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Secretary Tom Price
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted via parity@hhs.gov

Dear Secretary Price:

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We appreciate the opportunity to comment on strategies for improving parity for mental health and substance use disorders, and we commend the Department of Health and Human Services (HHS) for focusing on the challenges our nation faces in serving individuals with mental health and substance use disorders.

Health plans work diligently to ensure compliance with requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). Many insurers have adopted a variety of medical management tools that are used across both medical/surgical and mental health/substance use disorder benefits to help promote access to clinically safe, appropriate, and cost-effective health care and services.

We note however, several challenges to be addressed including: providing more flexibility in the sharing of substance use information among providers and with health plans to support care coordination and protect patient safety, developing a more robust quality measurement infrastructure, providing validated accreditation standards, and providing continued flexibility in implementation of medical management programs.

Health Plans Promote Access to Quality, Affordable Behavioral Health Care

Our members support the protections established by the federal MHPAEA, and those established by state requirements[1]and have been working diligently to implement them. A 2013 report

[1] In the 1990s, many states had established legal requirements for mental health parity (i.e., by 1997, approximately 30 states had enacted or adopted such requirements). At the federal level, The Mental Health Parity Act of 1996,

prepared for the Department of Health and Human Services found that "…employers and health plans have made substantial changes to their plan designs in order to comply with MHPAEA…"[2]

AHIP's issue brief, *Ensuring Access to Quality Behavioral Health Care*, based on a series of interviews, describes a range of creative and comprehensive approaches plans have developed to meet the needs of individuals with mental health and substance use disorders.[3] We would like to highlight the following key components of these programs.

First, these programs rely on ***proactive identification and outreach***. Case managers work with individuals with chronic medical conditions to screen for mental health and substance use disorders and service needs. When identified, case managers help these individuals navigate the system and coordinate ongoing care and services – a process which supports more integrated, holistic care for individuals and improves long-term health and wellness.

Second, these programs are founded on ***quality, evidence-based care***. Using nationally-recognized evidence and internally identified evidence-based criteria, health plans develop clinical guidelines for behavioral health conditions in the same way they do for medical conditions. And, as with medical conditions, recognized quality metrics are used to track and improve behavioral health care quality.

Third, just as with medical conditions, ***coordination and integration*** are used to ensure follow-up care, manage medications, and identify community support resources. Some plans have created behavioral health home models; others have co-located behavioral health providers in primary care practices or trained PCPs to screen for behavioral health conditions in their patients. These approaches are consistent with and integral to health plans' overall efforts to implement delivery system reforms that improve value and outcomes for patients.

Pub. L. No. 104-204, gained significant attention by establishing federal parity requirements and modifying the Public Health Service Act, the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code. The law included a "sunset provision" of September 30, 2001, meaning that the requirements would expire on that date. In subsequent years, legislation was enacted to extend the "sunset provision." See, Pub. L. Nos. 107-116, 107-313, 108-197, 108-311, 109-151, 109-432, 110-245. In 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was enacted by Pub. L. No. 110-343, and is now commonly referred to as the "Mental Health Parity and Addiction Equity Act" or "MHPAEA." Most recently, the Patient Protection and Affordable Care Act Affordable Care Act also addressed coverage of mental health care services as "Essential Health Benefits (EHBs)," in addition to ongoing regulatory changes and "sub-regulatory" guidance documents issued by the federal agencies to clarify the application of the federal parity rules.

[2] Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Prepared for the Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. November 2013.

3 See https://ahip.org/mental-health-month-case-studies-highlight-behavioral-health-benefits/, May 2016.

And fourth, health plan programs provide ***timely access*** to behavioral health care. In addition to meeting state and federal network adequacy requirements, health plans actively recruit behavioral health providers, monitor the availability of appointments, help members get appointments when needed, and many plans are also using telemedicine to augment network capacity.

Workforce Shortages and Other Challenges

It is important to note that multiple challenges exist and there is more work to be done to ensure individuals have access to comprehensive, quality mental health and substance use disorder coverage.

Workforce Issues

One of the most significant challenges is the **widespread shortage of appropriately licensed behavioral clinicians**, particularly psychiatrists and psychologists who specialize in supporting children, adolescents, and young adults. This shortage of behavioral health clinicians spills over into reduced hours of operation for many behavioral health providers and facilities. The shortage of non-clinical supports, especially peer supports, is also a challenge in the expansion of evidence-based supports and services that assist with recovery and resiliency. The limited capacity of the behavioral health workforce, paired with the scarcity of community support options, is an area ripe for policy solutions that could greatly improve plans' ability to provide timely access to behavioral health care.

Other Challenges

- **The laws and regulations applicable to mental health and substance use disorder treatment are subject to multiple jurisdictions and interpretations**. It is difficult for consumers and health care entities to understand what law or regulation governs. This can be particularly challenging when state regulators provide guidance or give interpretations about the application of federal parity requirements and whether the state retains jurisdiction. There are also situations in which several federal and /or state regulations may apply. Currently, plans must scour through a myriad of documents, such as various FAQs, scattered across multiple agency websites. This is confusing, burdensome, and makes it challenging to ensure plans are in compliance. To address these issues, we encourage federal regulators to either provide guidance for states that review compliance with benefits and parity, or provide more information and expand awareness of federal

jurisdiction and state roles. Federal regulators should consider consolidating and streamlining all mental health parity guidance into a single source to help ensure that health plans are complying with the agencies' interpretations of the statute and regulations. Additionally, the agencies should provide support and non-binding guidance to states to help improve efficiency of parity reporting/monitoring processes. For example, it would be helpful if states had clear guidance on what is allowed under 42 CFR Part 2 when requesting data from plans. Ultimately, these efforts will help achieve the goal of consistent interpretations across oversight agencies, provide a level of regulatory certainty, minimize variation in interpretations, and help consumers understand when and which federal and/or state laws apply to their individual health needs and healthcare services.

- **Federal rules limit the sharing of substance use information** among providers, health plans, and pharmacy benefit managers, affecting coordination and integration of care. Particularly concerning is that patient safety may be impacted if providers are not aware or alerted that an individual is taking a prescribed medication to support recovery from a substance use disorder.

- **A quality measurement infrastructure that is less developed than that for medical/surgical care makes** it difficult for insurers to monitor quality and measure improvement without established behavioral health outcomes measures. The lack of readily available information on the quality of behavioral health clinicians and facilities makes effective treatment decisions a challenge. The fact that behavioral and medical conditions can often interact also complicates effective measurement.

- **A lack of validated evidence-based quality standards and certification/accreditation standards** for behavioral health facilities, particularly inpatient or 24-hour residential care facilities, adds to the ongoing challenge of identifying the most effective and appropriate facility for any given patient. There is significant ambiguity and wide variation in what is considered a residential treatment facility.[4] As a result: loose definitions (e.g., residential facilities may include group homes, spas, etc.); an undefined scope of service; lack of evidence supporting effectiveness; and, often, very long duration, isolating treatment options all lead to challenges for improved outcomes, continuity and coordination of care, and patient satisfaction.[5]

[4] Marketing Residential Treatment Programs for Eating Disorders: A Call for Transparency 67:6, March 2016.
[5] *Ibid.*

Cures Act Impact

The 21st Century Cures Act was signed into law on December 14, 2016. This broadly-focused bill encompasses revised *21st Century Cures Act* legislative language; revised *Helping Families in Mental Health Crisis Act* legislative language; and new language entitled the *Increasing Choice, Access, and Quality in Health Care for Americans Act*. The section on Mental Health addresses informational guidance on mental health parity compliance and guidance on sharing protected health information (PHI) under HIPAA.

Section 13001 of the Cures Act requires regulators to release a compliance program guidance providing examples of past findings of compliance and noncompliance with existing mental health parity requirements, including disclosure requirements and non-quantitative treatment limitations (NQTLs), (e.g., medical management, step therapy, prior authorizations, etc.). We believe more guidance is needed with regard to NQTL compliance. We must be careful NQTL compliance does not produce unintended consequences. For example, there have been widespread reports of fraudulent practices around "sober homes" for substance use disorder treatment, particularly for opioid use disorder. It would be in consumers' and other stakeholders' best interests to put in place stronger medical management and/or accreditation procedures for substance use disorder treatment facilities. However, there is no direct analogy with medical/surgical facilities that can be applied. Essential to the successful implementation of parity is health plans' ability to use reasonable medical management to promote appropriate, safe, evidence-based care.

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Our members recognize that behavioral health conditions, particularly with their often-close relationship to chronic medical conditions, have a significant impact on individuals, families, our society, and our economy. Our members will continue to implement innovative programs that improve access to quality, affordable, evidence-based care to meet the needs of those with behavioral health conditions. It is also critical for policymakers to work collaboratively with stakeholders to address workforce shortages of appropriately licensed behavioral health clinicians, allow sharing of substance use information to protect patient safety, and further develop validated evidence-based quality standards and certification/accreditation standards for behavioral health facilities.

If you have questions or would like to discuss our comments, please contact Kate Berry, Senior Vice President of Clinical Affairs and Strategic Partnerships at 202-778-3229.

Sincerely,

Richard Bankowitz, MD MS MBA FACP
Executive Vice President, Clinical Affairs