

October 12, 2023

Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services

Re: Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA)
[CMS-9902-P]

Dear Administrator Brooks-LaSure,

Thank you for requesting comments on the Proposed rule entitled: Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA). In what follows, we offer comments and suggestions on some of the provisions in the proposed rule. Our comments will focus on the emphasis placed on outcomes in determining adherence to MHPAEA; the proposals for improving assessment of compliance and enforcement of Non-Quantitative Treatment Limitation (NQTL) provisions and the burden on payers of the processes outlined for improving oversight and enforcement of NQTL provisions; the provisions granting exceptions to the NQTL assessments; and the standard and measures used to evaluate network adequacy.

Focus on Outcomes

We applaud the emphasis placed on tracking access-related outcomes to make judgements about adherence to MHPAEA. We believe that applying outcomes standards consistently in evaluation of adherence to MHPAEA will improve the effectiveness of the policy and strengthen the ability to enforce the compliance with specific features of the regulations such as NQTLs. Choosing a set of indicators based on services utilization can strengthen accountability associated with NQTLs, be deployed in a way that can reduce the burden on payers and can bolster the approach to assessing network adequacy.

Example of Indicators: To illustrate the types of outcome measures that are at once practical to collect and potentially useful for assessing access to care, we created a table of simple indicators based on utilization information typically reported in claims and encounter data bases.

Table 1 highlights how readily available utilization data can be used to assess adherence to the terms of MHPAEA. The data in the table is sourced from publicly available data files from the Medical Expenditure Panel Survey. These data are like those captured by claims and encounter data collected by health insurance plans. The sample we used includes all visits to hospital outpatient departments or office-based providers for mental health care or primary care services included in the survey between 2018 and 2020 (these correspond roughly to the outpatient-in network category used in MHPAEA).

Table 1: Utilization-Based Access Indicators of Mental Health Care and Primary Care

		Utilization Share		Parity Indicator
		Mental Health Care	Primary Care	Ratio MHC/PC
Overall				
	Used health service	15.86%	69.12%	0.23
	Accessed follow-up	85.91%	77.16%	1.11
Age				
18 and under	Used health service	15.04%	35.19%	0.43
	Accessed follow-up	85.51%	56.89%	1.50
19-64	Used health service	18.54%	78.81%	0.24
	Accessed follow-up	87.52%	75.75%	1.16
65 and over	Used health service	10.35%	91.91%	0.11
	Accessed follow-up	78.63%	92.78%	0.85
Care Setting				
	Care visits occurring with office-based providers	94.96%	93.83%	1.01
	Care visits occurring in hospital outpatient setting	5.04%	6.17%	0.82

Source: Authors' analysis of Medical Expenditure Panel Survey data, 2018-2020

The percentages reported in the table reflect utilization rates of various kinds. For example, among the overall sample, 15.86% of people use a mental health care service. Among those who accessed a mental health care service, nearly 86% received a follow-up visit. Such measures are basic indicators of care utilization for treatment of mental illnesses and substance use disorders. They can be used to construct overall norms against which individual insurance plans can be evaluated. Regulators can choose the standard by identifying where in the distribution of utilization to establish the utilization benchmark. The table is constructed based on population averages.

Taking the ratio of utilization of mental health care and primary care can help illuminate parity in care access. The observed ratio indicates the overall rates of utilization or follow-up care of mental health care relative to medical/surgical care. That ratio can serve as the benchmark against which one could assess potential compliance with MHPAEA for an individual health plan. For example, consider a health plan that had a mental health care utilization rate of 10% and a rate of 69% for general medical care for outpatient in network services. This scenario would imply a parity indicator ratio of 0.14, well below the overall ratio of 0.23 reported in the table. That difference could be used to trigger further probing of the reasons for the apparent limitation on access to mental health care. One implication of using such ratios is that they highlight that parity does not mean expecting a one-to-one correspondence between mental

health and substance use disorder care and other types of medicine. Such measurements can also be used to probe other dimensions of access to care, such as follow-up treatment of utilization by specific demographic groups. This approach to measurement could readily be implemented within each of the MHPAEA benefit classification groupings and by type of insurance.

Non-Quantitative Treatment Limits (NQTLs)

The proposed rule appropriately devotes a great deal of attention to improving the ability to monitor and enforce compliance with the NQTL requirements contained in MHPAEA. The experience to date with NQTLs suggests ambiguities and uncertainty that hinders the implementation of the intent of MHPAEA, which as the proposed rule states is to prevent health plans from designing NQTLs that limit access to treatment for mental health conditions and substance use disorders. Some of the steps aimed at ensuring access at parity outlined in the proposed rule include demonstrating that an NQTL is no more restrictive as applied to mental health and substance use disorder benefits than it is for medical/surgical benefits; establishing that strategies, evidentiary standards, and other factors are designed and applied in ways that are no more restrictive for mental health and substance use disorder benefits than for medical/surgical benefits; and by providing evidence that NQTLs do not impede access to mental health and substance use disorder treatment more than when applied to medical/surgical benefits.

Applying for Substantially All and Predominant Tests to NQTLs:

The proposed rule contains provisions that would apply the so-called “substantially all” and “predominant” tests to NQTLs. Those tests were established as a means of appropriately making comparisons between nominal terms of coverage for mental health and substance use services to those for medical-surgical services. This primarily involved cost sharing and limits on services, such as visits or hospital days. They provided a convenient way of comparing quantitative features of health insurance that might be differentially applied to mental health and substance use disorder care. While the MHPAEA statute states that treatment limitations be “no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits...”, it does not necessarily imply that the same basis of comparison is appropriate for all types of treatment limitations. The so-called quantitative treatment limitations serve to define the financial protection provided to people that experience a need for treatment. NQTLs, in part, affect coverage, but they involve mechanisms that apply clinical judgements in many cases to the management of utilization and costs (e.g., prior authorization, concurrent reviews).

We are supportive of efforts to improve the basis of comparison for what constitutes “more restrictive,” as the ability to compare under existing regulation is more limited than is necessary or effective. Nevertheless, broadly applying the substantially all and predominant tests has the potential to distort comparisons.¹ In the case of NQTLs, heterogeneity in the nature of illnesses treated in the two benefits segments may cause legitimate and fair application of NQTLs to be

¹ The discussion and examples provided on pages 51570-51572 illustrate why the parallel to the cost sharing and limit calculation for substantially all and predominant do not fit comfortably with NQTLs.

ruled out. For example, among general medical physician visits, roughly 41% of visits are for chronic conditions, while 9.3% are for injuries, 21% are for preventive services (e.g., vaccinations), and nearly 6% are for either pre- or post-surgery visits.² Injury, preventative and pre- and post-operative visits are less likely to be subject to concurrent review. Mental health and substance use disorder care from physicians and psychologists focus on treatment of mood disorders, anxiety disorders, psychoses, and personality disorders, all frequently chronic recurring conditions. Those account for between 64% and 69% of visits.³ Even if all chronic visits in general medical practice were subject to concurrent review, any concurrent review for mental health or substance use disorder services would fail the “substantially all” test. Because of this heterogeneity in illness composition, we would suggest that the Departments consider a more fine-grained method of comparing the use of NQTLs between mental health and substance use benefits and those for medical/surgical benefits. Such a fine method for comparison might include type of illness and provider types (e.g., specialty or PCP) in addition to other indicators. Such comparison methods would be embedded within the existing services classification system (e.g., inpatient in and out of network, emergency, etc.).

In considering these provisions, we think that it is important to recall the history of the enactment of MHPAEA.⁴ The Congress had been reluctant to enact what became MHPAEA in its earlier incarnations because of concerns over costs.⁵ The Congressional Budget Office (CBO) reduced its estimated cost of MHPAEA because of evidence of the ability of managed care arrangements to control spending without compromising quality.⁶ Based on this history, we think it is important to be mindful of the need to achieve a balance between promoting access and preserving the ability of health plans to legitimately manage care.

Complexity and Burden:

The proposed rule adds considerable specificity to the process for assessing NQTL provisions used by a health plan and the information that that must be provided in connection to the use of NQTLs. On one hand, that reduces uncertainty for all parties, which typically promotes efficient responses to regulations. It also offers a clearer road map for consumers and other stakeholders to make judgements regarding whether an NQTL is compliant with MHPAEA. On the other hand, the extensive reporting and analysis called for in the rule will likely increase administrative burdens and increase costs. In the schematic below, we summarize the structure of reporting and analysis associated with the NQTL provisions of the rule.

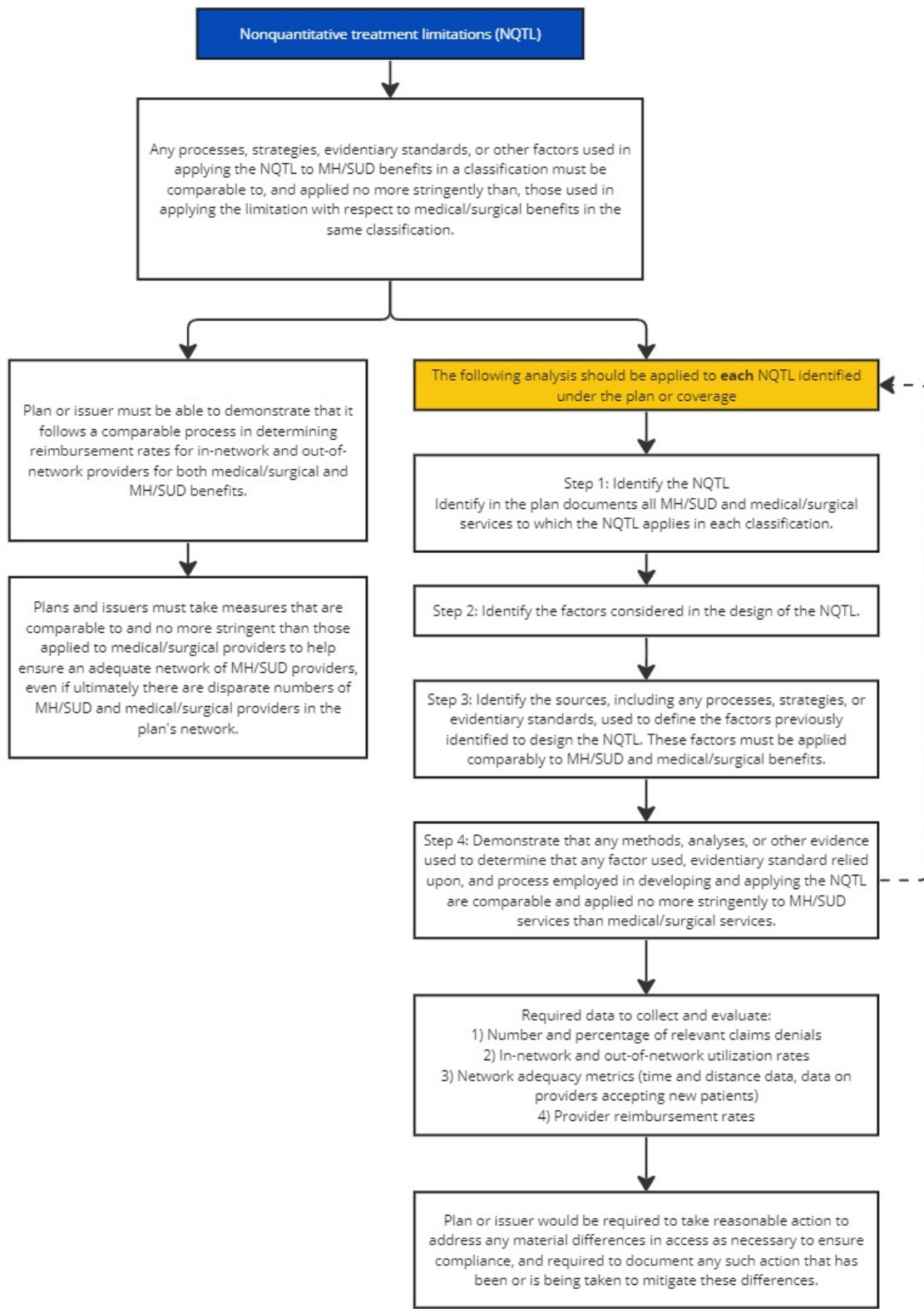
² See, for example, <https://www.cdc.gov/nchs/data/nhsr/nhsr184.pdf>

³ Pingitore DP, RM Scheffler et al, Comparison of Psychiatrists and Psychologists in Clinical Practice, *Psychiatric Services* 53: 977- 983, 2002; and <https://www.psychiatrist.com/jcp/medical/primary-care/trends-office-based-mental-health-care-provided-psychiatrists/>

⁴ To review the history of the enactment of MHPAEA, read https://www.everycrsreport.com/files/20081119_RS22958_63bab5711eca41cbcd9550e0a0980193ee1300a5.pdf

⁵ See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2950754/pdf/milq0088-0404.pdf>

⁶ See <https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/costestimate/hr1424wm0.pdf>



As highlighted in the schematic, in-depth analysis is required for every NQTL. A substantial amount of effort is involved in demonstrating compliance for a single NQTL – from identifying which services apply to the NQTL, identifying factors considered in the design of the NQTL, identifying sources used to define these factors, and demonstrating that the NQTL is applied no more stringently to mental health and substance use disorder benefits than medical/surgical benefits. At that point, all steps must be repeated for each additional NQTL. The loop of this process is likely to become burdensome, as the NQTL must be applied to each of 6 classifications (emergency care; prescription drugs; and inpatient and outpatient care, both in-network and out-of-network, respectively). For example, a prior authorization NQTL must be analyzed for in-network inpatient separately from out-of-network inpatient, again separately from partial hospitalization, and so forth, as these settings all fall into different classifications.

While we agree that it is essential for regulators and others to have the authority to query plans about the basis for NQTLs and their impact, the requirements for responding to such queries should be set forth as they are in the proposed rule. However, we suggest that the rule offer a hierarchical approach to establishing whether there is an access problem to reduce reporting burdens. The proposed rule appears to recognize this possibility in some places when it states:

“The proposed rules do not require or suggest a particular sequence to the analysis for evaluating compliance, and no inferences should be drawn from the order in which each of these independent requirements appear in the proposed regulatory text.”

Yet each of the analyses required by the proposed rule do not carry equal evidence with respect to whether access to mental health and substance use disorder care is more restricted than for medical/surgical care. For this reason, we suggest that a test assessing whether overall access to care is comparable be conducted first and that if no difference is found the plan be required to conduct fewer other analyses unless there is a challenge to its compliance with NQTL requirements. If a challenge were made, then the full set of analyses outlined in the proposed rule would be required.

Exceptions to NQTL Provisions:

The proposed rule identifies two exceptions to the NQTL requirements.

- The first is an exception for NQTLs based on Independent Professional Medical or Clinical Standards [(c)(4)(i)(E), (c)(4)(ii)(B), (c)(4)(iv)(D), and (c)(4)(v)(A)]
- The second creates an exception for NQTLs aimed at Fraud, Waste, and Abuse [(c)(4)(i)(E), (c)(4)(ii)(B), and (c)(4)(v)(B)]

Our review of the history of such exceptions and the changes that have been made through the Consolidated Appropriates Act (CAA) along with the improved specificity of the NQTL requirements that considerations of medical and clinical standards can easily be incorporated into existing assessment of the compliance of NQTLs with MHPAEA. That is, in providing evidence about the medical and clinical bases for creating an NQTL a health plan must provide evidence concerning *“whether the processes, strategies, evidentiary standards, and other factors used to apply an NQTL to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those used to apply the limitation with*

respect to medical/surgical benefits in the same benefit classification.” The statute and existing regulations require this, and a key element of such evidence is whether the NQTL is consistent with “best practices.” The language in the proposed rule also opens the door to regulatory gaming because it is overly broad. That is, there are many differing approaches to treating mental illnesses and substance use disorders, so making any one of them a standard would likely create potential for regulatory gaming. If the goal of this provision is to promote adherence to established medical and clinical standards, there are a variety of other accountability mechanisms available that can address that issue more directly and would not present new opportunities for regulatory gaming.

Turning to the fraud, waste, and abuse, the evidence on the main sources of these ills point to fraudulent billing, upcoding, unbundling, provision of unnecessary services, doctor shopping and medical identity theft.⁷ Few of these would be affected by an NQTL. Provision of unnecessary services might be, but evidence should be readily available to health plans to demonstrate why a targeted NQTL aimed at unnecessary services would be justified. That type of evidence could be incorporated into the assembly of evidence called for in these proposed regulations. Once again, the creation of an exception would likely serve to encourage regulatory gaming and new frictions to implementing the regulatory improvements in the proposed rule. This is because adjudicating claims of an NQTL being exempt due to its rationale would be cumbersome and would result in frictions that would impede the basic purpose of the improved NQTL provisions, which are promoting fair access to care. This makes the exceptions process unworkable. More direct evidence-based approaches to curbing fraud, waste, and abuse are available to public and private payers. Those include screening of claims using analytics to identify fraud, waste, and abuse⁸; education of providers; enhanced provider screening and enrollment requirements and promotion of consumer reporting of potential cases of fraud and abuse.⁹

Medicaid

The omission of rules that apply to Medicaid is striking. It will be necessary to consider how the advances included in the proposed rule apply to Medicaid. Some modification will undoubtedly be necessary. However, maintaining key principles that shaped the improvement in the proposed rule for Medicaid will be of critical import.

Network Adequacy Considerations

We are supportive of the use of outcome-based measures of access as the basis for evaluating network adequacy. We support provisions in the proposed rule that aim to improve measurement of network adequacy. At the same time, we are doubtful that measures based on time and distance, or availability of providers will yield useful and actionable information and may in fact produce misleading results.

The overall thrust of the proposed rule is to focus on fair access to services for people regardless of the illnesses they suffer from. Some of the network adequacy provisions reflect

⁷ For more, see <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9013219/>

⁸ Ibid. and Busch, R. S. 2012. Healthcare Fraud: Auditing and Detection Guide. New York: Wiley

⁹ See <https://www.justice.gov/opa/pr/fact-sheet-health-care-fraud-and-abuse-control-program-protects-consumers-and-taxpayers>

this philosophy, but a number do not. One outcomes-based approach is “out of network utilization.” The “percentage of network providers submitting claims” indicator suffers from several weaknesses. First, a single claim would yield a positive count in the participation column while providing little evidence about access to care. A second difficulty is the indicator relies on an accurate count of which providers are “in network.” Network directories are often out of date or incomplete.¹⁰ Finally because providers typically serve multiple networks, evidence of participation may offer only limited insight into the availability of care from those providers. The “time and distance” and “network availability” are not focused on outcomes and have not worked well when used in other contexts. Time and distance measures become especially problematic in the presence of telemedicine. Network availability measures suffer from the problems noted earlier.

Distribution of providers associated with a network also offers very limited insight into access to care. That is because many mental health professionals offer similar types of services. Thus, establishing standards for each professional potentially limits legitimate substitution among professionals, while a global standard creates incentives to over rely on low-cost providers that may not provide an adequate array of services.

We propose that network adequacy be judged by the rate at which enrollees are referred to specialty behavioral health providers and the out-of-pocket costs for those visits (as for example illustrated in table 1 above), among those referred to specialty care. One would also measure the percentage of patients that are monitored according to evidence-based guidelines.¹¹

Regulatory Impact Analysis (RIA)

The RIA associated with the proposed rule is quite incomplete. This incomplete analysis is exemplified by the statement on page 51610 under section 1.9, that states that *“it is unclear what percentage of participants, beneficiaries, and enrollees experience more restrictive NQTLs and more stringent practices related to the design and implementation of MH/SUD benefits, as compared to medical/surgical benefits.”* The implication of this is that the impact of the most significant changes made to MHPAEA regulations are not addressed quantitatively. That is, the service utilization and accompanying cost response to changes in the application of NQTLs that stem from the new requirements for NQTLs are not included in the RIA. Likewise, the changes in the demand for and spending on mental health and substance use disorder services for enrollees in previously exempt health plans are not included. Making estimates of these changes is possible using the extensive research on parity and managed behavioral health care. CBO made estimates of the impact of mental health provisions of the CAA.¹² That suggests that estimates are possible. Such estimates would be subject to meaningful

¹⁰ For more on the state of provider directories, see Busch SH, KA Kyanko, Incorrect Provider Directories Associated with Out of Network Mental Health Care and Outpatient Surprise Bill: An Examination of the role inaccurate provider directories play in out of network mental health treatment and surprise bills, *Health Affairs* 39 (6): 975-983, 2020.

¹¹ For a more complete discussion of these issues, see Glied S, K Aguilar, The Behavioral Health Workforce Shortage: Can we make better use of the providers we have? Brookings Institution May 2023.

¹² See https://www.cbo.gov/system/files/2023-01/PL117-328_1-12-23.pdf

uncertainty but would provide a more useful gauge of the potential impact of the proposed rule than offering no estimates.

In crafting the RIA, there should be attention given to the changes in the behavioral health environment that has occurred in recent years. The discussion of services utilization relies on impact estimates from data in the 2007 to 2012 period. That is understandable, but changes in the prevalence of illness, especially among children, adolescents, and young adults needs to be considered when constructing the baseline. For example, the doubling in the prevalence of depression among adolescents from 2010 to 2020 would be important to consider.¹³ Similarly, changes in substance use disorders and their treatment are also important to incorporate into estimates of spending impacts.

Shifting treatment patterns are recognized as a potential consequence of the proposed rule. The RIA cites the experience in Oregon prior to 2012. More recent data on increased demand for mental health services is readily available from the Medical Expenditure Panel Survey (MEPS).¹⁴ Those data confirm some of the observations from the earlier period but also highlight the role of nurse practitioners in the supply of behavioral health services. Again, more recent information is available to make estimates of utilization and spending impacts of changes in demand.

The utilization changes prompted by the proposed NQTL requirements, and the spending associated, will likely dwarf the estimates of the implementation costs that were set forth in the RIA. It is therefore essential to include those estimates in an RIA.

Finally, the RIA makes the following statement: *“while the Departments expect that these proposed rules would result in plans and issuers expanding coverage of mental health and substance use benefits, it is possible that instead of relaxing the use of NQTLs on mental health and substance use disorder benefits, some plans and issuers may impose additional NQTLs on medical/surgical benefits. As a result, some types of medical/surgical benefits may become less accessible for some participants, beneficiaries, and enrollees, which could lead to an increase in out-of-pocket costs.”* Such speculation has been offered since the beginning of the century, when the FEHBP parity study was underway. It was proposed again in connection to the Interim Final Rule for MHPAEA. No evidence of this behavior has been observed. Thus, the final rule should note that there is no evidence of an impact of new NQTLs resulting in changes in medical/surgical care management provisions, cost sharing, or coverage. Moreover, given the intense scrutiny being given to NQTLs outside of behavioral health, it seems highly unlikely that such a response would be realized

¹³ See Daly, Michael. 2022. “Prevalence of Depression Among Adolescents in the U.S. From 2009 to 2019: Analysis of Trends by Sex, Race/Ethnicity, and Income.” *Journal of Adolescent Health* 70 (3): 496-9. <https://doi.org/10.1016/j.jadohealth.2021.08.026>.

¹⁴ See Germack, Hayley D., Coleman Drake, Julie M. Donohue, Ezra Golberstein, and Susan H. Busch. 2020. “National Trends in Outpatient Mental Health Service Use Among Adults Between 2008 and 2015.” *Psychiatric Services (Washington, D.C.)* 71 (11): 1127–35. <https://doi.org/10.1176/appi.ps.201900576>.

While we believe that it is likely that a modified version of the proposed rule would generate benefits that significantly exceed the costs, it is important to more completely conduct the necessary analysis to demonstrate those net benefits.

We applaud the proposed rule in its efforts to advance access to mental health and substance use disorder care services. The proposed rule offers much improvement to the current guidance for health plans and insurers in completing comparative analyses. However, we hope you consider our feedback for making meaningful changes in crafting the final rule.

Sincerely,

Richard G. Frank and Chloe Zilkha

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