ABHW

Advancing Health Care Policy for
Mental Health & Substance Use Disorders

April 16, 2024

The Honorable Rachel Roberts
House Minority Whip, Commonwealth of Kentucky
Chair, Joint State-Federal Relations & International Insurance Issues
National Council of Insurance Legislators
616 Fifth Avenue, Suite 106
Belmar, New Jersey 07719

RE: NCOIL Mental Health Parity Model Act

Dear Chair Roberts,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments to the National Council of Insurance Legislators (NCOIL) on the Nov. 18, 2023, NCOIL draft Mental Health Parity Model Act (Model Act).

ABHW is the national voice for payers managing behavioral health (BH) insurance benefits. Our member companies provide coverage to approximately 200 million people in the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness. Since its inception, ABHW has been at the forefront of and an advocate for MH and SUD parity. ABHW was instrumental in drafting the legislation for the initial Mental Health Parity and Addition Equity Act (MHPAEA) of 2008, and our members have worked tirelessly over the past 15 years to implement parity for behavioral health services.

Our organization aims to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes. Furthermore, through our policy work, we strive to promote equal access to quality treatment and address the stark inequities created by historic structural and systemic disparities in access and quality of care. We are deeply concerned about health disparities in MH and SUD services in this country. We are committed to promoting health equity in the healthcare system that addresses those access and quality of care issues.

We appreciate NCOIL's efforts to expand behavioral health access and enhance MHPAEA compliance through this Model Act. ABHW and our members advocate for consistent and transparent guidance to ensure compliance with existing laws. As a result, we encourage NCOIL to postpone this Model Act until the U.S. Departments of Health and Human Services (HHS), U.S. Department of Labor (DOL), and Treasury (collectively the Tri-Departments') 2023 MHPAEA proposed rule is finalized. This will reduce the possibility of conflicting language, which could lead to additional confusion among states and issuers.

Additionally, systemic issues remain challenging in the MH and SUD space due to external factors such as the shortage of physicians, including psychiatrists and other behavioral health providers. We are writing to recommend modifying the proposed Model Act to reflect the current behavioral health workforce crisis. The United States (U.S.) does not have enough MH and SUD professionals to meet the demands of the current crisis. According to the Health Resources and Services Administration (HRSA), as of March 2023, 163 million Americans live in MH professional shortage areas (HPSAs), with over 8,000 more professionals needed to ensure an adequate supply. Furthermore, while nearly one-third of the U.S. population is Black or Hispanic, only about a tenth of practicing psychiatrists come from these communities.[1]

Please see our detailed comments below, organized by section.

I. Section 1: Definitions

NCOIL should ensure the proposed definitions in their model law reflect current evidence-based best practices and medical appropriateness standards. Additionally, some of the proposed definitions could drive misalignment with definitions at the federal level and complicate implementation.

- Generally Accepted Standards of MH and SUD care, Section 1, a (1):

The proposed definition of "generally accepted standards of MH and SUD care" could limit the inclusion of crucial information and allow providers too much discretion in defining what services are included. The definition suggested in the Model Act implies but doesn't clarify that other evidence-based sources can be accepted as standards of MH and SUD care, including Milliman, InterQual, or other third-party criteria guidelines. **ABHW urges that NCOIL clarify that this is not an exhaustive list by adding the following as suggested below: "but are not limited to." Another suggestion is explicitly including "Milliman, InterQual, or other third-party criteria."**

> "Examples of valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include, **but are not limited to**, peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration."

- Medical Necessity, Section 1, (a) (2):

ABHW objects to creating a separate definition of medical necessity specifically applied to MH/SUD. While we appreciate that NCOIL has proposed this definition because many existing definitions of medical necessity don't reference behavioral health directly, **we encourage using one universal definition of medical necessity that should apply to all benefits**. **ABHW urges that a better approach**

[1] https://data.hrsa.gov/topics/health-workforce/shortage-areas

is for states to revise their definitions of medical necessity to include a reference to behavioral health.

- Mental Health and Substance Use Disorder Emergency Services, Section 1, (a) (4):

ABHW believes that there should only be one existing definition of emergency services that should cover behavioral health and medical emergencies. As discussed above with the proposed medical necessity criteria, creating separate definitions explicitly for behavioral health emergency services will create significant operational challenges.

Additionally, it is essential to note that "crisis " and "emergency" are not perfectly synonymous. There are crisis situations where the services necessitated are not emergency services, such as crisis stabilization services and residential treatment. For example, some crisis continuum services, such as residential crisis stabilization services that are greater than 24 hours, require flexibility to manage so that health plans can build a network of providers, establish utilization management standards, and conduct quality oversight activities. Moreover, since there are no physical health services comparable to residential crisis stabilization, health plans need the flexibility to implement these services, depending on their design, and map them into a category other than emergency for purposes of MHPAEA. ABHW hopes to continue to work collaboratively with federal and state regulators in this space.

- Mental Health Professional, Section 1, (a) (5):

Regarding the proposed Section 1 (5), viii, **ABHW urges NCOIL to remove "art therapist" and "licensed professional art therapist associate" from the MH professional definition.** Art therapy is generally considered experimental, investigational, and not evidence-based. There are little to no studies that support art therapy as an effective modality in isolation.

Furthermore, under the proposed Section 1 (5), x, it is essential to point out that numerous states have different certifications that need to be able to fit under the clinical alcohol and drug counselor definition. For instance, peer recovery support specialists have a specific type of certification in some states. **ABHW encourages NCOIL to include language that ensures certified peer support specialists fit into the definition of an MH and SUD professional.**

- Mental Health Wellness Examination, Section 1, (a) (6) iv:

NCOIL should not mandate that a mental health wellness examination include a discussion of potential medication limits. This would restrict mental health wellness exams to only those conducted by providers for whom prescribing falls within their scope of practice. **ABHW suggests this be modified to say that the examination MAY include this element but should not be required.**

ABHW also recommends that the Model Act mirror the United States Preventative Services Taskforce (USPST) recommendations for screening for depression in the general adult population, including pregnant and postpartum women aged 18 and older. [2]

II. Section 2: Ensuring Mental Health and Substance Use Disorder Medical Necessity Determinations Follow Generally Accepted Standards of Care

- Section 2 (d): Utilization Management and Medical Necessity Coverage Determinations, Section 2 (d) and (e):

ABHW encourages NCOIL to broaden the language on utilization management (UM) below to indicate that professionals with appropriate clinical experience and training should do the reviews. The Model Act's provisions would compel health plans to retain an overly expensive panel of providers for reviews to be compliant, which would be operationally infeasible and impose higher costs that consumers would bear with limited added value. Most states have laws like the suggested language below. Please see the suggested edits bolded below:

(d) An insurer, **and any entity acting on its behalf**, that c**overs and/or administers mental health and substance use disorder benefits** shall **make** medical necessity **coverage** determinations **relating** to health care services **rendered** for the diagnosis, prevention, and treatment of mental health and substance use disorders **in accordance with** current generally accepted standards of mental health and substance use disorder care. All denials and appeals shall be reviewed by a professional **with licensure and training comparable to, or greater than, that of the requesting provider.**

(e) An insurer, **and any entity acting on its behalf**, that **covers and/or administers** mental health and substance use disorder benefits shall make medical necessity **coverage** determinations relating to health care services rendered for the diagnosis, prevention, and treatment of mental health and substance use disorders **based on the application of utilization review criteria developed in accordance with** current generally accepted standards of mental health and substance use disorder care.

- Section 2 (f):

Section 2 (f) mandates that the limits of utilization review be based on criteria and guidelines outlined in the treatment criteria developed by nonprofit associations, which precludes the evidence-based and well-recognized guidelines developed by Milliman, InterQual, and other third-party guidelines. **ABHW recommends altering this section to include evidence-based guidelines, including but not limited to Milliman and InterQual, that have been widely adopted.**

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[2] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

III. Section 3: Ensuring Coverage of Mental Health and Substance Use Disorder Benefits are at Parity with Medical/Surgical Benefits

ABHW generally supports this section as it codifies parity requirements in federal law. Our members have worked tirelessly over the past 15 years to implement parity for behavioral health services.

We encourage consistency and uniformity with the application of federal MHPAEA law, guidance, and sub-regulatory guidance. The Model Act should not exceed the scope of MHPAEA by establishing mandates for health plans to cover MH/SUD services. While MHPAEA requires that any plan that covers MH and SUD services cover them at parity with any medical/surgical (M/S) services in the same classification, health plans may otherwise determine their coverage policies.

We encourage NCOIL to consider identifying a specific list of Non-Quantitative Treatment Limitations (NQTLs) for parity compliance. This can help regulators focus on the most pressing needs and ensure health plans are prepared to respond in a timely manner.

- Section 3 (a) 3 (c):

Additionally, to limit variability and confusion, **we recommend that NCOIL clearly define the "other specific criteria" and provide guidance and examples for issuers on developing and producing complete and compliant comparative analyses for market conduct examinations.**

IV. Section 4: Increasing Access to Medication-Assisted Treatment

Medication-assisted treatment (MAT) should be available to patients without significant hurdles. We agree that evidence-based MAT therapies are essential to treating SUDs and are the gold standard for care in addiction medicine.

- MAT, Section 4 (a):

ABHW supports the removal of prior authorization on certain forms of MAT, including methadone and buprenorphine. There is overwhelming evidence that buprenorphine and methadone are safe and effective in treating OUD. In particular, Buprenorphine is one of the gold standards of care for OUD. The medication prevents painful withdrawal symptoms and, in doing so, helps people secure long-term recovery and cuts the risk of overdose death in half. The medication has been approved by the Food and Drug Administration (FDA) for nearly twenty years, and data demonstrates that it is one of the safest medications healthcare providers prescribe - far safer than common medications like insulin and blood thinners.

However, it is important to note that prior authorization and other medical management tools were not designed to impede needed care. Instead, they were designed to ensure safe and adequate access to MAT. More specifically, these tools have been designed to (1) ensure that the clinician administering MAT has the required training and regulatory approval; (2) promote appropriate use of methadone and naltrexone because they could interfere with other types of medications and potentially worsen existing conditions, including asthma, chronic obstructive pulmonary disease (COPD), and hepatitis; (3) make sure MAT medications are not co-prescribed with medications that could have dangerous, even

potentially fatal, interactions, such as benzodiazepines; (4) work with clinicians to ensure tailored, patient-focused treatment programs are in place to promote adherence and improve outcomes; (5) encourage the use of "centers of excellence" for opioid use disorder (OUD) that coordinate with specialized staff and peer recovery specialists; and (6) monitor members newly prescribed MAT to make sure the medication is accompanied by services such as cognitive behavioral counseling, peer support, and community-based support groups.

Additionally, ABHW encourages NCOIL to adopt the following principles in the Model Act:

(1) A study should be conducted outlining what the removal of prior authorization has meant for patient outcomes (including harmful drug interactions and participation in care management programs), costs, and drug diversion.
(2) Before discharge, an inpatient facility shall provide the patient and the insurer with a written discharge plan, which must describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the insurer which is designated by the state office of alcohol and substance abuse services. The facility shall indicate to the insurer whether services included in the discharge plan are secured or determined to be reasonably available.
(3) Consideration should be given to new drug treatments that may be developed and whether such drugs should be subject to prior authorization (some bills seem to prohibit prior authorization for any new class of drugs).
(4) A review of the provider's effectiveness and adherence to evidence-based practices should be required.

V. Section 5: Mental Health or Substance Use Disorder Emergency Care Benefits

MH and SUD benefits should be considered emergency care benefits to the extent that this definition is consistent with federal law, including but not limited to the MHPAEA provisions.

- Crisis Stabilization Unit, Section 5 (a) (1):

It is essential to point out that many crisis stabilization units, as suggested in Section 5 (a) (1), will not meet the federal and state law prudent layperson emergency service standards and, therefore, will not meet NCOIL's proposed definition of emergency services. As an example, as discussed above regarding the proposed definition of MH and SUD Emergency Services under Section 1 (a) (4), **ABHW urges NCOIL not to conflate the definitions of emergency behavioral health crisis services with crisis services as many crisis continuum services, such as residential crisis stabilization services that are greater than 24 hours, should not be considered emergency services**.

- Evaluation and Treatment Facility, Section 5 (d):

NCOIL should add that the evaluation and treatment facility proposed to provide crisis stabilization services in Section 5(d) needs to be licensed or certified by the relevant Department of Health to

mirror federal requirements.[3]

- An agency certified by the Department of Health to provide medically managed or medically monitored withdrawal management services, Section 5 (a) (5):

ABHW requests that NCOIL remove Section 5 (a) (5). Currently, most health plans assign these acute care benefits, such as ASAM Level 4 and ASAM Level 3.7, to the inpatient classification of benefits, not emergency services.

VI. Section 6: Coverage of Mental Health Wellness Examinations

ABHW supports efforts to improve overall wellness and access to behavioral health services**.** Given the significant behavioral health workforce crisis we discussed in the introduction and the importance of integrating behavioral health and primary care, **ABHW believes it is essential to allow primary care providers (PCP) also to conduct mental health wellness examinations.** Currently, PCPs identify approximately one-third of their patients as MH patients. They already treat a wide range of psychiatric conditions and prescribe a variety of psychiatric medications.[4]

In addition, appointment times differ in length depending on the severity of the healthcare issues that need to be assessed, time constraints, and provider availability. **ABHW urges NCOIL to eliminate the 45-minute mandate as it will be impossible to operationalize and, as a result, impede access to qualified practitioners.**

Conclusion

Thank you for the opportunity to provide feedback on the Model Act. We are committed to engaging with NCOIL, the Joint State-Federal Relations & International Insurance Issues Committee, and other partners to improve behavioral health access. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,

Pamela Greenberg, MPP
President and CEO

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[3] No Surprises Act, Requirements Related to Surprise Billing; Part 1, July 2021
[4] https://bhbusiness.com/2022/09/06/1-2m-health-care-practitioners-could-be-considered-mental-health-providers-new-data-reveal/