

National Association for Behavioral Healthcare



Access. Care. Recovery.

17 October 2023

The Honorable Xavier Becerra
U.S. Department of Health and Human Services Secretary
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Lisa M. Gomez
Employee Benefits Security Administration Assistant Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20002

The Honorable Douglas W. O'Donnell
Internal Revenue Service Deputy Commissioner for Services and Enforcement
U.S. Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Requirements Related to the Mental Health Parity and Addiction Equity Act; 938-AU93, 1210-AC11, and 1545-BQ29.

Dear Secretary Becerra, Assistant Secretary Gomez, and Deputy Commissioner O'Donnell:

The National Association for Behavioral Healthcare (NABH) appreciates the opportunity to comment on the proposed rule addressing requirements related to the *Mental Health Parity and Addiction Equity Act* (MHPAEA) from the U.S. Health and Human Services Department (HHS), the U.S. Labor Department's Employee Benefits Security Administration, and the Internal Revenue Service ("departments"). In addition, NABH is a signer to the multi-stakeholder comment [letter](#) on this rule that the Mental Health Liaison Group (MHLG) – a coalition of national organizations representing consumers, family members, mental health (MH) and substance use disorder (SUD) providers, advocates, and other stakeholders. NABH also is a co-signer of MHLG's separate comment [letter](#) on the parity technical report related to this rule.

Representing the entire behavioral healthcare continuum, NABH members treat children, adolescents, adults, and older adults with MH and SUDs in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication-assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C.

This proposed rule signals the departments' strong determination to clarify and enforce the MHPAEA and address the longstanding lack of parity between physical and behavioral healthcare related to health insurance coverage, access, and payments. The proposed rule also recognizes a critical need for adequate resources to ensure parity across the healthcare delivery system. For 15 years, the lack of meaningful consequences for MHPAEA violations have ignored the many patients who urgently need behavioral healthcare services. As such, we applaud the rule's commitment to prohibiting treatment limitations that oppose both the standards and spirit of the landmark 2008 law.



In particular, NABH supports the proposed rule's requirement that each plan's comparative analysis on parity compliance include substantive data on non-quantitative treatment limitations (NQTL), including network composition. These requirements will do much to enforce both the letter and spirit of the MHPAEA.

However, to fully realize the objectives of the rule, as well the MHPAEA itself, the final rule must eliminate the proposed, too-broad NQTL exceptions related to "independent professional medical or clinical standards" and "fraud, waste, and abuse." Applying these exceptions to NQTLs, such as prior authorizations, unintentionally would counteract significant, positive elements in the rule, thereby allowing current access barriers to persist. We anticipate that health plans could treat these exceptions as loopholes to optimize.

PARITY IN BEHAVIORAL HEALTHCARE BENEFITS

Beyond our concerns with the proposed exceptions, as we discuss below, the remainder of the proposed rule would help improve and enforce the MHPAEA. Behavioral healthcare providers recognize that current regulations have been insufficient to prevent plans from narrowing coverage of behavioral healthcare services in a manner that prevents physical and behavioral healthcare parity. Given the resulting disparity, we strongly support this proposal to remove the prohibited coverage practices that continue to block behavioral healthcare access.

Criteria for NQTLs Cannot Narrow Coverage

NABH strongly supports the proposed use of "substantially all" and the "predominant test" to determine whether parity is achieved between behavioral and physical healthcare NQTLs. This approach aligns with the MHPAEA's clear requirement that behavioral healthcare benefit limits be "no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits..." We support expanding these criteria beyond their current, successful use with financial requirements and quantitative treatment limitations, to also apply to NQTLs. If a plan/issuer does apply an NQTL to "substantially all" MH/SUD benefits within a classification of care, a plan/issuer must then show that the NQTL applied to MH/SUD benefits within that classification is no more restrictive than the predominant variation applied to MH/SUD benefits within the classification.

Only Allow Clinical Criteria Based on Generally Accepted Standards

Medical management—an NQTL in its own right—should be based exclusively on medical and clinical criteria that are fully consistent with generally accepted standards of care, without exception. To ensure that such transparently vetted and publicly available standards are applied to every behavioral healthcare NQTL, the final rule must eliminate the proposed, hazardous exception that would allow health plans to use their independent standards. Doing so would remove from the plans the unintended opportunity to narrow behavioral healthcare coverage by exploiting an exception, thereby perpetuating disparity rather than advancing parity.

Further, we note that a 2011, HHS-convened, technical expert panel did not support a clinically appropriate standard of care exception to the general NQTL rule. Likewise, HHS determined in 2013 that the requirement for independent professional medical or clinical standards should be treated as a core requirement of the NQTL legal and regulatory framework, without exceptions. In addition, the MHPAEA's statutory text does not support applying this proposed exception and instead, as noted, prohibits any limitations that narrow behavioral health coverage. Finally, in the *Consolidated Appropriations Act (CAA)* of 2021, Congress chose not to add any criteria exceptions to the existing MHPAEA statute.



State Action

An increasing number of states have adopted a strong definition of “generally accepted standards of care” for behavioral healthcare services, including [California](#), [Georgia](#), Illinois, and [New Mexico](#). **We support the following version, which is a composite of the almost-identical definitions used by these states for “independent professional medical or clinical standards,” which we treat as synonymous with “generally accepted standards of care.”**

“Independent professional medical or clinical standards” mean standards of care and clinical practice that are generally recognized by healthcare providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting independent professional medical or clinical standards are peer-reviewed scientific studies and medical literature, recommendations of federal government agencies, drug labeling approved by the U.S. Food & Drug Administration, and recommendations of nonprofit healthcare provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines.

Unfortunately, the rule’s language describing “independent professional medical or clinical standards” is weak: ...these standards “must be independent, peer-reviewed, or unaffiliated with plans and issuers.” This language would not prevent plans from indirectly funding and publishing their own standards. **Instead, the departments must strongly and clearly link the definition of “independent professional medical or clinical standards” to criteria/guidelines established by the relevant nonprofit clinical specialty associations,** such as The American Society of Addiction Medicine, the American Association of Community Psychiatrists, and/or the Academy of Child and Adolescent Psychiatry. It is critical to understand these associations provide clinical criteria that are fully transparent and accessible, developed through a consensus process that protects against conflicts of interest, and are externally validated.

Remove the “Fraud, Waste, and Abuse” Exception for NQTLs

NABH supports legitimate measures to address fraud, waste, and abuse in the healthcare delivery system. Such measures protect the already inadequate resources and access to care that all patients nationwide with behavioral health problems need. Unfortunately, some health plans appear to have exploited providers by using unwarranted “fraud, waste, and abuse” audits with providers who have no history or evidence of fraud or abuse. Such audits actually appear to be seeking denials although they also waste limited provider resources and can create an unwarranted combative relationship between providers and plans. **Based on this history, NABH opposes the proposed NQTL exception for “fraud, waste, and abuse,” which has a high probability of unintentionally counteracting the NQTL oversight gains this rule proposes.** Importantly, we note that the MHPAEA statutory text includes no exceptions for “fraud, waste, and abuse.” This includes the recent MHPAEA action by Congress in the CAA of 2021, which excluded any “fraud, waste, and abuse” exceptions to the MHPAEA statute.

To combat fraud, waste, and abuse, plans/issuers should identify “fraud, waste, and abuse” as a distinct NQTL, subject to MHPAEA’s comparability and stringency tests. This is the most transparent way to ensure the plans are not inappropriately limiting MH/SUD treatment under the guise of efforts to combat “fraud, waste, and abuse.” Locating “fraud, waste, and abuse” within the existing and



proposed NQTL requirements also has the advantage of being well-grounded in MHPAEA's statutory text.

Incompatible Provisions

As we described above for the "independent professional medical or clinical standards" exception, we also believe this exception is broadly unworkable. For instance, it is unclear how plans/issuers that use "fraud, waste, and abuse" as a factor in designing and applying an NQTL would perform the more restrictive (substantially all/predominant) test. The proposed rule did not comprehensively explain how CMS expects the plans to operate with these seemingly incongruent standards. **We urge the agency to clarify its expectation, including whether one standard is intended to supersede the other, in the final rule.**

Clarifying "Meaningful Coverage" and "Scope of Covered Services"

We appreciate that the rule addresses ambiguous definitions that contribute to the disparity between mental and physical healthcare. Such ambiguity tends to yield overly flexible interpretations that generally favor health plans over patients. In particular, the proposed, more specific definitions for "meaningful coverage" and "scope of covered services" will bring valuable clarity and consistency to coverage determinations. Of notable benefit, we strongly support the proposed requirement for plans that provide behavioral healthcare benefits in any classification of care, to do so in all classifications of care. Similarly, we urge the departments to add to the final rule a definition of "meaningful" as it applies to scope of covered MH and SUD benefits in each classification. Such clarification would mitigate future coverage disagreements across stakeholders, including plans, providers, auditors, and the courts. Specifically, we endorse the following:

- "Meaningful benefits" should be defined as the full continuum of services that are consistent with generally accepted standards of care that align with those set by the relevant independent, professional medical or clinical associations, as discussed at numerous points in this letter.
- "Scope of covered services" should be treated as an NQTL with regard to streamlining requirements and removing ambiguity. Today, determining scope of covered services involves comparing actual services versus the scope of covered services, including accounting for exclusions. The new definition, which would reduce complexity and subjectivity in the NQTL compliance assessment process, should be implemented in the final rule, along with the related, proposed requirements on outcomes data.

Establishing these definitions in the final rule would standardize health plans' policies and actions related to routine exclusions for services such as:

- coverage of mobile crisis response teams and crisis stabilization services;
- coverage of coordinated specialty care, an evidence-based intervention for early psychosis; and
- aligning the use of methadone in opioid treatment programs with the medical literature.

Currently, these common exclusions shift costs to patients and public payers, or in worst-case scenarios, block access to medically needed care.

Limit Reimbursement and Payment Decisions to Relevant Criteria. NABH encourages the departments to explicitly prohibit a plan/issuer from narrowing behavioral healthcare coverage based on



payment system approaches and/or payment data that are not subject to the MHPAEA. For example, some plans justify reimbursement rates by citing the Medicare Physician Fee Schedule PFS, although Medicare is not subject to MHPAEA and has long undervalued MH/SUD services. In fact, in current Medicare outpatient rulemaking for 2024, prior undervaluation has been recognized with increases proposed to begin to address to underpayment practices. Given this recognition by Medicare and its harmful impact on access to care, we urge the Departments to explicitly prohibit health plans from using non-MHPAEA payment structures and related data, including the Medicare PFS, as a basis for setting payments for services covered by MHPAEA.

Use Outcomes Data & Actions to Address Uneven Access

NABH supports the proposal to require health plans only to collect and evaluate relevant data to assess the impact of a NQTL on behavioral health benefits. However, as discussed below, most of our members likely would struggle to comply due to their outdated health information technology (IT) systems. That said, on straight policy grounds, we recognize that this provision addresses a regulatory gap that prevents comprehensive measurement and analysis of an NQTL's impact on access to behavioral versus medical care. Today, without this requirement in effect, plans/issuers often rely on process-related rationales to justify disparate access to care. The rule proposes standardized definitions and methodologies for data collection that would improve stakeholders understanding of access limitations. Also, in compliance with the law, we urge the departments to explicitly require that outcomes data separately be reported for MH and SUD services, which would provide greater detail on the nature of parity discrepancies.

In addition, to optimize health plan remediation of access disparities, we urge the departments to define both "reasonable actions" and "material." We also urge the departments to incorporate MHPAEA's statutory standard of "no more restrictive" rather than the proposed standard of "material difference." We also call for remedial steps to be required to address *any* disparities in access, or at least to use the narrowest definition of "material" that is possible. These additional clarifications will improve compliance and mitigate future disagreements over the corrective actions required by law, including the type and scope of required remediation. Without these clarifications, we expect that remediation to correct noncompliance would remain "unmeaningful" in too many cases and, further, noncompliance determinations would remain too subjective, which favors the health plans over patient access.



Modern Information Technology (IT) Infrastructure Needed

While behavioral health IT is beyond the purview of this rule, we highlight for policymakers that most of the behavioral healthcare field is using information technology systems that are a generation behind those used by general acute-care hospitals and settings that received health IT funding support from Congress through the *HITECH Act* of 2009. Similarly, most BHIT systems do not comply with current HHS standards for data exchange and other functional specifications. Given this significant limitation, compliance with the proposed provisions related to outcomes-reporting likely would present difficulties for our members. The field's limited IT capacity already is a barrier to complying with several recent proposals from CMS and other regulating bodies in areas such as integrating with key clinical partners, functioning fully with federal and state health exchanges, and managing electronic prior authorization processes. To elaborate on the common level of IT interoperability, most BH providers are able to electronically submit bills, and some have a form of electronic prescription management; however, most lack the ability to send or receive interoperable patient health information with external healthcare partners. Rather, unfortunately, the majority of the BH field still relies on outdated communication methods including faxes, emails, and phone calls.

Prohibiting Noncompliant NQTLs

We urge the departments to prohibit applying a noncompliant NQTL after a final determination of noncompliance is made. As proposed, individuals would wrongly be denied access to necessary behavioral healthcare services. Plans that continue to implement noncompliance NQTLs should be subject to penalties, as the MHPAEA allows. In addition, states should be granted related authority to issue penalties for this action. State insurance departments have primary enforcement authority for state-regulated fully insured plans and have played a leading role enforcing the MHPAEA.

NQTL COMPARATIVE ANALYSIS REQUIREMENTS

The Process for Reprocessing Erroneous Denials Should be Patient-friendly

NABH strongly supports the proposal of detailed requirements for the key elements of an NQTL comparative analyses, as the 2021 amendments to the MHPAEA statute require. The proposed clarifications on comparative analyses components represent a meaningful improvement in the oversight and enforcement of the MHPAEA.

In addition, regarding a health plan's corrective action plan that is required following a finding of noncompliance, we appreciate the proposed criteria, including the requirement for details on how an initially denied claim can be reprocessed. **However, the rule's description of this patient right as an "opportunity" wrongly places the burden on patients, who generally lack an understanding of an NQTL, what compliance standards exist for NQTL to determine if their coverage rights erroneously have been limited, and the process to challenge such an error.**

Further, the rule does not identify the actual process for a patient to appeal an NQTL violation. Given these significant shortcomings, we urge the departments to instead place an affirmative obligation on health plans, as a required element of the corrective action plan. This duty of the health plans should be to specify a method to identify affected patients; notify the patient with specific details on the coverage requirements that were violated; and provide a user-friendly method to reprocess an approval of the



incorrectly-denied claim. As in other sections of the rule, in this case we ask the departments to finalize an approach that shifts the burden away from patients to the health plans.

IMPROVING AND EXPANDING MEANINGFUL PARITY STANDARDS

Requiring Compliance by Self-funded Plans

NABH supports eliminating the option for self-funded non-federal government plans to opt out of MHPAEA. This change will boost coverage and access to needed behavioral healthcare services for the thousands of public employees and their family members who currently lack MHPAEA protections because their public-sector employer opted out of MHPAEA oversight. Given this gap in protection, we urge HHS to prioritize robust MHPAEA compliance reviews of these plans as soon as its opt-out is no longer valid. Also, the departments should immediately request these plans' NQTL compliance analyses to assess their respective MHPAEA-compliance status and plans to achieve compliance.

Consistent Parity Standards Also Needed for Other Public Health Plans

We urge HHS to move quickly to propose and finalize similar parity rules for Medicaid managed care, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans (ABPs) after finalizing this proposed rule. The Biden administration must not permit a strong set of MHPAEA rules for individuals in individual and group plans, and a weaker set of rules for individuals in Medicaid managed care, CHIP, and ABPs. This is particularly critical given that these plans serve lower-income individuals and families who are disproportionately Black, Latino, Native American, and from other marginalized and underserved communities. Many of the entities that serve as Medicaid MCOs also operate in the state-regulated insurance markets and serve as TPAs for employer-sponsored plans. HHS must also finally hold state Medicaid agencies accountable for strong oversight, given most states' deeply inadequate MHPAEA enforcement efforts.

NETWORK ADEQUACY

Special NQTL Rule on Network Composition

Inadequate networks are among the most significant barriers to accessing needed behavioral healthcare services. **We strongly support the proposed "network composition" standards designed to ensure access.** We are pleased that the proposed NQTLs network composition rule would base findings of non-compliance on quantifiable data that identify material differences between in-network medical/surgical versus behavioral healthcare benefits within a care classification. Such data should, at a minimum, include metrics such as reimbursement rates, time and distance standards, and patient-to-provider ratios.

Provider Directory Requirements

To ensure that health plan directories include information that is current and useful to patients seeking care, NABH supports regular, independent third-party testing of provider directories to assess their accuracy and the amount of care that actually is available.

Finally, the departments should ensure that those who cannot access in-network services on a timely basis can access out-of-network services, with out-of-pocket costs limited to the amount paid for the same services received from an in-network provider. We note that in May 2023, HHS took important steps to improve network directory by proposing NABH-supported standards for Medicaid managed care and CHIP wait times (maximum of 10 business days) and implementing independent secret shopper surveys. This proposed rule should be used as a model for the departments for individual

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and group plans. Additionally, plans/issuers should be required to identify providers who are available via telehealth.

Thank you for considering NABH's recommendations on this critically important rule. We look forward to supporting and working with you and your staff to address these issues. Please contact me at shawn@nabh.org or 202-393-6700, ext. 100 if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Shawn Coughlin'. The signature is fluid and cursive, with the first name 'Shawn' and last name 'Coughlin' clearly distinguishable.

Shawn Coughlin
President and CEO