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 and will eliminate 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 and align the requirements for network composition NQTLs with other NQTLs that do not carry an automatic finding of noncompliance. Plans should have an opportunity to explain any differences in relevant data between MH/SUD and M/S services in a benefit classification.**
- **Develop a method to assess the 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.

NEGATIVE IMPACT: REAL-LIFE EXAMPLES

Reducing 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 low-quality 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 provide high-quality, evidence-based OUD treatment.

However, under the new rule, his health plan was forced to accept a less qualified provider to meet new network composition requirements which did not adequately account for whether there were enough high-quality providers of evidence-based treatment available in Nathan's community.

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 helped her learn to manage her condition within her normal environment and re-integrate into her community more quickly. This was because the new rule prohibited her health plan from using concurrent review to ensure that her course of treatment was evidence-based and in Jane's best interest.

Mandate for Unsafe or Unproven Mental Health/Substance Use Disorder Care: Current parity law expressly did not create a benefit mandate. Yet by establishing an undefined "meaningful benefit" requirement, the proposed rule risks being interpreted to require coverage of every possible treatment for a mental health/ substance use disorder condition, however unproven or unsafe. As a result, plans could be required to cover unproven treatments like wilderness therapy. This will not help patients and could lead to real harm.

BETTER SOLUTIONS TO INCREASE ACCESS

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

Integrating MH/SUD care with primary care and providing training for primary care providers, nurses, school counselors and beyond to identify mental and behavioral health or substance use disorder symptoms. One of the most promising solutions for increasing mental health care access is integrating MH/SUD treatment into primary care settings. Primary care clinicians are better resourced to integrate physical and mental health care, treat mild/moderate conditions, and facilitate consultations and referrals to mental health care specialists. Equipping these individuals to identify symptoms, and even treat mild symptoms, will allow patients to better understand and seek care for their specific needs.

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, fill gaps left by provider shortages, help identify a patient in crisis, and is even preferred by some patients for its convenience. Expanding telehealth services across state lines will increase access to 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.