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President and CEO

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

Ms. Lisa M. Gomez
Assistant Secretary
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
ATTN: 1210-AC11
Room N-5653
200 Constitution Avenue, NW
Washington DC 20210

Mr. Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

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

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

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. The FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members

include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH appreciates the opportunity to provide comments in response to the Proposed Rules "Requirements Related to the Mental Health Parity and Addiction Equity Act" [CMS-9902-P], 88 *Fed. Reg.* 51552 (August 23, 2023) issued by the Departments of Health and Human Services, Labor, and the Treasury (the Departments). We appreciate the Departments' commitment to ensuring that individuals enrolled in group health plans and health insurance offered in the group and individual markets have access to services for mental health and substance use disorders under those plans to meet their health care needs.

The FAH expressed strong support for passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). That legislation was critical to laying the foundation of ensuring parity of access of patients enrolled in group health plans and health insurance offered in the group and individual markets (collectively referred to as "plans") to mental health and addiction services as compared to medical and surgical services. There has been some improvement in addressing the issue of lack of parity to mental health and substance use disorder (SUD) services as compared to medical and surgical services covered under plans since regulations were promulgated to implement requirements imposed on plans by the MHPAEA. However, continued noncompliance with MHPAEA requirements by some plans, especially with respect to nonquantitative treatment limitation (NQTL) requirements, led Congress in the Consolidated Appropriations Act of 2021(CAA) to amend MHPAEA to ensure that limitations on mental health and SUD benefits are no more restrictive than the limitations applicable to medical and surgical benefits.

FAH members are on the front line helping to address the mental health and SUD crises affecting our nation. The studies cited in the Proposed Rules that describe the scope and extent of these crises reflect the challenges our health care providers and facilities face daily. Plan policies that restrict access to coverage of health care services for mental health and SUD services, either initially or during a course of treatment, severely reduce the likelihood of successful medical intervention, which further complicates efforts to address the needs of these patients. Needless delays in access to care, through complicated prior authorization requirements and other utilization management policies that are not supported by clinical guidelines, or that impose requirements that are different from those imposed for medical and surgical benefits covered under the plan are both indefensible as a matter of appropriate clinical care and contrary to law and regulation. Plan networks also play an extremely important role in ensuring patients have access to care; limited plan networks, low provider reimbursement rates, and high cost-sharing requirements, especially for out-of-network care, pose significant barriers (financial as well as access) for many patients.

The Proposed Rules would implement the changes to MHPAEA made by the CAA and make other improvements with the goal of ensuring individuals enrolled in plans benefit from the full protections afforded to them under MHPAEA by establishing in regulations clear standards for plans and issuers for compliance with requirement under the MHPAEA as amended by the CAA. These Proposed Rules are principally designed to improve the manner in which parity is

measured, compared, and demonstrated by plans for NQTLs. The FAH strongly supports those regulatory proposals to hold plans accountable to MHPAEA requirements to ensure parity for mental health care services and access compared to medical and surgical plan benefits as was intended by Congress. It is important that there be transparency for all parties on the specific expectations the regulations would impose on plans. Similarly, we support proposed changes that would facilitate the analyses of NQTLs as applied to mental health and SUD benefits under a plan as compared to those limitations for medical and surgical benefits to determine whether there is in fact parity in coverage and access to mental health and SUD coverage policies under the plan. We encourage the Departments to finalize those proposals.

However, as described in more detail below, the FAH is very concerned with the two proposed exceptions to requirements that would be imposed for NQTLs. We believe those exceptions could be manipulated by plans to avoid compliance with statutory and regulatory requirements for NQTLs, which would defeat the intent of the amendments made by the CAA and the apparent intent of the Departments to truly hold plans accountable for parity in access to mental health and SUD coverage under plan policies as designed and implemented.

Data Collection

Under the Proposed Rules, plans would have to collect and evaluate outcomes data for the NQTLs they design and implement. Further, if the plan determines that there are material differences in access to mental health and SUD benefits as compared to medical and surgical benefits by reason of the NQTLs applied to both categories of covered services, they would have to take action to address them. This would also require that plans ensure there are no material differences in access because of the standards they use to establish the composition of their network providers. The data would include information on prior authorization requests and decisions, claims denials, data relevant to NQTLs as required by State law or private accreditation standards, utilization rates, network adequacy metrics, and provider reimbursement rates.

The FAH urges the Departments to finalize the proposals to expand the set of plan-specific outcomes data to analyze whether NQTLs will meet the refinements to the standards established by the CAA. Lack of relevant outcomes data has been a serious impediment to any analysis of parity for limitations or restrictions to access for mental health and SUD benefits. In conducting any review of plan NQTLs, we encourage the Departments to carefully analyze the data plans report. If the Departments finalized either or both of the exceptions to the NQTL standards, we urge careful scrutiny of any exception claimed by the plan and an assessment of the impact of those exceptions on patients.

We also would strongly encourage the Departments to ensure that data are collected and analyzed on denied days of care after patients have begun to receive care under their treatment plans. Only a minority of plans is currently required to report these types of denials, and these types of data are critical to making meaningful comparisons of the impacts of NQTLs that apply to mental health and SUD care and to those that apply to medical and surgical care. Plans often use a different set of teams to review mental health and SUD benefits.

Additionally, the Departments should scrutinize plan use of peer review to justify denial of behavioral health care. Health care providers report excessive use of peer review as opposed to traditional utilization management policies or concurrent review for behavioral health care. Peer review is a subjective assessment of medical necessity with respect to a patient's mental health or SUD needs that lacks adequate patient protections, and its overuse results in a significant number of denials that would not be made under other plan utilization management policies.

Network Composition

A plan with an NQTL in operation that results in material differences in access to in-network mental health or SUD benefits as compared to in-network medical or surgical benefits would be treated as a violation of the MHPAEA parity requirements. Any determination that an NQTL violates the MHPAEA parity requirements based on network matters would be based on data collected on in-network and out-of-network utilization. These data would include information related to in-network providers who are actively submitting claims, network adequacy metrics (including but not limited to time and distance data, and data on providers accepting new patients), provider reimbursement rates, and other types of data specified by the Departments.

The proposals to further refine network adequacy requirements and to collect relevant data to ensure broad networks and equitable provider payment rates should be finalized. Inadequate provider networks restrict access to care, especially for lower income patients. The problem is not limited to any type of geographic area, though rural areas may face greater difficulties. Narrow networks result in patients resorting to seeking care from out-of-network providers, assuming those providers are accepting new patients. Higher financial burden and likely greater distances to travel to those provider appointments contribute to a likelihood that treatment may not be sought or, if it is commenced, not abandoned before the treatment plan can result in marked improvement. Additionally, substandard provider payment rates limit the willingness of qualified providers to join or remain in plan networks, and lower out-of-network provider payment rates impose severe financial burden on patients and further jeopardizes access to care and adherence to treatment plans over time.

In analyzing plan networks, the FAH encourages the Departments to consider additional categories of data to make comparisons of network adequacy, provider payment rates, and the impact of NQTLs under plan utilization management policies.

NQTLs for Mental Health/SUD—Design and Comparative Analysis

Under the Proposed Rules, a nonquantitative treatment limitation could only apply to mental health and SUD benefits if (i) the limitation is “no more restrictive” for those benefits as compared to NQTLs for medical/surgical benefits; (ii) the factors and evidentiary standards relied on in designing and applying the NQTL are “not discriminatory against” mental health and SUD benefits; and (iii) the plan collects, evaluates, and considers the impact of relevant data on access to mental health and SUD benefits as compared to access to medical and surgical benefits. Additionally plans would have to take reasonable action to address any material differences. The

FAH strongly supports the proposed revised standards for NQTLs for mental health and SUD benefits and the duty for plans to address material differences in NQTLs within the same benefit classification.

The proposed revised standard that an NQTL be “no more restrictive” as written or operationalized than the predominant NQTL applied to substantially all medical and surgical benefits in the same benefit classification under generally recognized independent standards of current medical practice is appropriate. It is important that both the design and implementation of the NQTL meet this standard. The proposal is also consistent with both the language and intent of the amendments made by CAA, and we note that the same standard currently applies under MHPAEA to financial requirements and quantitative treatment limitations.

The FAH also supports the nondiscrimination standard. An NQTL may not be discriminatory in its design or implementation. An NQTL would be treated as discriminatory if it relied on any factor or evidentiary standard that is biased against or not objective with respect to mental health or SUD benefits as compared to medical and surgical benefits under generally recognized independent standards of current medical practice. Information would be deemed to be biased or not objective if it results in less favorable treatment of mental health or substance use disorder benefits, based on all the relevant facts and circumstances including, the source of the information, the purpose or context of the information, and the content of the information. The less favorable test reflects the overall goal of parity under the MHPAEA and its regulations. However, the Departments also proposed to provide two possible exceptions to these NQTL standards and to the network adequacy and data collection requirements. The FAH believes that these proposed new and revised standards and requirements are critical to ensuring there is equal access to mental health and SUD services under plan policies; these proposals should be finalized with the adoption of any exception described below.

Exceptions

The Departments propose two exceptions to the standards and requirements under the Proposed Rules. The first exception would apply to the requirement for an independent professional medical or clinical standard, and the second exception would apply to plan efforts to detect or prevent and prove fraud, waste, and abuse.

1) Exception for Independent Professional Medical or Clinical Standards

Under this proposed exception, in lieu of an NQTL standard that uses an independent professional medical or clinical standard, a plan could substitute an NQTL that impartially applies generally recognized independent professional medical or clinical standards (consistent with generally accepted standards of care) to medical and surgical benefits and mental health and SUD benefits. Such an NQTL could not deviate from those standards in any way, such as by imposing additional or different requirements.

Unfortunately, some plans have consistently demonstrated noncompliance with MHPAEA policies and requirements using different mechanisms and availing themselves of perceived loopholes in the regulations to avoid compliance with the law and regulations, as well

as congressional intent. This has resulted in continued inequity of access to mental health and SUD services. The Proposed Rules are designed to address those issues by clarifying new standards for the design and implementation of NQTLs, requiring the collection and analysis of data to make meaningful comparisons between NQTLs that apply to medical and surgical benefits and mental health and SUD benefits, and ensuring the development of meaningful networks. Earlier MHPAEA regulations included such an exception, but the Departments withdrew it in part due to concerns that many plans were using it to avoid compliance with the law and regulations.

Even though the Departments have sought to make the exception narrow, we reiterate our concern over potential plan abuse of this exception. For example, it would not be difficult for plans to develop their own recognized clinically appropriate standard of care without input from multiple stakeholders and experts, which could be detrimental to access. These standards should at a minimum incorporate guidelines and criteria developed by clinical specialty associations. Additionally, there is a substantial risk of a lack of transparency in the development of a standard of care by plans. Though the Proposed Rules call for independence (meaning “independent, peer-reviewed, or unaffiliated with plans and issuers”) in the preamble, nothing would prevent plans from using proprietary criteria that the Departments or other relevant parties may not be able to review. This lack of transparency raises concerns that the criteria or the standard itself was not developed to ensure parity in access to mental health and SUD services; rather, it may have been developed principally for utilization management purposes. We are also concerned that the use of this exception appears to exempt a plan from data collection requirements. This would fundamentally undermine a principal goal of the Proposed Rules, which is to collect data to improve the accuracy of comparative analyses of NQTLs by plans and by the Departments and to impose requirements on plans to make reasonable efforts to address material differences between them.

2) Exception to Detect or Prevent and Prove Fraud, Waste, and Abuse.

This exception would permit plans to design and implement NQTLs that use standards “reasonably designed” to detect or prevent and prove fraud, waste, and abuse. These standards would have to be (i) based on indicia of fraud, waste, and abuse that have been reliably established through objective and unbiased data, and (ii) be narrowly designed to minimize the negative impact on access to appropriate mental health/SUD benefits.

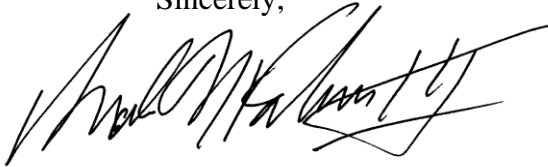
As a general policy matter, we agree that waste, fraud, and abuse should be prevented. What we disagree with is the Departments’ proposal to make this an exception to the requirements that would otherwise apply under an NQTL that is supposed to be designed to permit easy and accurate comparison to an NQTL applied to a medical and surgical benefit to ensure parity in coverage of and access to mental health and SUD benefits. We strongly urge the Departments to include standards protecting against waste, fraud and abuse within all NQTLs to permit the very comparison the Proposed Rules seek to facilitate. Creating an exception to NQTL requirements for mental health and SUD benefits frustrates that goal. Additionally, as noted above, plans that availed themselves of this proposed exception would be excused from data collection requirements under the rule, which as noted above would appear to undermine an important goal of the Departments’ rulemaking.

FAH members have experienced plan behavior where plans deny payment of claims or coverage of benefits where there is no indicia of waste, fraud, or abuse by a provider. Additionally, plans have used this rationale, again without any evidence, to conduct routine audits of providers for fraud. These burdensome practices serve to lessen the willingness of providers to participate in certain plan networks, which in turn reduces access to services.

Finally, we would note that the MHPAEA statute, as amended, does not provide for any such exception from the requirements that should otherwise apply to an NQTL for mental health and SUD benefits. We urge the Departments not to finalize these two exceptions.

Thank you for the opportunity to comment on the Proposed Rules. If you have any questions, please contact me or a member of my staff at 202-624-1534.

Sincerely,

A handwritten signature in black ink, appearing to be "Andrew M. ...". The signature is fluid and cursive, with a large initial letter 'A' and a long horizontal stroke at the end.