing mental health care priorities, especially in light of the evolving landscape of health care needs and access. Please contact Nissa Shaffi, Associate Director of Public Policy, at nshaffi@achp.org with any questions or to discuss these recommendations further.

Sincerely,

Dan Jones

Dan Jones
Senior Vice President, Federal Affairs
Alliance of Community Health Plans