BlueCross BlueShield Association

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

October 17, 2023

The Honorable Julie Su
Secretary of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted via the Federal Rulemaking Web Portal: http://www.regulations.gov

RE: Requirements Related to the Mental Health Parity and Addiction Equity Act Proposed Rule (EBSA-2023-0010)

Dear Secretaries Su, Becerra and Yellen,

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the Proposed Rule on "Requirements Related to the Mental Health Parity and Addiction Equity Act," as published in the Federal Register on August 3, 2023 (88 FR 51552).

BCBSA is a national federation of 34 independent, community-based and locally operated BCBS companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own.

BCBSA and BCBS Plans have a strong but straight-forward commitment: We believe that everyone deserves affordable access to mental health care, no matter who they are or where they live. We are committed to ensuring that the people we serve have robust access to mental health and substance use disorder (MH/SUD) services that will improve their health and keep them well. With our partners in the employer community, we are working hard to make sustained and significant progress so that everyone gets the care, support and services they need. We continue to build out robust MH/SUD benefits; ensure high-quality, comprehensive networks; and attract provider participation to support the broader populations and communities that our Plans serve.

We appreciate the investment the Departments have made to think critically on how to ensure compliance with parity. However, we have significant concerns that elements of this rule, as currently written, will have unintended consequences for patient safety, outcomes and access, as discussed below. Before we examine those issues, we first want to share information on what BCBS Plans are doing to bolster MH/SUD access for members, particularly since many actions taken go well beyond what is reflected in MHPAEA compliance analyses and reporting.

Building robust benefits.

For the last two decades, BCBS Plans have made significant investments to support the growing needs of members to access MH/SUD services. Specifically, since the passage of MHPAEA in 2008, the richness of MH/SUD benefits has expanded considerably with a paid-to-allowed ratio[1] 2 points above what was observed for medical surgical (M/S) services over the same period of 2008-2017.[2] This is further demonstrated by the increases in overall spending for MH/SUD services, driven by both increasing utilization and higher reimbursement rates.[3] Between 2013 and 2020, average spending on a patient with a mental health condition increased by 20 percent, with a growing portion of those dollars going to outpatient services.[4] In addition, spending on mental health services continues to be a growing portion of overall health care spending, and mental health services spending is growing faster than spending on M/S services.[5] These trends accurately reflect the investments BCBS Plans have made on behalf of their members to bolster MH/SUD benefits, including efforts such as expanding access to ABA therapy and peer support services which broader the accessibility of services and supports.

Recognizing the burden that MH/SUD conditions place on our members and communities and that early treatment is directly tied with improved outcomes, Plans have invested in programs to help members identify mental health care needs and to connect them to the appropriate services as early as possible. For example, Plans have implemented numerous screening and training programs to increase early identification of behavioral health conditions, particularly in youth populations. Several BCBS Plans are funding the development or administration of mental health assessment screening tools for youth populations to detect those at risk, particularly in underserved areas. These tools are combined with guidance and support to help direct patients to care to help drive better outcomes for patients. For patients already receiving care, Plans have programs to help them navigate and access the right services for their needs. For example, one program provides wrap-around services to children in need of behavioral health support, including care management, peer support specialists, and linkages to community-based services for children and their families.

These programs are in addition to strong, community-based partnerships with local leaders as mental health supports are not exclusive to the doctor's office. For example, BCBSA recently announced a four-year, $10 million initiative with the Boys & Girls Clubs of America. We are

[1] A paid-to-allowed ratio is the ratio dollars paid by the health plan to providers to the allowed amount, or the maximum dollars a plan will pay for a covered service.
[2] Milliman, "Impact of Mental Health Parity and Addiction Equity Act.", Nov. 2017. Impact of Mental Health Parity and Addiction Equity Act (milliman.com)
[3] Employee Benefit Research Institute, "Use of Health Care Services for Mental Health Disorders and Spending Trends." Sept. 2022. Use of Health Care Services for Mental Health Disorders and Spending Trends (ebri.org)
[4] IBID.
[5] IBID.

bringing together our local leadership in every zip code in America to train and implement trauma-informed behavioral health practices into its more than 5,000 Clubs across the country.

This type of comprehensive approach helps people get the care they need when and where they need it. By building out MH/SUD benefits to reflect the changing and growing needs of members as well as executing strategies to connect patients to the right care and community support, BCBS Plans are supporting members' need for affordable MH/SUD services.

Ensuring high-quality, comprehensive networks.

BCBS Plans have made substantial investments to build plan networks that provide comprehensive access to quality providers across all zip codes in America. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country. In addition, Plans work with a broad scope of practitioners beyond medical doctors who support patients' MH/SUD needs, including licensed clinical social workers, therapists and peer support personnel. While there are many reasons a patient may choose to use an out-of-network provider, particularly for mental health services, Plans work to support patients' ability to choose the provider that best meets their needs. Mental health practitioners have been a particular focus for the BCBS System over the last 5-10 years given the increasing demands from patients for these services, as well as the seemingly intractable challenges of shortages and capacity of mental health professionals.

Our collective goal is for every patient we serve to get the care and support they need from a qualified practitioner at an affordable price – and we are making meaningful progress. Over the last 5 years, collectively the BCBS system has seen an increase of 14% in overall MH/SUD provider participation, including psychiatrists, psychologists, licensed social workers, counselors, therapists and nurses for a total of over 425,000 providers. This represents one of, if not the, most robust behavioral health networks across the country. This growth has been achieved through various types of impactful efforts, including funding the training of new peer support specialists, partnering with third parties to augment networks, and expanding access to tele-mental health services and other digital solutions. Telehealth specifically has been an invaluable tool to expand access to MH/SUD services in underserved areas and now represents 30-50% of all outpatient MH/SUD care.[6] To build on these gains, we have been actively engaging policymakers to ensure the continued use and expansion of telehealth by reducing barriers to use, ensuring flexibility in coverage and enhancing consumer trust.

Unfortunately, patients often have difficulties finding available providers despite these improvements due to the significant lack of available practitioners. As the Departments note in the Proposed Rule, there is a severe shortage of mental health providers, particularly in rural areas and communities of color. More than one third of Americans live in areas with far fewer mental health[7] specialists than the minimum needed to meet the need.[8]

The inadequacy of supply has been exacerbated by a significant increase in demand. The percentage of the population under age 65 with employment-based health coverage diagnosed

[6] Per Oliver Wyman, 30-50% of MH/SUD services are provided through telehealth compared to 5-10% of medical/surgical services.
[7] Mental health disorders "involve changes in thinking, mood, and/or behavior." https://www.samhsa.gov/find-help/disorders
[8] https://data.hrsa.gov/topics/health-workforce/shortage-areas

with a mental health disorder increased from 14.2% in 2013 to 18.5% in 2020.[9] As of August 2023, the Business Group on Health reported that roughly 77% of large employers reported an increase in the mental health needs of their employees, a 33-point increase from 2022.[10] While there has been significant attention to the MH/SUD needs because of the COVID-19 pandemic, increases in demand were already accelerating – and continue to do so. Yet, the workforce has not kept pace and, instead, has decreased over the last several years – as has happened across medicine.

We are doing our part to close the supply and demand gap by funding behavioral health workforce development, supporting integrated behavioral and primary care practices and supporting primary care providers (PCPs) who are often on the front lines of MH/SUD care:

- BCBS Plans are leveraging platforms and technical solutions that can expand network breadth and diversity as well as improve the ability for individuals to navigate accessing behavioral health services. In some instances, this includes the use of analytics to monitor provider gaps as well as appointment and provider availability for both in-person and virtual care.
- Several BCBS Plans are expanding use of integrated care by offering incentives to provider organizations that implement the collaborative care model (CoCM). Use of care integration increases mental health screenings, eliminates wait times for patients to see behavioral health providers and improves care coordination.
- PCPs play a critical role in delivering mental health care services, especially when treating patients who have both mental health diagnoses as well as chronic medical conditions, which is often the case. “Primary care physicians have the training and expertise required to treat mental illness and they are often the first place a patient with mental health concerns presents. Given their comprehensive scope of practice, they are uniquely qualified to treat mental illness in the context of other disease processes.”[11] Research shows primary care physicians provide “... a considerable volume of office-based mental health services, see a wide variety of mental illnesses, and prescribe various psychotropic medications.”[12] In this 2021 study, primary care physicians were more likely than psychiatrists to treat patients with mental illness as well as multiple chronic conditions; patients with severe mental illness, however, were more likely to be treated by a psychiatrist.[13] Thus, while psychiatrists are better prepared to treat patients with significant mental health problems, primary care physicians may more appropriately treat patients with both mental illness and non-mental illness diagnoses. Providing PCPs with support via virtual behavioral health consults empowers the PCPs to support patients’ MH/SUD needs and enables them

[9] Employee Benefit Research Institute, “Use of Health Care Services for Mental Health Disorders and Spending Trends.” Sept. 2022. Use of Health Care Services for Mental Health Disorders and Spending Trends (ebri.org)
[10] Business Group on Health, “Large Employer Health Care Strategy Survey.”, Aug. 2024
[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8202306/
[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8202306/, Accreditation Council for Graduate Medical Education. ACGME program requirements for graduate medical education in family medicine; 2019; Kroenke K, Unutzer J. Closing the false divide: sustainable approaches to integrating mental health services into primary care. *J Gen Intern Med*. 2017;32:404-410; Olfson M. The rise of primary care physicians in the provision of US mental health care. *J Health Pol Policy Law*. 2016;41:559-583.
[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8202306/#bibr13-21501327211023871

to treat their patients locally. Paring the PCPs with the specific expertise of behavioral health providers integrates care to improve management of the patient's health.

These efforts are supporting the communities Plans serve, but we know this is a national challenge that will take a range of actions to address. We want to work with providers and policymakers to implement short- and long-term solutions to the shortage challenges and have recommended the following for policymakers to consider:

- Expand quality assurance and oversight mechanisms for peer support specialists and community health workers. Non-clinical personnel can extend the behavioral health workforce and support diverse member needs, and additional standards and expectations can support the quality of services provided by these workers to realize their optimal value. We recommend Substance Abuse and Mental Health Services Administration (SAMHSA) encourage state uptake of its peer support certification standards and develop guidance to support supervision mechanisms and long-term career paths for peer support specialists and other non-clinical personnel. These actions will make the support specialist workforce more predictable and sustainable.

- Continue to support expanded access to behavioral health tele-mental health services through reducing barriers to access, including accelerated implementation of the investments in broadband and telehealth infrastructure, and permanent removal of geographic and originating site requirements. Policymakers can also support flexibilities in tele-mental health coverage by removing in-person visit requirements and promoting Health Insurance Portability and Accountability Act (HIPAA)-aligned privacy protections. Telehealth has been an invaluable tool for expanding access to MH/SUD services in underserved areas and in connecting patients with the providers who fit their unique needs.

- Promote diversity in the long-term pipeline across programs and policies through creation of pathway programs to behavioral health professions for high school and community college students across communities.

It is essential that we have a comprehensive approach to mental health that addresses not just payment and coverage parity but workforce, licensing, quality, and other critical components. We hope to find opportunities to engage with the Administration and Congress on these and other solutions so that patients can get the services and support they deserve.

Reducing barriers for MH/SUD provider participation.

It is a fact that many behavioral health providers, especially small or independent practitioners, intentionally choose not to contract with health plans. Administrative burden and low reimbursement are often cited as reasons for choosing to stay out-of-network and directly charge patients their full billed rate. While administrative processes can be streamlined and improved, that may not be sufficient, even if paired with reimbursement changes, to attract network participation. Compared with all other health care professionals, mental health practitioners have the lowest office overhead costs.[14] Many, if not most, are simply not oriented

[14] https://www.ama-assn.org/system/files/practice-expense-component.pdf

toward the administrative complexity of third-party billing because they have been able to build a practice outside of network participations. In addition, it is not obvious that increasing plan payment rates will materially add to provider networks, especially as demand for mental health care services has increased.

Unfortunately, there is a long history of MH/SUD providers choosing to stay out-of-network (OON) and operating independently of the broader health care infrastructure. The reasons for this go beyond network administration burdens and/or reimbursement. *Our experience has shown that improvements to network administration and higher reimbursement often do not result in significant increases in network participation.* In 2020, one Plan, which operates in a region with some of the highest MH/SUD provider density areas, made meaningful improvements to reimbursement with the goal of increasing network participation. These improvements included paying at parity for in-person and telehealth visits, increasing reimbursement rates by 50% for child psychiatrists, and offering financial incentives for PCPs to integrate mental health services into their practices. Despite these significant actions, there was only a modest increase in network participation. Another Plan noted that it maintains a list of behavioral health providers that, previously, it had contacted regularly to discuss contracting and these providers requested not to be contacted moving forward – they weren't interested in discussing network participation under any terms.

Research confirms this experience. A recent analysis by the Employee Benefit Research Institute indicates that year-over-year increases from 2017 to 2021 in MH/SUD provider reimbursements are outpacing medical/surgical (M/S).[15] Comparing common clinic visit payment rates over the 2017-2021 period, MH/SUD payment rates increased by an average of about 18.5%, nearly double the payment increases to non-mental health providers of 9.5%.[16] An article in the Journal of Mental Health Policy and Economics showed a significant increase in mental health care provider wages from 2013 to 2018, casting further doubt on the assumption that plans' reimbursement policies are responsible for lower participation.[17] There is a relatively inelastic supply of MH/SUD providers coupled with a surplus of demand, which further indicates that increasing reimbursement rates and lowering the administrative burden is unlikely to materially impact network participation.[18]

Raising reimbursement rates for private insurance would also change the relative price with respect to public reimbursement (i.e., Medicare and Medicaid reimbursement rates). While this would not deter commercial efforts to encourage provider participation, it could further disincentivize behavioral health provider participation in Medicare, or more likely Medicaid. The challenges with low MH/SUD provider network participation are not unique to commercial markets. Across most specialties the majority of physicians accept both Medicare and private insurance, but the rate of physicians accepting new patients is lowest among psychiatrists compared to other medical specialties for both Medicare and privately insured patients.[19] The

[15] Unpublished EBRI analysis of provider reimbursements for 2017-2020, 2023
[16] EBRI, 2023
[17] Golberstein E, Busch SH., "Mental Health Insurance Parity and Provider Wages," The Journal Of Mental Health Policy And Economics, 2017 June 1.
[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3967759/
[19] https://www.kff.org/medicare/issue-brief/most-office-based-physicians-accept-new-patients-including-patients-with-medicare-and-private-insurance/

likelihood of psychiatrists accepting Medicaid declined between 2010-2011 and 2012-2013.[20] We raise this to highlight that network participation is not unique to any one market – it is a challenge across the system driven by the severe disconnect between supply of providers and demand for services.

Efforts to encourage provider participation are critical to supporting the most robust in-network access, and Plans remain committed to taking these actions. It is important to note, however, that the addition of new network providers does not always equate to broad patient access. In-network providers often engage multiple carriers, and most MH/SUD providers are already at or near full capacity today. These are real challenges that health plans are working hard to resolve by advocating for comprehensive solutions that result in a bigger workforce, broader access, and better patient care.

Implications for the Proposed Rule on ensuring patient access to high-quality care.

BCBS Plans have undertaken a myriad of efforts to address the MH/SUD needs of members and the communities we serve. We recognize we have a pivotal role in continuing to improve access for patients. That is why we want to work with other health care leaders to break down the broad, systematic barriers to access that exist today – that health plans cannot address alone.

Unfortunately, this Proposed Rule takes a narrow view of the broader challenges health plans face in ensuring access to MH/SUD services. The rule, if finalized as proposed, would hinder health plans' ability to protect patients through standards that ensure high-quality providers and do not compromise patient safety or outcomes. We have significant concerns that the rule will make it harder – not easier – for patients to get the care and support they need:

- **Whole-person Care.** BCBSA, BCBS Plans, policymakers and the broader industry have been undertaking efforts to break down barriers to whole-person care. For example, the Consolidated Appropriations Act of 2023 contained important provisions to support integrated care, a model of care and reimbursement where MH/SUD and M/S services are administered in tandem. BCBSA was invested in supporting efforts like this one to reduce barriers for provider uptake of care integration models, driving improved patient outcomes, reducing health disparities and helping behavioral health providers reach more patients to reduce the impacts of provider shortages.

  BCBS Plans have made this a priority, taking important steps to support providers and implement integrated care, including:

  - Expanding behavioral health care management teams and pairing with internal medical operations
  - Embedding lower licensure behavioral health professionals in PCP and specialty settings (e.g., emergency medicine, obstetrics and gynecology)
  - Funding behavioral health professional training and placement
  - Educating and engaging provider groups on integration opportunities

[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6551583/

- Entering partnerships with integration enablers
- Expanding coverage of CPT codes for the Collaborative Care Model (CoCM)
- Expanding coverage of lower behavioral health licensures
- Incentivizing evidence-based integrated models
- Assessing current level/types of integration across behavioral health network

An outcomes-based approach to MHPAEA compliance would not drive integration but would reinforce the narrative that these are two separate sets of benefits and services rather than components in the continuum of whole-person care. The increased emphasis on numerical equivalency disincentivizes health plans from practices that improve patient access to MH/SUD care, including driving integration to encourage the increased role of primary care providers in delivering MH/SUD services that would not be reflected in network compositions analyses, and partnering with providers to develop alternative reimbursement methodologies and value-based care arrangements that cannot be easily translated to make comparisons with M/S reimbursement.

- **Health Outcomes.** There are proposals in the rule, particularly the application of the substantially all/ predominant three-part test to nonquantitative treatment limit standards (NQTLs), that are likely to result in poorer health outcomes for patients. *Medical management tools are used to ensure that the services, drugs and devices patients receive are supported by current, credible medical evidence and are administered by a clinician with the appropriate expertise and training. If this approach is restricted, patients will pay more for treatment that varies widely in quality.*

  For example, concurrent review is often used for inpatient MH/SUD treatment to ensure patients are not kept in an inpatient facility beyond what is in their best interests. There is wide recognition that patients recover better at home and that, particularly for MH/SUD services, it is critical for patients to learn how to manage their conditions within their normal environments.[21] CMS recognized the importance of this in the Proposed Rule on "Nondiscrimination in Health Programs and Activities"[22] which works to ensure individuals with disabilities have access to care in the most integrated setting appropriate. However, there are incentives and pressures to encourage longer inpatient stays, and concurrent review is an essential tool to balance those pressures. However, concurrent review is not as commonly used for medical/surgical (M/S) inpatient services as compared to MH/SUD because they are often based on different payment methodologies (i.e., DRG- versus per diem-based) and have more discrete timeframes established in their associated clinical guidelines. Creating standards where the prevalence of the application of concurrent review to MH/SUD must mirror M/S without exception establishes an impossible standard for its continued use and can impact the health and wellbeing of patients, including by preventing plan activities that protect patients receiving MH/SUD care in inpatient settings.

[21] https://zerosuicide.edc.org/toolkit/treat/least-restrictive-care
[22] Issued in the Federal Register on Aug. 4, 2022 (87 Fed. Reg. 47824)

- **Quality.** Health plans are uniquely positioned to protect patients from bad actors in health care and to help them find high-quality services. BCBS Plans take these responsibilities very seriously. Plans partner with both MH/SUD and M/S providers every day to ensure quality networks that meet the needs of members; these partnerships range from solo PCPs to highly trained, highly specialized clinicians, to large, nationwide hospital systems. Plans invest in ensuring that in-network providers meet strong standards of participation, including establishing quality benchmarks for performance, verifying that the providers have no existing red flags of delivering inappropriate care and monitoring delivery patterns to ensure adherence to evidence-based guidelines.

  For example, there is tremendous variation in treatment practices and quality for SUDs and documented instances of problematic and sometimes predatory practices by some providers. This leaves patients vulnerable in a desperate time of need, with impacts exacerbated by the continuing opioid epidemic and troubling SUD trends since the COVID-19 pandemic. To help address this, BCBSA invested in developing Blue Distinction Centers for Substance Use Treatment and Recovery ("BDCs") to identify higher-performing providers focused on treating SUDs to support Plans' ability to direct patients to the highest quality services. This designation is assessed using strong, specific criteria, including the center demonstrating the use of evidence-based therapies, patient and family centered long-term goal planning, quality measurement and improvement programs, individual care planning, and the application of industry standard assessment and screening tools. BDC-eligible providers demonstrate better overall quality with 27% lower readmission rates 90 days after treatment.[23] This is just one example of how BCBSA and Plans are investing to support patients. However, all of this is predicated on health plans' ability to prevent the participation of sub-par providers and promote the use of the highest quality providers. Network standards are absolutely essential for patients to receive quality care from a credentialed practitioner.

  Specific to the proposed network composition NQTL standards, we believe they will lead to an impossible choice for health plans: 1) ensure compliance by accepting lower quality providers into networks (who likely have full patient panels already given provider shortages), which would compromise outcomes and patient safety, or 2) retain existing quality standards that prioritize patient health and quality outcomes but be out of compliance with federal and state regulators. Both outcomes run counter to the goals of the Departments to support access to drive better health for Americans.

- **Access.** Members are supported by plans to get the right level of care in the most effective setting, a practice that is particularly important for MH/SUD services that can be challenging for patients to navigate. This often means connecting patients with a wide range of experience, expertise and training. Some patients need intense, higher-level support from practitioners like clinical psychologists and psychiatrists, while other patients have less intense care needs that can be addressed by social workers, therapists and PCPs. *We have significant concerns that this rule will restrict the support that patients need in order to choose the right approach for them, resulting in a bigger*

[23] https://www.bcbsm.com/amslibs/content/dam/public/employers/documents/share-resources-employees/individual-files/bdc-substance-use-flyer.pdf

chokepoint with practitioners, especially among the most skilled clinicians, and fewer patients getting help.

For example, the scope of NQTLs has been expanding to treat programs like care management as NQTLs. This is reinforced by the Proposed Rule. BCBSA is concerned that programs to direct patients to the right level of care could be treated as an NQTL. If this happens, health plans may be forced to discontinue these important programs to demonstrate compliance. Health plans will likely be unable to demonstrate parity with M/S because the provider continuum that exists on the MH/SUD side (licensed clinical social workers, counselors, psychologists, psychiatrists) is not mirrored in M/S, so plans do not have comparable programs across M/S. As result, patients may be incentivized to see psychiatrists because they are perceived as being "the best" when the patient could benefit most from a counselor. This would exacerbate the pressure on psychiatrists, constraining their ability to see the patients who really need them, with no additional benefit to the patient.

- **Cost.** *Potential increases in unnecessary care – whether driven by unchecked overutilization, prioritizing higher-level providers when not needed or patient health worsening because they cannot get the care they need – will likely result in higher costs for the system, eventually translating into premium increases for consumers.* For example, the elimination of prior authorization would cost up to $63 billion annually.[24] While MH/SUD services would only be a portion of that, removing the checks and balances to support high-quality care would raise overall patient costs.

We cite these concerns because we want to make improvements that result in broader access and better individual care. We want to work with the Departments to accomplish this shared goal. To implement the Departments' rigorous compliance standards in a way that will be best for patients as well as operationally feasible, we urge the Departments to consider the following key recommendations:

- **Remove substantially all/ predominant test for NQTLs.** We urge the Departments not to include the application of this test to NQTLs in the Final Rule as it could have significant unintended consequences for patients to access high-quality, affordable and comprehensive support. Applying this test to NQTLs could reduce use of medical management practices that protect patients by ensuring they are receiving medically necessary care consistent with clinical evidence. Removing these tools from MH/SUD benefits would likely lead to more variation in care, more inappropriate and risky care, and ultimately poorer outcomes for patients. However, if finalized, we ask the Departments to carefully consider how this test can be applied to different benefit categories and how to fully realize the proposed exceptions to account for clinical best practices and fraud, waste and abuse.
- **Define material difference standard for outcomes data.** We recommend a clear definition of "material difference," as proposed in our detailed comments, to ensure a common understanding and to support continued use of critical patient-centered programs and NQTLs that deliver value and protect members. If there are no material

[24] https://www.milliman.com/en/insight/potential-impacts-elimination-of-prior-authorization-requests

differences in outcomes data, there should be a presumption that the plan or issuer is in compliance with the NQTL requirements.

- **Refine network composition NQTL standards.** We recommend specifics for how outcomes are reported for this NQTL to make certain that standards are feasible to meet without compromising the quality of health plan networks. We have proposed a discrete, exhaustive list of recommended outcomes that aligns to commonly requested metrics from investigators during investigation, which would promote clarity in expectations for reporting and investigations. These recommendations are also reflected in BCBSA's response to the Departments' "Request for Comment on Proposed Relevant Data Requirements for Nonquantitative Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act."
- **Define meaningful benefits standard.** We recommend a clear definition of "meaningful benefit," as proposed in our detailed comments, which aligns with established standards of care to protect patients from inappropriate, substandard care.
- **Refine the definition of evidentiary standards.** The definition of "evidentiary standards" should be modified to not include reference to specific benchmarks or thresholds, as many evidentiary standards cannot be appropriately defined numerically. In addition, the definition also should not include professional standards and protocols because doing so could force plans to incorporate potentially unproven medical guidance as a standard.
- **Define "variation" with regard to the substantially all/ predominant test.** If the Departments retain the proposal for the substantially all/ predominant test, the term "variation" should be defined to provide clarity and ensure that it does not create an impossible standard for compliance and, therefore, create unintended consequences.

We ask that the Departments continue to provide clearer and more detailed guidance on what constitutes compliance and on how health plans should report their NQTL analyses. While regulators have provided a series of helpful guidance to date, the additional level of documentation required under the Consolidated Appropriations Act and through this Proposed Rulemaking has further heightened the need for a clear roadmap for compliance, particularly in regard to the data elements the Departments expect to receive in order to demonstrate compliance. Without this common understanding, it will continue to be challenging for plans and issuers to comply with the requirements but, more importantly, may crease unintended consequences for MH/SUD benefits and access for patients.

We appreciate your leadership on this critical issue, and we share your commitment to broaden access to the care, support, and services that people need. To support these goals, we provide below detailed recommendations for your consideration, along with additional recommendations to support more seamless operationalization of the final requirements. We look forward to continuing to work with the Departments on this issue as well as additional ways to ensure all Americans have affordable access to high-quality MH/SUD services.