From:	Spirn, Daniel
To:	EBSA MHPAEA Request for Comments
Subject:	URAC Comments on Technical Release 2023-01P (File Code 1210-AC11)
Date:	Thursday, October 12, 2023 9:53:47 AM
Attachments:	URAC Comment Letter and Exhibit 1 on Parity Rule.pdf URAC Comment on Parity Rule Exhibit 2.xlsx

To Whom It May Concern,

Please see URAC's comments in response to **Technical Release 2023-01P**. Thank you.

Sincerely,

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October 13, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
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Lisa M. Gomez
Assistant Secretary for Employee Benefits Security
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
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Danny Werfel
Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

RE: CMS-9902-P Requirements Related to the Mental Health Parity and Addiction Equity Act: Proposed Rules, File Code 1210–AC11 and 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

Dear Administrator Brooks LaSure, Assistant Secretary Gomez and Commissioner Werfel:

Please accept the below comments from URAC on the Department of Labor (DOL), U.S. Department to Health and Human Services (HHS), and Department of Treasury's (collectively, "the Departments") recently issued *Notice of Proposed Rulemaking CMS-9902-P Requirements Related to the Mental Health Parity and Addiction Equity Act* (NPRM or Proposed Rule) and the corresponding "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" (the "Technical Release").

URAC is an independent, nonprofit accreditation entity that has been working to improve the quality of health care since our founding in 1990. URAC provides health care organizations with renowned accreditation and certification programs that set the highest standards in quality and safety. Our standards use evidence-based measures and are developed in collaboration with a wide array of stakeholders, including health plans, providers and associations. URAC operates the sole dedicated accreditation program for organizations' capacity to meet the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). Organizations that complete URAC Mental Health/Substance Use Disorder (MH/SUD) Parity Accreditation demonstrate to both internal and external stakeholders that they have taken critical steps toward complying with the Mental Health and Addiction Equity Act (MHPAEA) requirements.

URAC's MH/SUD Parity Accreditation standards track to the current federal MHPAEA Final Rules, have direct relevance to many state mental health parity laws, and will be updated to reflect federal regulations once the Proposed Rule is finalized. URAC's accreditation program helps achieve important milestones for a variety of stakeholder groups:

- **Promoting national consistency**. The standards help identify a consistent approach for organizations to demonstrate capacity to comply with the requirements of federal MHPAEA. Currently, there is significant variation in how health plans, issuers and third-party administrators are demonstrating parity compliance. Likewise, there is variation in how state and federal regulators are enforcing it.
- **Supplying a proactive roadmap for health plans, issuers and third-party administrators.** URAC's MH/SUD Parity Accreditation Program provides a roadmap to help health plans and others create true parity between MH/SUD and medical/surgical benefits and maintain it proactively.
- **Recognizing parity excellence.** Employers and health insurance purchasers are increasingly recognizing that the

benefits they offer their populations are not compliant with parity requirements. For risk management reasons, purchasers may require health plans, issuers, and third-party administrators to become URAC accredited to show their commitment to MH/SUD parity.

- **Risk mitigation.** An organization that has successfully earned URAC's MH/SUD Parity Accreditation will have created a robust operational framework to limit regulatory fines and reduce the likelihood of parity-related litigation.
- **Establishing dynamic thresholds.** URAC works with a variety of stakeholders to address areas of ambiguity and continue to raise the bar as new regulatory guidance and other aspects of parity compliance are introduced.

The standards development process was, by necessity, intensive, due to the complexity of the federal guidance on MHPAEA and the underlying complexity of the managed care system. The resulting MH/SUD Parity Accreditation Program represents a significant advance in promoting the identification, implementation, and auditing of parity compliance activities. URAC's standards were developed with input from health plans, community advocates, and other health care experts. Those experts continue to advise URAC via our Parity Advisory Council.

URAC MHPAEA Thought Leaders Summit

As an instance of URAC seeking to serve as a convenor and contributor to building policy consensus, on September 7, 2023, URAC convened a MHPAEA Thought Leaders Summit at our headquarters in Washington, D.C. and through a virtual platform. The MHPAEA Thought Leaders Summit brought together leaders from health plans, health plan coalitions, employer plan sponsors/coalitions, academic researchers, patient and provider advocacy organizations, and representatives from government agencies. The MHPAEA Thought Leaders Summit participants contributed metrics for use in the "Relevant Data" component of the NQTL analysis considered in the Proposed Rule and Technical Release based on those in current use in the MHPAEA compliance marketplace, as well as those metrics discussed in the Proposed Rule and Technical Release. URAC's MHPAEA experts organized the measures submitted for

consideration and moderated a day-long discussion of technical specifications.

URAC intends to consider the feedback on the measure list and technical specifications and anticipates adopting some sub-set of the metrics as a component of a forthcoming update to the MH/SUD Parity Accreditation Program standards, pending finalization of other specific measures by the Departments in the future.

For the benefit of the Departments' consideration of the approach to the Relevant Data component of the NQTL compliance process and of the specific measures discussed in the Technical Release, we have assembled the feedback from the Summit participants on each measure as Exhibit 1 and the metrics and technical specifications submitted by participants as Exhibit 2. Exhibit 2 also includes the proposed measures URAC has developed with initial technical specifications within Exhibit 2.

URAC is not taking a position on which measures the Departments should adopt as a component of a final rule or in future technical guidance. URAC simply intends to share the results of the MHPAEA Thought Leaders Summit for the benefit of the public and the continuous improvement in the effectiveness of MHPAEA compliance efforts.

Safe Harbor for MH/SUD Parity Accreditation

URAC would like to take this opportunity to recommend that the Departments formally identify URAC's MH/SUD Parity Accreditation Program as a component of the consideration of the "safe harbor" concept discussed in the Technical Release or in future rulemaking. Although the Proposed Rule as drafted does not raise the prospect of a "deemed status" or analogous treatment of an issuer or health plan administrator that has obtained accreditation, the concept of the enforcement safe harbor in the Technical Release is highly conducive to the potential recognition of the value of accreditation as a clear signal of meaningful compliance with the requirements of MHPAEA.

Recognizing accreditation of issuers or administrators serving group health plan sponsors would have multiple significant benefits to the marketplace. First, URAC brings more than three decades of managed

care operational and compliance expertise and has served as a leading independent voice in building consensus on principles of MHPAEA compliance for years. This expertise, capacity, and objectivity makes URAC a natural partner to the Departments in achieving the objectives of MHPAEA. Second, the MH/SUD Parity Accreditation is a national and cross-market program that allows for efficient and uniform application of MHPAEA compliance activities across markets. This allows for inter-regulator consistency and application to the third-party administrator market in a manner that supports the needs of employer sponsors across the country. Third, URAC's role as a non-profit accreditation organization that does not offer consulting services (and thus avoids any conflict of interest), is able to push MHPAEA standards that exceed the minimum requirements of federal regulations and further advance the access and quality outcomes goals of MHPAEA.

For these reasons, URAC urges the Departments to use the opportunity of the final rule and the Technical Release to recognize that an issuer or group health plan using a third-party administrator with URAC MH/SUD Parity Accreditation should be eligible for a safe harbor or other form of oversight/enforcement discretion during the accreditation period.

Conclusion

URAC would like to commend the Departments for the focus on MHPAEA compliance and the considerable efforts that have gone into the development of the Proposed Rule and Technical Release. Thank you for your consideration of our comment as to the treatment of the URAC MH/SUD Parity Accreditation and URAC experts are available to discuss the metrics and feedback from the MHPAEA Thought Leaders Summit at your convenience.

Sincerely,

Shawn Griffin, M.D.
President and CEO of URAC

Exhibit 1: URAC MHPAEA Thought Leaders Summit Measure Feedback

Exhibit 2 Row #	Measure Name	Measure Description	Summit Feedback
	UM Denial Rates Measures		
N/A	General feedback on measure category		- Important to use different measures for (1) denial rates for all claims and (2) adverse coverage determinations through UM functions because claim denial rates are not a meaningful metric for UM activities. In particular, many UM adverse determinations do not become claims and many claims are denied or approved that are not subject to UM at all. - For measures that require reporting separate data for different NQTL-types, recommend having NQTL-type definitions to support reporting. - Some measures require reporting on sub-types of provider settings that do not align with MHPAEA classifications. Summit participants had mixed opinions on this approach but agreed that subclassifications need to be defined if required. - Need definitions for duplicate claims/authorization requests and medical necessity vs. administrative adverse determination/denials. - Recommend collecting denial reasons with instructions on categorization and guidance on approaching claims/requests denied for multiple reasons. - For claims denial metrics, need to specify unit of claim to analyze (claim line vs. date of service). Either works, just need to be specific in technical specifications. - For unit of data submission, for self-funded employer reports recommend including both national book of business data and employer-specific data for each measure and for fully-insured issuers, recommend both national book of business data and state-specific full state market data (not product-or plan specific). - Recommend using +/- 10% as definition of "material difference."

2	Denial Rates	Comparison of UM denial rates for certain provider categories between MH/SUD and M/S	- Measure is missing definition for an authorization request that aligns with ERISA and state UM laws for populating denominator. - Denial definition conflates claim and authorization requests and approaching through denial categories rather than as separate measures does not address this issue. - "Modifications" are not necessarily a coherent concept for adverse determination or claim denial purposes and is not administrable. - Does not provide for collection of denial reasons.
3	Denial Rates and PA Denial Rates	Comparison of all claims denial and UM denial rates for all Medicaid MHPAEA classifications between MH/SUD and M/S	- Includes NQTL-type definitions. - Reports UM denials and all claim denials as separate metrics. - Needs duplicate claim definition. - Includes helpful definitions of administrative vs. clinical denial and denial reason guidance.
4	Prior auth and Claims Received, Approved, and Denied	Comparison of all claims denial and UM denial rates for all MHPAEA classifications between MH/SUD and M/S	- No additional comments.
5	Pre-Service Ratios/Claim Ratios/Modification Ratios	Comparison of all UM denial rates and "modification" for all	- "Modifications" are not necessarily a coherent concept for adverse determination or claim denial

		MHPAEA classifications between MH/SUD and M/S	purposes and is not administrable.
6	Denial Rates, Informal Reconsideration Rates, Internal Appeal Rates, and Appeal Overturn Rates	Comparison of PA/CR/RR denial, reconsideration, appeal, and overturn rates between MH/SUD and M/S	- No additional comments.
	Other UM Measures		
N/A	General feedback on measure category	- Participants recommended also considering measures on turn-around times for UM determinations.	
2	Operational Proportionality	Comparison of ratio of service utilization subject to UM between MH/SUD for certain categories.	- Data sub-classifications don't align with NQTL classifications and introduce different sub-classifications to those in the regulations. Summit participant indicated the technical specification seeks to distinguish between levels of care within outpatient (facility and non-facility) to acknowledge differences between them. - Some participants discussed whether comparing the relative number of services subject to UM would serve as simpler alternative to this measure but others discussed that this measure is intended to get to service utilization weighting of UM practices.
3	Interrater Reliability	Comparison of PA/CR/RR interrater reliability between MH/SUD and M/S	- No additional comments.
	Prescription Drug Measures		

N/A	General feedback on measure category	- Participants did not have strong opinions about any of the submitted metrics on the NQTLs for the prescription drug classification.	
2	Formulary Exception Requests	Comparison of off-formula request approval and denial rates for MH/SUD vs M/S medications	- No additional comments.
3	Formulary Tiering	Comparison of Tier placement by primary diagnosis	- No additional comments.
4	Specialty Drug Count	Comparison of Specialty Drug designation by primary diagnosis	- No additional comments.
5	Prior Authorization	Compares # and % of drugs per tier subject to PA	- No additional comments.
6	Step Therapy	Compares # and % of drugs per tier subject to step therapy	- No additional comments.
7	Quantity Limits on fills	Compares # and % of drugs per tier subject to quantity limits	- No additional comments.
	OP/IN Network Management Measures		
N/A	General feedback on measure category	- Participants at the Summit identified additional metrics that were not submitted for consideration on these NQTL types including: the gap exception metrics currently being used by the New Mexico Department of Insurance, provider to enrollee ratios.	
2	Out-of-network use	Comparing ratio of out-of-network utilization for certain categories of MH/SUD services compared to	- Summit participants identified that the inability of using this metric for HMO or closed network product designs. Participants raised that the network gap analysis used in New Mexico can serve as a supplement.

		certain categories of M/S services for PPO/GPO product categories	- Participants all agreed that there are a number of reasons that participants go out of network and that this measure should be used as a signal of a *potential* parity issue triggering further investigation to identify the causes of out of network use disparities and take comparable steps to reduce out of network use rates.
3	INN to OON Utilization Rates	Comparing ratio of plan's in-area OON utilization rate relative to in-network utilization	- Same comments as on earlier OON metric. - No comment or opinion on distinction between provider sub-classification specifications used in measure #2 and #3 though participants agreed that clear definition of any alternative provider-based sub-classification is essential.
4	Network Adequacy and Participation (shadow network measure)	Reporting the member-to-psychiatrist ratio and the number and percentage of psychiatrists submitting claims for beneficiaries	- As specified in the version submitted, this metric did not provide for a comparison of MH/SUD to M/S ratios and many participants identified that as a problem for using it for MHPAEA compliance purposes. - Participants representing network lease and TPA vendors also identified that this measure was not administrable for them as they don't have "members".
5	Credentialing and Re-Credentialing Turn-around Times	Comparing the time from application complete date to credentialing complete dates for MH/SDU to M/S providers. Re-credentialing also reviewed as separate measure.	- No additional comments.

6	Credentialing and Re-Credentialing Turn-around Times	Comparison of a variety of metrics on credentialing activities between MH/SUD and MS providers	- No additional comments.
7	Network Admission Request Acceptance Rates	Analysis of approval rates for network admission requests	- No additional comments.
8	Network Adequacy Gap Identified	Comparison of reports of identified gaps in applicable network adequacy criteria for M/S providers compared to gaps identified for MH/SUD providers in the same classification	- Participants generally supported this metric, especially for product markets that have an applicable set of regulator-imposed network adequacy criteria. - Participants emphasized that even many of those are not currently a meaningful basis of assessing adequacy and therefore gaps may not exist for either classification. - Participants agreed that this metric, like out-of-network utilization should not be the basis of a per se finding of discrimination and should be used to identify potential issues, investigate, and implement comparable strategies to address gaps for MH/SUD and M/S providers.
9	Provider Participation Rate	Comparison of the rate of participation of providers with active spend in each region, by provider type.	- Participants did find this to be a meaningful metric.
	OP/IN Reimbursement Measures		
N/A	General feedback on measure category	- Some Participants at the Summit recommended that default fee-schedules be used for reimbursement rate comparisons rather than allowed amounts or paid amounts. Other participants contended that negotiated allowed amounts or paid amounts are a better metric for	

		evaluating the operational outcomes of NQTLs related to network reimbursement.	
2	In-Network Reimbursement Rates	Comparison of in-network reimbursement for certain enumerated CPT codes between PCPs and non-psychiatrist physicians (M/S provider) and Pyschiatrists, Psychologists, and LCSWs (MH/SUD providers) (as a percentage)	- Participants representing MH providers indicated that this metric has significant weakness of not including codes that can be billed by mid-level MH providers. - Participants expressed concern that the use of E/M codes represents a narrow subset of even outpatient office services and not a meaningful representation of any NQTL types.
3	In-Network Reimbursement Rates	Comparison of in-network reimbursement for certain enumerated CPT codes forPCPs and non-psychiatrist physicians (M/S provider) and Pyschiatrists, Psychologists, and LCSWs (MH/SUD providers) to the allowed Medicare fee schedule for the same CPT code and provider type (as percentage)	- Participants expressed concern that the use of E/M codes represents a narrow subset of even outpatient office services and not a meaningful representation of any NQTL types.
4	In-Network Reimbursement Rates	Comparison of in-network reimbursement for certain enumerated CPT codes for	- Participants expressed concern that the use of E/M codes represents a narrow subset of even outpatient office services and not a

		enumerated classes of physicians, PhD, and Masters level (M/S provider) and Pyschiatrists, Psychologists, and LCSWs (MH/SUD providers) to the allowed Medicare fee schedule for the same CPT code and provider type (as percentage)	meaningful representation of any NQTL types.
5	In-Network Reimbursement Rates	Total Average Payment as a Percentage of Third-Party Benchmark (Medicare, FAIR Health, or other) rounded to nearest %	- Participant recommended using utilization-weighting for this measure. - Participants discussed that Medicare rates do not include fee schedule rates for some key MH/SUD services (like residential treatment) and preferred FAIR health for this reason.
6	Reimbursement Paid-to-Charge Ratio	Ratio of paid rates to provider charges compared between ratio for MH/SUD providers and M/S providers in each classification	- Participants were strongly opposed to using charge rates as they vary enormously by provider in a completely random manner and are not representative of a cash-pay rate for any markets.

Exhibit 2: URAC MHPAEA Thought Leaders Summit Initial Measure List

[Please see submitted spreadsheet]