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

December 4, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016, Baltimore, MD 21244–8016

The Honorable Daniel Tsai
Deputy Administrator and Director, Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure and Deputy Administrator Tsai,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments on the Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and CHIP Services (CMCS) Request for Comments on Processes for Assessing Compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) in Medicaid and CHIP.

ABHW is the national voice for payers managing behavioral health (BH) insurance benefits. Our member companies provide coverage to approximately 200 million people in the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness. Since its inception, ABHW has been at the forefront of and an advocate for MH and SUD parity. ABHW was instrumental in drafting the legislation for the initial MHPAEA of 2008, and our members have worked tirelessly over the past 15 years to implement parity for behavioral health services.

Access to comprehensive, evidence-based MH and SUD services is critical to enhance patients' health and overall well-being, whether covered by a commercial, Medicare, Medicaid, or another health benefit program. The distinctions in the Medicaid program make it necessary to keep a separate parity rule from the commercial space. The Medicaid program is specifically designed to address the nuances of the Medicaid benefit and the population it covers, especially for individuals with complex needs. Moreover, Medicaid services delivered through the Medicaid Managed Care model reflect a successful state-health plan partnership that provides the necessary infrastructure to meet Medicaid enrollees' physical and behavioral health needs.

There is significant variation in states' management of Medicaid MH and SUD benefits. Some states have specialty MH or SUD benefits carved out of Medicaid Managed Care Organization (MCO)

contracts provided by the state. Notably, MCOs in carve-out states generally do not have the requisite information to verify benefits and Non-Quantitative Treatment Limits (NQTLs) on the medical/surgical (M/S) side. MCOs must abide by each state's Medicaid Managed Care contract terms. For example, the MCO contract dictates certain limits, such as Quantitative Treatment Limits (QTLs) and NQTLs. Some contracts dictate the exact QTL levels, such as visit limits and copays, and these contracts ensure that benefits and offerings are aligned. Therefore, states are responsible and should be accountable for broad aspects of mental health and substance use disorder parity compliance, such as reporting and analysis within Medicaid-managed care.

CMS should not apply 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" newly proposed MHPAEA Notice of Proposed Rulemaking (commercial NPRM or commercial proposed rule) to Medicaid MCOs for parity compliance. As ABHW explained in our NPRM comment letter on Requirements Related to the MHPAEA, submitted to the Tri-Departments on October 17, 2023, if finalized, the commercial proposed rule could negatively impact health outcomes, patient service quality, and, ultimately, the cost of care. The commercial proposal shifts the focus from comparing methodologies to comparing outcome measures like denial rates and actual amounts paid to providers. This approach goes well beyond the intent of the MHPAEA law and suggests that any disparate outcome is noncompliance. In addition, compliance with a newly proposed three-part NQTL test, particularly the Substantially All Predominant Test, 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 costs down. The Tri-Departments' proposed rules suggest that parity is a magic bullet to achieve behavioral healthcare access. However, no matter how far health plans bend to comply with parity, there will still be challenges, such as the influx of pediatric emergency boarding, fragmented care, and a shortage of providers.

Additionally, the Tri-Departments' estimate of the administrative burden from their commercial proposed rule dramatically understates the additional labor and expenditures required to meet these documentation requirements. ABHW believes a more realistic estimate of the administrative burden imposed by the commercial proposed regulations would be closer to $3.49 billion in the first year.

Lastly, CMS must adopt parity regulations that are operationally feasible and efficient for states to implement. Given the different state requirements already in existence, substantial administrative burden and increased costs will come with imposing additional requirements on Medicaid and CHIP programs. Adopting the current Tri-Department NPRM for MHPAEA would significantly complicate and expand the burden on states and MCOs to demonstrate compliance.

Below, we have provided detailed responses to CMS's Request for Comments (RFC):

1. **What are some model formats (e.g., templates) and key questions to consider for improving the efficiency and effectiveness of documentation review of compliance with parity requirements in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?**

ABHW requests that CMS utilize a standardized template for compliance with NQTLs. ABHW members understand that the variation in state programs will mean variation in state reporting requirements but still see the benefit of a federal template as a starting point for all states. For example, our members would support CMS, providing a platform to build from with core standardized questions, but that allows for the nuances of state programs. The CMS standardized template should have simple fields and utilize universal terminology and consistent definitions across Medicaid and the Tri-Departments. ABHW also urges CMS to share an example of a model template with sample answers so stakeholders can learn best practices.

Some ABHW members have held out the North Carolina prior authorization NQTL inpatient template as it is a more simplified model that is a step in the right direction.[1] While certain members appreciate that this template has merits, they point out that it could be simplified even more. For example, the numbering and titling could be more precise, and there should be five steps instead of six to mirror the current federal guidance. Other members shared the California Department of Managed Health Care (DMHC) NQTL template.[2] These examples need improvement but could serve as a starting point for future discussions and showcase more simplified approaches taken by states. Most importantly, our members request standardization. Health plans that operate in numerous states struggle to complete the different format templates. ABHW urges CMS to create a technical workgroup that includes broad stakeholders of health plans, providers, associations representing patients, and regulators to develop a simplified NQTL analysis template that can reflect variances across states.

Regardless of the template, ABHW asks CMS to issue guidance that states are required to complete the sections of the template that are in the state Medicaid agency's control, as those are areas where health plans have no discretion. MCOs spend significant staff resources duplicating and summarizing state requirements back to the state.

Health plans frequently do not see the results from state mental health and substance use disorder parity assessments. ABHW encourages all stakeholders to be more transparent during parity compliance reviews. On the commercial side, there is more back and forth between regulatory reviewers and health plans to get the appropriate information and provide clarifications. We recommend that CMS mandate a standardized parity assessment process that states must follow, including appropriate follow-ups throughout the review process. Allowing health plans access to the results of these parity analyses will help improve systems.

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[1] Please see the North Carolina Inpatient Prior Authorization NQTL Analysis Template - https://abhw.org/wp-content/uploads/2023/11/NC-Inpatient-NQTL.docx

[2] Please see the California DMHC NQTL Analysis Template - https://abhw.org/wp-content/uploads/2023/11/NQTLComparativeAnalysisWorksheet_DMHC.docx

Lastly, we support CMS, providing increased training and technical assistance for state regulators on best practices and lessons learned through parity enforcement.

2. **What processes are states and managed care plans using to determine whether existing coverage policies are comparable for MH and SUD compared to medical and surgical benefits?**

ABHW encourages CMS and states to work together and be more actively involved in the reporting and analyses of parity within Medicaid contracts. Often, states ask health plans to conduct parity analyses when the states are responsible for some or all MH/SUD benefits. For example, since parity reporting is a contractual requirement managed by the state or the state directly provides behavioral health services, states already have robust data from Medicaid MCOs. In these instances, as was mentioned above, ABHW recommends that states respond to CMS questions directly rather than requiring managed care plans to duplicate their answers. States should prepopulate reporting documents based on the data they already have. For example, if a state requires 12 outpatient visit limits in the contract, it should prepopulate any compliance form with this recognition explicitly noted.

As was explained above, states often require health plans to manage Medicaid MH and SUD benefits in a certain way. MCOs must occasionally justify specific contract requirements in their parity analysis, such as mandated fee schedules, visit limits, utilization management metrics, and network adequacy criteria. ABHW recommends that if MCOs must contractually agree to specific requirements in the Medicaid managed care plan contract, then health plans shouldn't have to justify it in a parity analysis**.**

Additionally, as stated above, MCOs should see the initial results of a state's parity analysis and be able to make adjustments/corrections. States frequently do not provide MCOs with feedback on gaps or CMS guidance to states related to parity compliance. As a result, MCOs may miss opportunities to make improvements. If states are audited by CMS and CMS has provided feedback, MCOs should have access to that information.

3. **What are some key issues to focus on in reviewing policy or coverage documents that may indicate potential parity compliance issues, including regarding NQTLs in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?**

As discussed, states mandate Medicaid MH and SUD benefits and services differently. We encourage CMS to review state statutes and regulations, Medicaid managed care contracts, and state guidance to determine federal standardization and where flexibility can be provided.

Addressing the substantial behavioral health workforce shortage that challenges growing networks is critical. One hundred and sixty-three million Americans live in mental health professional shortage areas (HPSAs), with over 8,000 more professionals needed to ensure an

adequate supply.[3] For example, while nearly one-third of the U.S. population is Black or Hispanic, only about a tenth of practicing psychiatrists come from these communities.[4] Medicaid enrollees seeking behavioral health care are particularly impacted. Even when providers accept Medicaid, they may only take a few patients or may not be taking new Medicaid patients at all. On average, only 36% of psychiatrists accept new Medicaid patients – lower than the acceptance rates for physicians overall (71%).[5] Mental health professionals are often in small or solo practices with limited office support and, as a result, less willing to take on the administrative requirements of joining networks or increasing patient loads. There is also a burden driven by regulatory and accreditation requirements on providers outside the health plan's control.

Telehealth has become vital to providing health care, particularly behavioral health care. State Medicaid agencies have significant options to cover telehealth, and all states currently offer some Medicaid telehealth coverage. States reported that telehealth helped maintain and expand access to behavioral health care during the COVID–19 pandemic. Consumers can access behavioral health care more quickly and easily when virtual care is an option. ABHW urges CMS to ensure that telehealth is incorporated into assessing the quality and strength of provider networks.

4. Which NQTLs and/or benefit classifications should `be prioritized for review?

ABHW requests CMS produce an exhaustive list of NQTLs. MCOs should only have to complete a comparative analysis for those NQTLs explicitly identified in published guidance. DOL identified four core NQTLs in 2021 and six in 2023**.** However, state regulators have gone beyond that and are prioritizing 12-15 NQTLs for review, which differ from state to state. If CMS cannot produce an exhaustive list of NQTLs, we urge CMS to identify the core set of NQTLs that are the focus of Medicaid reporting annually. ABHW also encourages CMS to create a sample analysis for each NQTL that MCOs must analyze.

CMS and states should prioritize NQTLs and benefit classifications not defined by the state Medicaid program, where plans have the discretion to apply NQTLs. States define many of the parameters around NQTLs. For example, states define which benefits to cover, visit limits, fee schedules, some utilization management and network adequacy requirements, and what prescription drugs are covered. There are slight variations allowed (for example, payment increases beyond the allowable fee schedule), but there is limited scope or applicability for such deviations. As such, NQTLs should be evaluated for parity differently for Medicaid MCOs than in commercial plans.

5. What should be the criteria for identifying high-priority NQTLs for review?

[3] https://data.hrsa.gov/topics/health-workforce/shortage-areas
[4] Kepley HO, Streeter RA. Closing behavioral health workforce gaps: a HRSA program expanding direct mental health service access in underserved areas. American Journal of Preventive Medicine 2018; 54(6 suppl 3): S190–S191. doi: 10.1016/j.amepre.2018.03.0066
[5] https://www.kff.org/mental-health/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/

CMS should prioritize NQTLs, which will have the greatest impact on Medicaid members. Parity analysis should target NQTLs or specific aspects of NQTLs that generate substantive change and result in a material improvement in patient outcomes. ABHW also urges consistency in identifying priorities and criteria between commercial and Medicaid**.**

ABHW requests that CMS identify and define compliance safe harbors for enforcement of the most investigated NQTL types. Each safe harbor should identify those aspects of plan design and outcomes that are most indicative of parity in access to MH/SUD benefits. These safe harbors would be designed and administered like those administered by the Office of Inspector General for the U.S. Department of Health and Human Services for compliance with the Anti-Kickback Statute and Civil Monetary Penalty Rules.

6. **What are some measures or datapoints or other information that could help identify potential parity violations in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?**

ABHW values and shares in CMS's goal of ensuring mental health and substance use disorder parity. We believe the contractual requirements placed on Medicaid MCOs already address the compliance standards for which CMS seeks feedback. Many data points proposed below are outside the control of Medicaid MCOs and health plans in the commercial context, such as out-of-network (OON) utilization and reimbursement. Other measures, like network adequacy, are already highly regulated in the Medicaid context.

Further, we believe additional measurements should be decided between state Medicaid programs and the Medicaid MCO.

6A. For example, are the following measures effective for identifying coverage that may not comply with parity requirements?

- **Comparison of <u>rates of coverage being denied</u> for MH and SUD benefits compared to rates of coverage being denied for medical and surgical benefits.**

The rates of coverage being denied from MH and SUD compared to M/S benefits is an overinclusive measure and will include administrative and medical necessity denials. It is essential to use different criteria for (1) denial rates for all claims and (2) adverse coverage determinations through utilization management functions because claim denial rates are not a meaningful metric for utilization management (UM) activities. In particular, many UM adverse determinations do not become claims, and many denied or approved claims are not subject to UM. (Please see URAC Exhibit 1 URAC MHPAEA Thought Leaders' Summit Measure Feedback in Appendix 1.)

- **Comparison of <u>average and median appointment wait times</u> for MH and SUD providers compared to medical and surgical providers.**

As noted in ABHW's response to CMS's Managed Care NPRM, numerous external factors beyond an MCO's control determine the ability to meet wait-time standards, such as the patient's clinical needs, preferences, and geography. For example, an enrollee might be awaiting the results of diagnostic tests performed by third parties before an appointment can occur, or the enrollee might prefer to see a specific mental health or substance use disorder practitioner who is temporarily unavailable. Geographic differences also influence wait times, especially for patients living in rural areas or other HPSAs where providers are more dispersed and transportation support is limited. Weather and time of year also need to be considered.

ABHW encourages a focus on workforce development before implementing wait time standards for BH providers. This includes bolstering programs that recruit people into the behavioral health workforce by increasing Graduate Medical Education (GME) residency spots, loan repayment programs in HPSA shortage areas, and utilizing certified peer support specialists and other allied health professionals to allow providers to practice at the top of their licensure.

- **Comparison of payment rates for MH and SUD providers compared to payment rates for medical/surgical providers.**

As discussed above, many states define fee schedules for payments outside of Medicaid MCO control, and this is not a relevant datapoint for parity compliance.

- **Comparison of prevalence rates of MH conditions or SUDs among certain groups of enrollees compared to the percent of enrollees from those groups who are receiving treatment for MH conditions or SUDs.**

ABHW believes that prevalence rates for MH and SUD conditions compared to those receiving treatment for MH conditions or SUD is not a relevant data point for parity compliance.

- **Comparison of the average time from receipt of a claim to payment of that claim for MH and SUD benefits compared to medical and surgical benefits**.

ABHW believes that the average time from receipt of a claim to payment of that claim for MH and SUD benefits compared to M/S benefits is not a relevant data point for parity compliance. A variety of factors influence the average time for receipt of a claim to payment of that claim.

- **Comparison of the percentage of MH and SUD network providers actively submitting claims compared to the percentage of medical and surgical providers actively submitting claims.**

ABHW believes this measure would be ineffective in demonstrating parity compliance. Although a few state regulators have required the collection of a comparable measure regarding MH/SUD providers, ABHW is not aware of any comparable measure being collected for M/S providers. The results may differ drastically depending on the specific provider types selected. Moreover, submitting claims for MH/SUD and M/S providers is largely outside an MCO's control. Please see further details in ABHW's response to the Tri-Department's MHPAEA Technical Release.

6B. Are there any other measures to consider regarding provider network composition and standards for provider network admission, including measures focused on?

- **Methods for determining reimbursement rates?**

Medicaid sets provider fee schedules, and MCOs have no input in how the fee schedule is determined. Therefore, this data point would not be effective in demonstrating parity compliance.

- **Credentialing standards?**

Numerous state laws and Medicaid agency regulations require or prohibit certain practices about provider credentialing. There is too much variation to utilize this measure for parity compliance.

- **Ensuring a network includes an adequate number of each category of provider?**

As stated above, state regulatory frameworks already govern network adequacy for Medicaid MCOs. This includes NPRM parameters that might take effect in 2024, such as the Fiscal Year (FY) 2024 Medicaid Managed Care Access, Finance, and Quality, NPRM, and the FY24 Notice of Benefit and Payment Parameters. ABHW believes network adequacy is an integral part of assessing access to care. However, we caution against creating complex new standards for network administration and network adequacy that significantly depart from and conflict with existing federal and state regulatory frameworks.

ABHW encourages CMS to focus on workforce development before implementing new standards that burden BH providers and health plans, as was outlined above.

Additionally, please see ABHW's comment letter on the commercial NPRM and the corresponding Technical Release to view our response to Tri-Departments' attempt to create an entirely new overlapping and divergent regulatory framework for network adequacy across markets that is beyond the scope of what Congress enabled in enacting MHPAEA.

6C. What terminology should CMS define to facilitate the collection and evaluation of data regarding these or other recommended measures?

ABHW recommends consistently using the term "claim" across all metrics. ABHW requests that CMS and the Tri-Departments define "claim" to reflect covered services from within the geographic service area (including telehealth), each claim line (as opposed to overall claim), and that the definition only includes finalized un-duplicated claims.

The term "out-of-network" should also be defined across regulatory agencies, as should the types of network designs subject to the measure.

Lastly, CMS should define "denial" and ensure to distinguish "administrative denials" and "medical necessity denials."

7. **How should data on these or other recommended measures be collected?**

ABHW supports efforts that help states utilize the data they are already collecting, which will help eliminate duplication of efforts. CMS should consult with states, Medicaid MCOs, and other stakeholders to determine whether additional measures are needed before deciding whether any changes are necessary.

ABHW also encourages CMS to aggregate the data collected based on Medicaid eligibility groups, especially for those eligibility groups that use the same network of providers and reimbursement rates.

8. **What are some potential follow-up protocols and corrective actions when measures indicate a possible parity violation in Medicaid managed care arrangements, ABPs, and CHIP?**

MCOs have long-standing relationships with state Medicaid agencies, which should be fostered to develop a collaborative approach to remedy parity actions, including a multi-process opportunity for corrective action consistent with existing managed care contract requirements. Moreover, Medicaid state contracts already have substantial corrective action requirements, including assessing liquidated damages, conducting accelerated monitoring, suspending enrollment of members, or declining to renew, extend, and even terminate a contract.

MCOs should be given ample time (e.g., 30 business days) to notify members after the receipt of a final notice of noncompliance. Imposing additional fines and sanctions beyond what is already in MCO contracts could vary from state to state and would be overly burdensome.

ABHW also recommends developing a procedural review process in cases of potential parity noncompliance. An appeals process is critical to maintaining checks and balances within the healthcare system. The right to an appeal, including an opportunity for an administrative hearing, should be granted, as a determination of parity noncompliance can cause substantial reputational and financial harm. Accordingly, MCOs should be afforded an adequate opportunity to dispute a finding of noncompliance or, even better, to work collaboratively with a state to come into compliance.

9. **What additional processes should be considered for assessing compliance with Medicaid and CHIP parity requirements, e.g., random audits?**

ABHW encourages CMS not to create additional processes for assessing compliance until appropriate parity guidance is developed. MCOs have sought clearer examples of demonstrating parity for NQTLs, noting that a lack of examples and specificity has led to confusion for stakeholders.

States are already conducting audits of compliance with parity requirements. These audits are time and resource-intensive for MCOs. ABHW encourages CMS to create an affirmative reporting obligation instead of audits. These affirmative reporting obligations could ensure recognition of disparities earlier in the process and make it easy to remedy potential noncompliance.

Also, we encourage transparency with parity comparative analyses so that all stakeholders can learn from the data and adjust their systems.

10. Are there any MH conditions or SUDs that are more prevalent among enrollees in Medicaid MCOs, Medicaid ABPs, or CHIP? What are the most significant barriers to accessing treatment among enrollees with these conditions?

The shortage of MH and SUD providers willing to accept Medicaid is a significant barrier to treatment. Additionally, requiring meaningful coverage in each classification can be a challenge in Medicaid because of the lack of providers, treatment facilities, and day treatment programs.

Lastly, the application of MHPAEA to the Medicaid population underscores the need to lift further restrictions on Medicaid Institutions for Mental Diseases (IMD). Freestanding community psychiatric hospitals are the only type of hospital explicitly excluded from the category of all hospitals, which perpetuates the discrimination that people living with MH/SUD issues feel. ABHW supports permanently eliminating the IMD exclusion to allow access to MH and SUD treatment delivered in IMDs. CMS should work with Congress to address this treatment limit.

11. Are there any particular MH conditions or SUDs or types of treatment that are at risk of not being covered in compliance with parity requirements for Medicaid managed care arrangements, Medicaid ABPs, or CHIP?

The variety of how Medicaid MH and SUD benefits are managed among states has led to a wide disparity in how services are provided. For example, in California, specialty mental health is carved out, and there are serious barriers to accessing treatment through the counties. This is a particular problem with specialty MH services and SUD treatment because the county providers do not have adequate capacity, and there are long wait times.

It is estimated that three million people have an opioid use disorder (OUD).[6] MAT is effective for patients with a SUD or an OUD. However, there are significant barriers to accessing it across states, such as insufficient provider training and education about the benefits of MAT and the stigma of SUDs impacting the number of providers delivering treatment.

[6] https://www.cdc.gov/nchs/products/databriefs/db457.htm#print; On July 4, 2022, the Biden Administration renewed the determination that the Opioid PHE exists nationwide.

Conclusion

Thank you for your efforts and consideration of our responses to the RFC on parity requirements. ABHW welcomes the opportunity to collaborate with CMS. Lastly, beyond parity enforcement, ABHW encourages CMS to bring heightened attention and examine ways to increase and improve quality and safety. We stand ready to provide further input and assistance and would appreciate meeting with you to discuss our responses and suggestions. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,

Pamela Greenberg, M.P.P.
President and CEO

APPENDIX 1

Exhibit 1 URAC MHPAEA Thought Leaders Summit Measure Feedback, September 7, 2023

Exhibit 2 Row #	Measure Name	Measure Description	Summit Feedback
	UM Denial Rates Measures		
N/A	General feedback on measure category		- Important to use different measures for (1) denial rates for all claims and (2) adverse coverage determinations through UM functions because claim denial rates are not a meaningful metric for UM activities. In particular, many UM adverse determinations do not become claims, and many claims that are denied or approved are not subject to UM at all. - For measures that require reporting separate data for different NQTL types, recommend having NQTL-type definitions to support reporting. - Some measures require reporting on sub-types of provider settings that do not align with MHPAEA classifications. Summit participants had mixed opinions on this approach but agreed that subclassifications need to be defined if required. - Need definitions for duplicate claims/authorization requests and medical necessity vs. administrative adverse determination/denials. - Recommend collecting denial reasons with instructions on categorization and guidance on approaching claims/requests denied for multiple reasons. - For claims denial metrics, need to specify unit of claim to analyze (claim line vs. date of service). Either works, just need to be specific in technical specifications. - For unit of data submission, for self-funded employer reports recommend including both national book of business data and employer-specific data for each measure and for

		fully-insured issuers, recommend both national book of business data and state-specific full state market data (not product-or plan specific). - Recommend using +/- 10% as definition of "material difference."	
2	Denial Rates	Comparison of UM denial rates for certain provider categories between MH/SUD and M/S	- Measure is missing definition for an authorization request that aligns with ERISA and state UM laws for populating denominator. - Denial definition conflates claim and authorization requests and approaching through denial categories rather than as separate measures does not address this issue. - "Modifications" are not necessarily a coherent concept for adverse determination or claim denial purposes and is not administrable. - Does not provide for collection of denial reasons.
3	Denial Rates and PA Denial Rates	Comparison of all claims denial and UM denial rates for all Medicaid MHPAEA classifications between MH/SUD and M/S	- Includes NQTL-type definitions. - Reports UM denials and all claim denials as separate metrics. - Needs duplicate claim definition. - Includes helpful definitions of administrative vs. clinical denial and denial reason guidance.
4	Prior auth and Claims Received, Approved, and Denied	Comparison of all claims denial and UM denial rates for all MHPAEA classifications between MH/SUD and M/S	- No additional comments.

5	Pre-Service Ratios/Claim Ratios/Modification Ratios	Comparison of all UM denial rates and "modification" for all MHPAEA classifications between MH/SUD and M/S	- "Modifications" are not necessarily a coherent concept for adverse determination or claim denial purposes and is not administrable.
6	Denial Rates, Informal Reconsideration Rates, Internal Appeal Rates, and Appeal Overturn Rates	Comparison of PA/CR/RR denial, reconsideration, appeal, and overturn rates between MH/SUD and M/S	- No additional comments.
	Other UM Measures		
N/A	General feedback on measure category	- Participants recommended also considering measures on turn-around times for UM determinations.	
2	Operational Proportionality	Comparison of ratio of service utilization subject to UM between MH/SUD for certain categories.	- Data sub-classifications don't align with NQTL classifications and introduce different sub-classifications to those in the regulations. Summit participant indicated the technical specification seeks to distinguish between levels of care within outpatient (facility and non-facility) to acknowledge differences between them. - Some participants discussed whether comparing the relative number of services subject to UM would serve as simpler alternative to this

			measure but others discussed that this measure is intended to get to service utilization weighting of UM practices.
3	Interrater Reliability	Comparison of PA/CR/RR interrater reliability between MH/SUD and M/S	- No additional comments.
	Prescription Drug Measures		
N/A	General feedback on measure category	- Participants did not have strong opinions about any of the submitted metrics on the NQTLs for the prescription drug classification.	
2	Formulary Exception Requests	Comparison of off-formula request approval and denial rates for MH/SUD vs M/S medications	- No additional comments.
3	Formulary Tiering	Comparison of Tier placement by primary diagnosis	- No additional comments.
4	Specialty Drug Count	Comparison of Specialty Drug designation by primary diagnosis	- No additional comments.
5	Prior Authorization	Compares # and % of drugs per	- No additional comments.

		tier subject to PA	
6	Step Therapy	Compares # and % of drugs per tier subject to step therapy	- No additional comments.
7	Quantity Limits on fills	Compares # and % of drugs per tier subject to quantity limits	- No additional comments.
	OP/IN Network Management Measures		
N/A	General feedback on measure category	- Participants at the Summit identified additional metrics that were not submitted for consideration on these NQTL types including: the gap exception metrics currently being used by the New Mexico Department of Insurance, provider to enrollee ratios.	
2	Out-of-network use	Comparing ratio of out-of-network utilization for certain categories of MH/SUD services compared to certain categories of M/S services for PPO/GPO product categories	- Summit participants identified that the inability of using this metric for HMO or closed network product designs. Participants raised that the network gap analysis used in New Mexico can serve as a supplement. - Participants all agreed that there are a number of reasons that participants go out of network and that this measure should be used as a signal of a *potential* parity issue triggering further investigation to identify the causes of out of network use disparities and take comparable steps to reduce out of network use rates.
3	INN to OON Utilization Rates	Comparing ratio of plan's in-area	- Same comments as on earlier OON metric.

		OON utilization rate relative to in-network utilization	- No comment or opinion on distinction between provider sub-classification specifications used in measure #2 and #3 though participants agreed that clear definition of any alternative provider-based sub-classification is essential.
4	Network Adequacy and Participation (shadow network measure)	Reporting the member-to-psychiatrist ratio and the number and percentage of psychiatrists submitting claims for beneficiaries	- As specified in the version submitted, this metric did not provide for a comparison of MH/SUD to M/S ratios and many participants identified that as a problem for using it for MHPAEA compliance purposes. - Participants representing network lease and TPA vendors also identified that this measure was not administrable for them as they don't have "members"
5	Credentialing and Re-Credentialing Turn-around Times	Comparing the time from application complete date to credentialing complete dates for MH/SDU to M/S providers. Re-credentialing also reviewed as separate measure.	- No additional comments.
6	Credentialing and Re-Credentialing Turn-around Times	Comparison of a variety of metrics on credentialing activities between	- No additional comments.

		MH/SUD and MS providers	
7	Network Admission Request Acceptance Rates	Analysis of approval rates for network admission requests	- No additional comments.
8	Network Adequacy Gap Identified	Comparison of reports of identified gaps in applicable network adequacy criteria for M/S providers compared to gaps identified for MH/SUD providers in the same classification	- Participants generally supported this metric, especially for product markets that have an applicable set of regulator-imposed network adequacy criteria. - Participants emphasized that even many of those are not currently a meaningful basis of assessing adequacy and therefore gaps may not exist for either classification. - Participants agreed that this metric, like out-of-network utilization should not be the basis of a per se finding of discrimination and should be used to identify potential issues, investigate, and implement comparable strategies to address gaps for MH/SUD and M/S providers.
9	Provider Participation Rate	Comparison of the rate of participation of providers with active spend in each region, by provider type.	- Participants did find this to be a meaningful metric.
	OP/IN Reimbursement Measures		
N/A	General feedback on measure category	- Some Participants at the Summit recommended that default fee-schedules be used for reimbursement rate comparisons rather than allowed amounts or paid amounts. Other participants contended that negotiated allowed amounts or paid amounts are a better	

		metric for evaluating the operational outcomes of NQTLs related to network reimbursement.	
2	In-Network Reimbursement Rates	Comparison of in-network reimbursement for certain enumerated CPT codes between PCPs and non-psychiatrist physicians (M/S provider) and Pyschiatrists, Psychologists, and LCSWs (MH/SUD providers) (as a percentage)	- Participants representing MH providers indicated that this metric has significant weakness of not including codes that can be billed by mid-level MH providers. - Participants expressed concern that the use of E/M codes represents a narrow subset of even outpatient office services and not a meaningful representation of any NQTL types.
3	In-Network Reimbursement Rates	Comparison of in-network reimbursement for certain enumerated CPT codes forPCPs and non-psychiatrist physicians (M/S provider) and	- Participants expressed concern that the use of E/M codes represents a narrow subset of even outpatient office services and not a meaningful representation of any NQTL types.

		Psychiatrists, Psychologists, and LCSWs (MH/SUD providers) to the allowed Medicare fee schedule for the same CPT code and provider type (as percentage)	
4	In-Network Reimbursement Rates	Comparison of in-network reimbursement for certain enumerated CPT codes for enumerated classes of physicians, PhD, and Masters level (M/S provider) and Psychiatrists, Psychologists, and LCSWs (MH/SUD providers) to the allowed Medicare fee schedule for the same CPT code	- Participants expressed concern that the use of E/M codes represents a narrow subset of even outpatient office services and not a meaningful representation of any NQTL types.

		and provider type (as percentage)	
5	In-Network Reimbursement Rates	Total Average Payment as a Percentage of Third-Party Benchmark (Medicare, FAIR Health, or other) rounded to nearest %	- Participant recommended using utilization-weighting for this measure. - Participants discussed that Medicare rates do not include fee schedule rates for some key MH/SUD services (like residential treatment) and preferred FAIR health for this reason.
6	Reimbursement Paid-to-Charge Ratio	Ratio of paid rates to provider charges compared between ratio for MH/SUD providers and M/S providers in each classification	- Participants were strongly opposed to using charge rates as they vary enormously by provider in a completely random manner and are not representative of a cash-pay rate for any markets.