



**National Association of State Mental Health
Program Directors**

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October 16, 2023

To The Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; and Centers for Medicare & Medicaid Services, Department of Health and Human Services:

The National Association of Mental Health Program Directors (NASMHPD)—the organization representing the state executives responsible for the public mental health service delivery systems in 50 states, 6 territories, and the District of Columbia— and the undersigned organizations, are writing to provide comment on the proposed amendments to regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the proposed new regulations implementing the nonquantitative treatment limitation (NQTL) comparative analyses requirements under MHPAEA, as amended by the Consolidated Appropriations Act, 2021 (CAA, 2021).

These rules and regulations constitute the most impactful changes related to parity rules and regulations since 2013, and these changes have the potential to improve states' ability to obtain sustainable funding for 988 and the crisis services continuum, for other behavioral health services, and future needs as the service continuum continues to change. States have relied heavily on federal grants to keep treatment programs viable and in developing new services as the industry continues to change but would prefer to be financially stable by enjoying equity with medical/surgical services as they are entitled to by law.

Covering Losses with Use of State Funds: States and local jurisdictions are increasingly covering losses on valid claims that have been denied or only paid in part by private insurers/plans through use of state funds to keep patients in needed treatment and to keep service providers financially viable.

Out-of-Network Inconsistencies with In-Network: The administrative and financial burdens placed on providers continues to grow and becomes a greater part of the overall cost of care. Processes such as the following are adding to the burden: prior authorization requirements, concurrent care review, admission standards. Also, the inconsistencies between in-network and out-of-network reimbursements are a financial burden. The causes are reimbursement rates, billed charges, payments, allowed amounts for specific Current Procedural Terminology (CPT) codes that are reimbursed to specific types of mental health or substance use disorder providers as well as to each other, to Medicare rates, to other insurers/plans, or to a similar benchmark. Out-of-network providers and services are becoming more difficult to obtain.

Concerns about Adequacy of Provider Networks: When patients are unable to access an in-network mental health or substance abuse disorder provider due to limited options, time/travel distance, scheduling challenges, or otherwise, the patient often relies on government provided/funded services because they are insured. Networks frequently or for extended periods

are not accepting new patients. We have heard of “ghost networks” that exist in difficult to find locations on insurers/plans websites. Patients are unable to locate them, but they exist for the purposes of regulation.

Restrictions: Restrictions that impact both providers and patients include: limits on International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorder (DSM) conditions; geographical location, provider specialty, facility type, and on other criteria that limit scope or duration of care; residential care for MH or SUD particularly for youth; following failure to complete course of treatment; on copayments, coinsurance, and pre-authorization requirements; allowed amounts for specific Current Procedural Terminology (CPT) codes that are reimbursed to specific types of mental health or substance use disorder providers and medical/surgical providers, as compared to each other as well as to Medicare rates or a similar benchmark.

Reimbursement Rates: Insurers/plans have generally been paying at or near Medicare reimbursement rates for behavioral health benefits, while paying much more than Medicare reimbursement rates for medical/surgical benefits; and reimbursing psychiatrists, on average, less than med/surg physicians for the same evaluation and management codes.

Crisis Services: As HHS oversaw the transition to the 988 [Suicide & Crisis Lifeline](#), there has been increased attention to current gaps in access to and provision of a full continuum of behavioral health crisis services. A [2013 study](#) found that State parity laws were associated with a five percent decrease in suicides. Any changes that would continue that decrease are welcome. However, final rules under MHPAEA do not specifically address mobile crisis services. Mobile crisis responses have the potential to generate considerable savings for the system as demonstrated in locations in which they are in place. Similarly, in the establishment of EHBs as part of required benefits for non-grandfathered individual and small group coverage under the Affordable Care Act, there is no specific reference to behavioral health crisis services as part of the EHB categories. It would be tremendously helpful for the Departments to ensure that community-based behavioral health crisis services are classified in the same way as particular medical/surgical services. The services include 988 call centers and crisis intervention/stabilization services provided by mobile crisis teams and in residential stabilization centers. The link back to community-based preventive care is also key to averting future crises. Trainings/certifications that are de-escalation and stabilization-oriented are growing for non-behavioral health professionals in the response field (e.g., EMS, Police (CIT), fire, and ambulance services), as well as for trained/certified citizen response teams that are invaluable in hard to reach rural and frontier areas.

The Departments can collaborate with state and local agencies to improve access by assisting in codifying definitions that would be uniform across federal and state government agencies (and local if possible) and insurers/plans thus narrowing questions and leaving gaps for insurers and plans to use to their advantage. Also, recognition of trainings/certifications may help assist in making services and service providers eligible for reimbursement.



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State Parity Laws: States prefer to have the ability to create and apply state law requirements related to parity if needed. State insurance laws that are more stringent than the Federal requirements are unlikely to ‘prevent the application of’ MHPAEA and be preempted. The states appreciate the Departments’ attempts to balance the States’ interests in regulating health insurance issuers/plans, and Congress’ intent to provide uniform minimum protections to consumers in every State. Although the federal laws and regulations provide comprehensive protections, this flexibility for states allows them to fill any gaps between state and federal laws, make clarifications, and take actions against insurers/plans when necessary. In fact, this is advantageous to the states considering the insurers’/plans’ history of averting sanctions by providing incomplete or faulty reporting to the Departments.

Amendments to Definitions: The states appreciate the Departments’ proposal to amend the existing regulatory definitions of the terms “mental health benefits,” and “substance use disorder benefits” to help delineate more clearly what is a benefit for purposes of complying with MHPAEA and such that it must be defined consistent with the most current version of the World Health Organization's International Classification of Diseases (ICD). As mentioned above we hope that uniform definitions will provide clarity and consistency thus eliminating insurer’s/plan’s ability to use inconsistencies as a reason to deny services or payments.

Thank you for the opportunity to provide these comments on amendments to regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the proposed new regulations implementing the nonquantitative treatment limitation (NQTL) comparative analyses requirements under MHPAEA, as amended by the Consolidated Appropriations Act, 2021 (CAA, 2021).

Sincerely,

National Association of State Mental Health Program Directors

National Alliance on Mental Illness

Center for Law and Social Policy

RI International

Association for Ambulatory Behavioral Healthcare

American Association on Health and Disability

Lakeshore Foundation

International Society for Psychiatric Mental Health Nurses