RECOMMENDED CHANGES TO PROPOSED MHPAEA FEDERAL RULE CHANGE FOR MENTAL HEALTH PARITY

Current Version of the Proposed Rule Would Lower Standards, Reduce Access and Increase Costs

CHANGES NEEDED TO AVOID BAD OUTCOMES

Policy and Operational Concerns

- Eliminate "no more restrictive" test that will be virtually impossible to operationalize while eliminating tools to ensure patients receive safe and appropriate care. Instead, Departments should update the current design and application requirements to address the Departments' and stakeholders' underlying concerns with NQTLs as currently applied.
- The Departments should clarify that their intention for the new design and application requirement for NQTLs is not to create an outcomes-only determination of compliance, and the Department should outline which specific data are used in that determination.
- Work with stakeholders to define an exhaustive list of outcomes data that must be collected and evaluated for each NQTL. As new NQTLs are identified by the Departments or state regulators, required data sets for those NQTLs should also be defined. If new data points are identified as being necessary to evaluate an NQTL, then the list should be updated with adequate time for plans and issuers to come into compliance.
- Rescind the proposed special rule for network composition and the application of the material difference standard to network composition. Instead, work with stakeholders to develop a set of objective metrics of MH/SUD access.
- Develop a method to assess the access impacts of a health plan's MH/SUD telehealth offerings when evaluating network adequacy.
- Provide an exhaustive list of NQTLs for which comparative analyses must be provided upon request. If the Departments determine that a plan practice is an NQTL, the plan should be given a reasonable amount of time to compile the comparative analysis.
- Adopt the CMS guidance used in Medicaid and CHIP requiring plans to use a reasonable method to determine whether a given service is a MH/SUD benefit or a M/S benefit.

NEGATIVE IMPACT: REAL-LIFE EXAMPLES

Lowering quality of care: Nathan is receiving treatment for his opioid use disorder (OUD). His provider does not offer him medication-assisted treatment, which slows his recovery, and instead bills him for unnecessary services that are not the standard of care for his condition. Before the rule, this provider would not have been in Nathan's insurance network and he would have known to look for a different provider whom his health plan had determined to be a quality OUD treatment provider. However, under the new rule, his health plan was forced to accept a less qualified provider to meet network composition requirements which did not adequately account for whether there were enough providers available in Nathan's community to comply.

Producing worse health outcomes: Jane was hospitalized for depression. She was kept in an inpatient facility longer than what was in her best interest. Instead, she could have been released to receive provider-led treatment at her home, or at least partially at home, which would have better helped her learn to manage her condition within her normal environment and re-integrate more quickly. This was because concurrent review had to be scaled back by her health plan due to new provisions in the rule and could not be meaningfully used to counterbalance incentives and pressures to encourage longer inpatient hospital stays.

Reducing access for patients in need: Anglela is searching for a specialized child psychiatrist to treat her daughter's eating disorder. However, the qualified providers in her area are all overbooked, and she cannot find anyone with the correct expertise who has availability to see her daughter. Her health plan had to remove supports for directing patients to the best providers to meet their needs under the new rule, and patients who would have benefited most from other provider types were instead incentivized to see specialized child psychiatrists unnecessarily. This increased their individual costs while reducing access for patients like Angela's daughter.

BETTER SOLUTIONS TO INCREASE ACCESS

Addressing limited access to mental health care resources can, and should, be addressed by engaging in the following:

Expanding quality training for primary care providers, nurses, school counselors and beyond to identify mental and behavioral health or substance use disorder symptoms. Equipping these individuals to identify symptoms, and even treat mild symptoms, will allow patients to better understand and seek care for their specific needs. Rather than leaving symptoms undiagnosed and untreated, providers would have the resources to accurately identify an issue and make an informed referral.

Expanding access to tele-mental health services and allowing behavioral health providers to practice across state lines to meet patients where they are regardless of their geography. Telehealth resources have proven to increase access to mental health and substance use disorder care. Expanding telehealth services across state lines will increase the number and types of specialized care for patients.

Promoting diversity in the long-term workforce pipeline by creating pathways for high school and community college students to become behavioral health professionals. By incentivizing individuals to enter into and stay in the mental health care workforce, over time the number of qualified providers will increase to meet the needs of patients.

RECOMMENDED NEXT STEPS:
The Departments should withdraw the proposed rules and re-start the process to create new proposed rules, beginning with the engagement of stakeholders in a series of working sessions to inform the policy and legal considerations.