



Oct 16, 2023

*Submitted via email*

Office of Health Plan Standards and Compliance Assistance,  
Employee Benefits Security Administration, Room N-5653,  
U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC  
20210

**Re: [Docket No. FR-51552] RIN 1210-AC11 Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA); Request for Comment**

Thank you for the opportunity to comment on **FR-51552 Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA); Request for Comment**. Please accept this letter as the comments of the undersigned Co-Chairs and members of the Consortium for Constituents with Disabilities (“CCD”), Health Task Force. CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of a society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ discrimination and religious intolerance.

The undersigned members of the CCD Health Care Task Force commend the Departments’ efforts to improve the implementation of the MHPAEA through the present rulemaking. We strongly support the goals of the proposed rules to ensure that all individuals have equal access to mental and behavioral health care by establishing comprehensive standards to root out insurers’ ongoing discriminatory practices of imposing a greater burden on mental and behavioral health.

At the same time, we wish to recommend several changes to improve this rule by ensuring that it correctly applies to all mental and behavioral health services that individuals may need, that the rules properly align with other federal regulations concerning the *Olmstead* integration mandate to ensure disabled individuals may seek services in the most integrated setting, and that insurers are not able to meet parity obligations through coerced or involuntary mental health treatments. Finally, we encourage the Departments to provide clarity on how insurers should cover mental health crisis services, how the Departments define exceptions based on “independent professional medical or clinical standards”, and for more rigorous data

transparency and regulatory enforcement standards. Please find our comments in detail as follows.

### **Avoiding Modality Prescriptiveness**

CCD appreciates the Departments' examples of nonquantitative treatment limitations (NQTL). We further urge the Departments, when evaluating an insurance plan's NQTLs, to ensure that people with mental health disorders have access to all treatment modalities and to include additional examples in the final rule illustrating this access. Plans should not exclude a modality from coverage. Plans should also not favor one modality over another in terms of reimbursement or prior authorization requirements. This is critically important because a modality that works for one person may not work for another, even if they share the same disorder. For example, the NPRM refers to treatments for Autism Spectrum Disorder (ASD) in examples 9, and 10. ASD is described by the National Institutes of Health as a neurodevelopmental condition that can be accompanied by mental health conditions,<sup>1</sup> and we agree with the Departments that services for ASD fall under MHPAEA parity protections. However, Applied Behavioral Analysis (ABA) is just one of many approaches to ASD.<sup>2</sup> Occupational and sensory therapies are examples of other evidence-based practices for ASD.<sup>3,4</sup> In specifying only one particular therapeutic modality in these examples, the Departments risk incentivizing additional restriction of ASD services by encouraging insurers to consider ABA coverage alone adequate to achieve parity, despite not aligning with all ASD individuals' needs. We encourage the departments to instead refer to ASD services more broadly in these examples, particularly given the fact that many therapeutic alternatives face similar or more restrictive limits under many insurance plans.<sup>5</sup>

### **Expanding Provider/Practitioner Definition**

CCD strongly believes that people with mental health disorders need access to the full range of mental health providers, including, but not limited to, peer specialists, social workers, master's level mental health therapists, Ph.D. level psychologists, and psychiatrists. People with mental health disorders, depending on their care needs, may see some or all of these providers at different points in their treatment. This is especially true given the shortages of mental health providers, and the often urgent need to treat possibly life-threatening mental health disorders. CCD recognizes that state practice laws can limit the scope of practice, but we believe the Departments should not further restrict access to these providers. In Example 8 of the proposed rule, the Departments find a plan does not violate the NQTL requirements by requiring any provider who is seeking to contract with the plan to have supervised clinical experience. CCD asks the Departments to recognize that some types of mental health providers, such as peer specialists, may not have the same kind or duration of supervised clinical experience. Plans should not discriminate against these peer providers, beyond what is in the state clinical practice laws, by requiring them to have supervised clinical experience before allowing them to

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<sup>1</sup> <https://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd>

<sup>2</sup> Ibid.

<sup>3</sup> <https://hacerlobien.net/lego/Ter-004-Interventions-for-Autism.pdf>

<sup>4</sup> <https://onlinelibrary.wiley.com/doi/pdf/10.1002/aur.2046>

<sup>5</sup> <https://autisticadvocacy.org/wp-content/uploads/2021/12/ACWP-Ethics-of-Intervention.pdf>

contract with the plan. Any plan that imposes such requirements without a reasonable alternative should be found to be in violation of the NQTL requirements.

### **Adopting an Integration Mandate and Ensuring Consistency with *Olmstead***

The Departments' parity efforts must be consistent with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act (Section 504), and they must be informed by *Olmstead* considerations. The ADA and Section 504 impose nondiscrimination requirements on many entities covered by the MHPAEA, and require covered entities to serve individuals with disabilities in the "most integrated setting." The "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled people to the fullest extent possible."<sup>6</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999), ruled that the needless segregation of individuals with disabilities is a form of disability discrimination. See also 28 C.F.R. § 35.130(b)(7).<sup>7</sup> Ensuring that individuals can access their mental health and substance use disorder benefits in parity with medical or surgical benefits is complicated by the fact that medical and surgical benefits have no analogous mandate for the "least restrictive environment."

The proposed regulatory amendments to the MHPAEA may not comply with *Olmstead* in some circumstances. For example, aiming for parity between "inpatient, in-network" medical/surgical services and "inpatient, in-network" MH/SUD services does not account for when MH/SUD services could instead be provided in more integrated settings, whether that means outpatient care or community-based care, such as walk-in respite centers. If rehabilitation services for physical conditions are covered in outpatient or in-home settings, rehabilitation services for psychiatric conditions must, in parity, be covered in outpatient or in-home settings. The same is true for emergency or crisis services.

Coverage decisions, reimbursement rates, and other forms of benefit design can only be provided in parity when they do not discriminate based on disability and hence do not result in individuals being served unnecessarily in segregated settings such as hospitals, nursing homes, or board and care homes. **In order to align with the priorities identified in the proposed rulemaking released earlier this year for Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act, the MHPAEA rule should also incorporate a comparable "integration mandate". HHS must consider how parity measures align with the integration goals evidenced in these rules.** Otherwise, insurance benefit packages may

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<sup>6</sup> U.S. DEPT OF JUSTICE, ENFORCEMENT OF THE INTEGRATION MANDATE OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT AND OLMSTEAD V. L.C. (2020) [hereinafter ENFORCEMENT OF THE INTEGRATION MANDATE]. "Integrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities. Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities." *Id.*

<sup>7</sup> Covered entities shall administer services to individuals with disabilities in the most integrated setting appropriate to their needs.

discriminate against disabled people by incentivizing segregated settings. The following NQTLs raise segregation concerns:

- Prior authorizations and other medical management techniques that limit the availability or usage of community services and that are not required in medical or surgical settings.
- Methodologies which impose higher reimbursement rates for services including peer support services, for individuals in segregated settings than for individuals in community settings; where those same differences are not reflected in medical or surgical settings.
- More restrictive conditions for provider admissions that are imposed on peer support specialists, but have no analog to medical/surgical support providers – including certification requirements that are more demanding than the Substance Abuse and Mental Health Services Administration’s (“SAMHSA”) National Model Standards for Peer Support Certification.<sup>8</sup>

In and of itself, an equal number of mental health and physical health facilities covered by an insurer does not imply parity of services or compliance with *Olmstead*. A discrepancy in the number of mental health facilities relative to medical or surgical facilities may reflect that more people are receiving treatment in community settings instead of in institutions, which this rule should not discourage. Indeed, CCD hopes that the NQTL requirements proposed will reflect the effectiveness of and promote access to community-based mental health treatment.

## **Involuntary Treatment**

Involuntary mental health care services should not be weighed as MH/SUD services in parity considerations, as involuntary treatment is coercive and voluntary options must be incentivized. Evidence shows that involuntary, coercive treatment, including involuntary medication, is harmful.<sup>9</sup> Involuntary commitment is associated with increased risk of suicide both during and after hospitalization.<sup>10,11</sup> To be clear, we strongly agree that issuers should cover a full, robust array of health care options - including *voluntary* inpatient, in-network services, so that people with disabilities have a choice about where to receive the care they need. However, the Departments must investigate the settings where people receive mental health and behavioral health services to ensure that design decisions do not wrongly incentivize the availability of facility-based services over home and community-based options, and HHS must investigate whether such care is delivered on a voluntary or involuntary basis.

## **Mental Health Crisis Services**

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<sup>8</sup> <https://store.samhsa.gov/product/samhsas-national-model-standards-peer-support-certification/pep23-10-01-001>

<sup>9</sup> See S.P. Sashidharan, Ph.D., et al., Reducing Coercion in Mental Healthcare, *Epidemiology and Psychiatric Sciences* 2019: 28, 605-12 (All forms of coercive practices are inconsistent with human rights-based mental healthcare); Daniel Werb, Ph.D., et al., The Effectiveness of Compulsory Drug Treatment: A Systematic Review, *International Journal of Drug Policy* 2016: 28, 1-9 (Because evidence, on the whole, does not suggest improved outcomes related to compulsory drug treatment approaches and some studies suggest potential harms, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms). See also Joseph P. Morrissey, Ph.D., et al., Outpatient Commitment and Its Alternatives: Questions Yet to Be Answered, *Psychiatric Services* 2014:812 at 814 (2014).

<sup>10</sup> <https://onlinelibrary.wiley.com/doi/full/10.1111/sltb.12560>

<sup>11</sup> <https://onlinelibrary.wiley.com/doi/abs/10.1111/cpsp.12332>

The mental health crisis services continuum is expanding, including many established “co-responder” programs and “alternative first responder” programs across the country.<sup>12</sup> Just as the health care system responds to physical health emergencies, be it with an ambulance, a medic, or other services, so too should the mental health system and peer support lead on responding to mental health crises. The federal government should help cities, states, and other localities invest in community-based alternative response models and mental health services. Here, this means that the MHPAEA must have clear guidance for how insurance companies should cover these mental health services in parity with other medical or surgical emergency services.

Parity is one tool to increase access and combat discrimination in private insurance. The Departments could further expand the availability of necessary home and community-based mental health services by incorporating crisis services, including those provided by peer support specialists, as an Essential Health Benefit (EHB). Crisis services, including mobile crisis services and crisis stabilization services, should be non-coercive, voluntary, and delivered in home and community-based settings wherever possible. If medical/surgical emergency EMT services -- which go into the community to provide emergency services on-site -- are covered as “emergency services,” both for MHPAEA considerations or for EHB purposes, mobile crisis services should likely fall under the “emergency services” category. This will both further goals of achieving parity and expanding the availability of these services to more beneficiaries.

To achieve parity with physical emergency response services, mobile crisis services should be included as an EHB under the “Emergency services” category. However, HHS should consider, in light of the integration mandate and Olmstead, whether stabilization services should be categorized as non-emergency services (“Rehabilitation” or “Mental Health” services) to guarantee both that parity for these services is achieved and that stabilization services are delivered in the most integrated setting -- which is, in most cases, a home or community-based location, not an emergency room.”

### **Data Transparency, Compliance, & Enforcement**

By incorporating the following data transparency requirements, the Departments have the opportunity to significantly strengthen the proposed § 146.137(c)(5) and ease their own enforcement activities by permitting the health services research community to assist in the evaluation of compliance with MHPAEA. The Departments should also require plans to provide de-identified data that is stratified according to key demographic characteristics such as race/ethnicity, disability, LGBTQI+ status, and other disparity factors. We urge the Departments to include language within § 146.137(c)(5) requiring plans and issuers to:

- Make arrangements to permit third-party researchers to access claims data for all health benefits for purposes of evaluating compliance with MHPAEA upon request, provided that they do so in a fashion that complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable laws;
- Indicate to whom such requests should be made at the plan or issuer;

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<sup>12</sup> <https://www.brennancenter.org/our-work/research-reports/rethinking-how-law-enforcement-deployed>

- Describe specific requests that have been made to access such data, and;
- Describe the results of such requests, including the results of such analyses (if data is made available) and the reasons why data was not provided (if data is not made available).

After this data is collected, the Departments must then use and interpret the data to ensure plan/issuer compliance. For too long, there have been no meaningful consequences when plans/issuers have violated MHPAEA. Through widespread inaction and the lack of meaningful consequences for violations of MHPAEA's requirements, state and federal regulators have prioritized plans/issuers' interests and profits over the ability of individuals to receive needed MH/SUD care. It is now finally time to put teeth into the rules and prohibit plans/issuers from imposing treatment limitations that are not in compliance with MHPAEA. After nearly 15 years since the enactment of MHPAEA, barring the application of non-compliant NQTLs is the only way to incentivize plans to more carefully evaluate NQTLs as they design and apply plan benefits and during the comparative analysis.

### **Network Adequacy and Impacts on Parity**

Inadequate networks are one of the most significant barriers to individuals accessing needed MH/SUD care. Thus, we strongly support the new proposed rules relating to "network composition," which would address many of these access issues. The special rule relating to network composition NQTLs is particularly powerful because a plan/issuer would fail to meet the requirements of (c)(4)(i) and (c)(4)(ii) "if the relevant data show material differences in access to in-network mental health and substance use disorder benefits as compared to in-network medical/surgical benefits in a classification." This strong requirement should be maintained.

### **Clarify the Definition of "Independent Medical Standards"**

The Departments propose exceptions to the proposed requirements for NQTLs that "impartially apply generally recognized independent professional medical or clinical standards (consistent with generally accepted standards of care) to medical surgical benefits and mental health or substance use disorder benefits". In the notice, the Departments further solicit comment on this exception, including ways this exception could be better or more specifically framed. We believe that the proposed standard requires substantial additional clarification in order to ensure that these exceptions do not serve to unintentionally "create potential loopholes that would undermine the statutory requirement that NQTLs applied to mental health and substance use disorder benefits be no more restrictive than the predominant NQTLs applicable to substantially all medical/surgical benefits."

We note that this concern is warranted; the Departments have noted in their 2013 Final Rule that under a similar exception in the 2010 interim final rule, "some plans and issuers may have attempted to invoke the exception to justify applying an NQTL to all mental health or substance use disorder benefits in a classification, while only applying the NQTL to a limited number of medical/surgical benefits in the same classification. These plans and issuers generally argue that fundamental differences in the treatment of mental health and substance use disorders and

medical/surgical conditions, justify applying stricter NQTLs to mental health or substance use disorder benefits than to medical/surgical benefits under the exception in the interim final regulations<sup>13</sup>.

We urge the Departments to provide a clear and explicit definition of “independent professional medical or clinical standards” that is tied to criteria and guidelines developed by the relevant nonprofit clinical specialty associations. A broad or vague definition would permit insurers and plans to create and exploit the exact loopholes contemplated in the notice and undermine the intent of this rule. We additionally recommend that the Departments consider the impact of these exceptions on their ability to assess compliance with the rule under its other tests; if, for example, an exception applies to outcomes data reporting standards because of an impartially applied medical or clinical standard, the resulting lack of data may impede the Departments’ ability to identify violations under its other tests. Where exceptions applied to reporting standards will prevent rule enforcement, the Departments should substantially revise or eliminate those exceptions.

### **Wait Times**

The Departments have requested feedback on how to improve provider directories through rulemaking. CCD urges the Departments to require periodic independent third-party testing of provider directories to assess the accuracy of information and that a sufficient percentage of providers are accepting new patients. HHS has already put forward strong proposed standards for Medicaid managed care and the Children’s Health Insurance Program(CMS-2439-P)<sup>14</sup> , which establish maximum appointment wait time standards for routine outpatient MH/SUD services of 10 business days and require such independent secret shopper surveys. This proposed rule should be a model for the Departments in individual and group plans. Additionally, plans/issuers should be required to identify providers who are available via telehealth, including the capacity to provide effective communication for people with disabilities and individuals with limited-English proficiency. Finally, the Departments should ensure that participants/beneficiaries who cannot access in-network services on a timely basis can access out-of-network services, with their out-of-pocket costs no greater than the amounts that they would have paid for the same services received from an in-network provider.

Thank you for the opportunity to provide comments on the proposed rule **FR–51552 Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA)**.

Sincerely,

Access Ready Inc  
American Association on Health and Disability

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<https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act>

<sup>14</sup>

<https://www.federalregister.gov/documents/2023/05/03/2023-08961/medicaid-program-medicare-and-childrens-health-insurance-program-chip-managed-care-access-finance>

American Music Therapy Association  
Autistic Self Advocacy Network  
Autistic Women & Nonbinary Network  
Bazelon Center for Mental Health Law  
Disability Rights Education and Defense Fund (DREDF)  
Epilepsy Foundation  
Family Voices  
National Association of Councils on Developmental Disabilities  
National Disability Rights Network (NDRN)  
National Down Syndrome Congress  
The American Association of People with Disabilities