ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

Parity Insights: A Summary of ABHW's Response to the MHPAEA Proposed Rule

On August 3, 2023, the U.S. Department of Labor (DOL), U.S. Department of Health and Human Services (HHS), and U.S. Department of Treasury (DOT) – collectively, "the Tri-Departments" – issued a notice of proposed rulemaking ("proposed rule" or "NPRM") titled *Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

Since its inception, the Association for Behavioral Health and Wellness (ABHW) has been at the forefront of and an advocate for mental health (MH) and substance use disorder (SUD) parity. ABHW was instrumental in drafting the legislative language of the initial MHPAEA of 2008, and our members have worked tirelessly over the past 15 years to implement parity for behavioral health services. Our members have significantly modified their requirements because of MHPAEA. For example, fewer mental health services at our member organizations are subject to prior authorizations than in the past. In fact, numerous members have removed or decreased the application of prior authorization and other medical management reviews from most in-network outpatient and telehealth-delivered services. Additionally, ABHW member companies have taken a wide range of actions during and after the COVID-19 public health emergency (PHE) to help ensure that people with MH and SUDs receive the care they need.

We are concerned that the proposed rule could impact health outcomes, service quality for patients, and, ultimately, the cost of care. The Tri-Departments' proposals, rather than providing clarity and specificity concerning what health plans and issuers must do and must document to comply with parity, if implemented, the NPRM would significantly complicate and expand the burden on health plans and issuers to demonstrate compliance.

Moreover, the Tri-Departments fail to substantiate how the proposed changes in the NPRM would enhance parity or help achieve parity compliance. Rather, the Tri-Departments seem to assert that the proposed changes would cure a range of ills beyond those sought to be addressed under the MHPAEA law, for example, the lack of available providers. Further, the Tri-Departments' estimate of the administrative burden from these proposed rules dramatically understates the additional labor and expenditures required to meet these documentation requirements.

Our key recommendations for the proposed rules are as follows:

1. **Substantially All/Predominant Test:** The Tri-Departments propose to reinterpret the parity statute to subject medical management techniques, called Non-Quantitative Treatment Limits (NQTLs), such as prior authorization and concurrent review, to the quantitative tests that are currently applied to financial and

treatment limits, called quantitative treatment limits ("QTLs") such as copays and deductibles. In other words, applying the Substantially All/Predominant test to medical management techniques would limit the ability to ensure patients receive safe, medically necessary care and keep costs low. Congress specifically allowed for these medical management techniques when enacting MHPAEA as they are vital to help safeguard effective treatment for patients and keep premium increases due to parity implementation low.

To explain the application of the Substantially All math test further, the Tri-Departments would require health plans and issuers to mandate that medical management techniques applied to MH/SUD benefits have to be applied to 2/3rd or more of the medical/surgical (M/S) benefits in the same classification.

Examples of how this rule would impact clinically appropriate medical management tools:

- Example #1: To apply prior authorization on outpatient in-network mental health and substance use disorder benefits such as Applied Behavioral Analysis (ABA) therapy, partial hospital or intensive outpatient treatment, health plans must apply prior authorization to 2/3rds of their outpatient in-network medical benefits. There are so many – thousands of – outpatient medical-surgical services that this would be impossible to calculate.
- Example #2**:** To apply concurrent review, a tool that protects against unnecessary risk and supports improved patient outcomes, on inpatient mental health or substance use services, a health plan must apply concurrent review on 2/3rd of the benefits in their inpatient M/S classification. Most plans and issuers do not apply concurrent review to 2/3rd of the benefits in the inpatient M/S classification, as the standards of care for many M/S treatments include a recommended duration of stay and are less variable.

Recommendation: ABHW requests that the Tri-Departments rescind the proposal to apply the Substantially All/Predominant Test for the following reasons: (1) the statutory text does not support the application of quantitative testing to NQTLs, (2) the proposed quantitative testing requirement would overturn 15 years of MHPAEA guidance and enforcement, (3) the proposed guidance for applying quantitative testing to nonquantitative treatment limits is excessively complex and ambiguous and will inevitably lead to arbitrary and capricious enforcement, (4) the proposed quantitative testing does not allow for plans to apply reasonable and appropriate clinical reasoning to the management of MH/SUD benefits, (5) the quantitative testing requirements are unnecessary to resolve the identified concerns in all of the proposed examples in the NPRM, (6) will eliminate a wide range of reasonable and important NQTL types, and (7) identification of "variations" and the predominant variation of an NQTL will be arbitrary and unpredictable.

ABHW recommends that the Tri-Departments, instead, maintain the current NQTL testing requirements. At a minimum, we request that the Tri-Departments better

explain the intended difference between the new quantitative testing requirements and the existing comparability and stringency requirements by creating examples in the final rules that would demonstrate scenarios where an NQTL would be permissible under the requirements for comparability of "processes, strategies, evidentiary standards, and other factors," both "as written" and "in operation," but would still be prohibited by the new quantitative testing requirements. We believe that such examples, if based on actual, common NQTL designs, will illustrate the perverse outcome of the proposed quantitative testing requirements and how it would extend beyond any reasonable interpretation of "parity" between MH/SUD and M/S benefits and would instead effectively privilege MH/SUD benefits while discriminating against M/S benefits.

2. Tri-Departments' Exceptions

2A. Independent Professional Medical or Clinical Standards: The Tri-Departments propose an exception for the Substantially All/Predominant Test; if a health plan can demonstrate that an NQTL impartially applies independent professional medical or clinical standards to MH/SUD benefits, then such NQTL will not violate the "no more restrictive" requirement.

Recommendation: ABHW requests that the Tri-Departments interpret independent professional medical or clinical standards broadly and provide examples of standards that would meet the exception. ABHW also encourages the Tri-Departments to provide further clarity and examples of situations that would meet this exception and what is required documentation.

2B. Exception for Fraud, Waste, and Abuse: The Tri-Departments propose a second exception for the Substantially All/Predominant Test; if a plan applies an NQTL to detect or prevent and prove fraud, waste, and abuse to MH/SUD benefits, then such NQTL will not violate the "no more restrictive" requirement. The NQTL must be reasonably designed to detect or prevent and prove fraud, waste, and abuse, based on forms of fraud, waste, and abuse that have been reliably established through objective and unbiased data, and be narrowly designed to minimize the negative impact on access to appropriate MH/SUD benefits.

Recommendation: ABHW requests that the Tri-Departments provide further guidance to illustrate the expected design and data thresholds for a plan to show that it has met all these requirements in order to rely upon the fraud, waste, and abuse exception. We also recommend that the Tri-Departments provide examples demonstrating that health plan experts may rely on professional judgment to evaluate the reliability of fraud, waste, or abuse that are not established through objective and unbiased data. Lastly, we recommend that health plans be permitted to redact all narrative discussion and data regarding fraud, waste, and abuse monitoring and detection strategies from publicly disclosed versions of their parity compliance documentation and that the Departments honor plan requests to

refrain from disclosing these proprietary and confidential details to any third party.

2C. ABHW Requests that the Tri-Departments Adopt Two Additional Exceptions. Recommendation: Adopt an Exception for Compliance with Federal and State Law: ABHW encourages the Tri-Departments to adopt an exception if a health plan applies a federal or state law to the design or operation of an NQTL. Many state laws require or prohibit certain practices regarding utilization management, provider credentialing, and other NQTL types. Federal and state law requirements may complement, alter, or even conflict with applicable independent clinical and medical standards and/or a health plan's strategies to detect or prevent and prove fraud, waste, and abuse.

Recommendation: Adopt an Exception for Quality and Safety: ABHW also requests that an exception be created for factors designed to ensure the quality and safety of covered services. For example, we suggest that if health plans and issuers can show that the lifting of an NQTL may directly harm quality or safety of members, the NQTL would neither not be subject to the Substantially All/Predominant Test nor would it need to demonstrate equity in outcomes. The quality or safety exception would need proof of professional judgment or explanation (e.g., medical management committee finding, clinical attestation, studies, or claims data analysis).

3. **Material Difference in Outcomes Data**: The Proposed Rule adds the requirement that a plan or issuer must collect and evaluate relevant data metrics in designing and applying an NQTL to assess the impact on access to MH/SUD disorder benefits relative to M/S benefits. If the data shows a material difference in access to MH/SUD benefits compared to M/S benefits, the difference strongly indicates that the plan or issuer violates parity. If a plan or issuer uncovers material differences in its data outcomes measures, it must take reasonable action to address any material differences as necessary to ensure compliance.

   Recommendation: The Tri-Departments' enforcement powers do not permit them to require corrective action in the absence of noncompliance; ABHW, therefore, recommends that these sections be revised to apply only where the plan is unable to rebut the presumption of noncompliance that is triggered by a material difference in a required data measure.

   3A. Network Composition - Outcomes Data and Special NQTL Rule: For NQTLs related to provider network composition standards, the Tri-Departments propose that not only do health plans have to evaluate outcomes data, but if there are "material differences" in outcomes data, that will be a strong indicator of noncompliance and health plans must show that they are taking steps to address material differences.

There are many reasons why a health plan or issuer may not achieve parity compliance for network administration NQTLs, many of which are outside the control of the plan or issuer. Network administration NQTLs are developed based on a dizzying array of complex business factors, including actuarial analyses, arms-length market negotiations, industry trends, government payor rate-setting (such as Medicare or Medicaid), among many other factors, and evidentiary standards. These factors vary considerably by benefit, provider type, service setting, and region. There is often no available data to assess the tendency of each factor for MH/SUD benefits compared to M/S benefits. This raises significant questions about whether the analysis can be performed for these NQTL types. The newly proposed discriminatory factors and evidentiary standards test will likely create significant challenges for demonstrating parity compliance for network administration NQTLs.

Recommendation: ABHW recommends that the Tri-Departments withdraw their proposal to override existing network adequacy regulations by superimposing a new framework for evaluating network adequacy under MHPAEA and instead acknowledge that "comparability" under MHPAEA requires analysis of whether the provider network meets applicable regulatory and accreditation requirements that define the adequacy of the network for MH/SUD and M/S.

Compliance determinations should also account for a variety of important distinctions between MH/SUD and M/S provider networks, including:

- Mental health professionals often practice via telehealth and across state lines. The rule does not include telehealth in its network adequacy data requirements. As the Tri-Departments acknowledge, telehealth has become vital to providing health care, particularly mental health care. Telehealth must be incorporated into the proposed rules' network adequacy standards and data collection requirements. The metrics around time and distance are much less relevant when most mental health care is delivered virtually.
- Medical/surgical professionals are more likely to be in integrated groups and value-based payment models, which may skew reimbursement data.
- There are newer, non-licensed specialties in mental health (e.g., non-licensed peer support specialists and non-licensed behavioral analysts providing therapy to individuals with autism spectrum disorder) that may require additional medical management or oversight.
- Mental health professionals are more often in small or solo practices with limited back-office support and, as a result, less willing to take on the administrative burden of joining networks or increasing patient loads, an administrative burden that is often dictated by regulatory requirements and not health plans.
- There are new out-of-network access points for mental health care delivery that policies should encourage, including crisis care delivery systems and school-based care, but that could impact out-of-network utilization (and data).
- ABHW requests that the Tri-Departments revise the proposed regulations to allow integrated health plans to conduct similar but separate analyses for NQTLs

of their (1) integrated care delivery models and (2) community contracted networks.