

January 31, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Information; Essential Health Benefits. File Code: CMS-9898-NC

Dear Administrator Brooks-LaSure,

The undersigned organizations represent millions of individuals and families impacted by substance use and mental illness as well as their treatment providers. Together we have a unique perspective on what individuals and families need to manage their chronic conditions and extensive experience with the Patient Protection and Affordable Care Act's (ACA) requirement for health plans to cover mental health and substance use disorder (MH/SUD) as an Essential Health Benefit (EHB). Together, we are able to draw upon our significant knowledge and expertise regarding ways to expand access to MH/SUD treatment. We encourage the Centers for Medicare & Medicaid Services (CMS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Before passage of the ACA, comprehensive health insurance was inaccessible for millions of people in the U.S., including many people with MH/SUD. Before the ACA, individual and small group plans historically excluded or offered very limited MH/SUD benefits and used excessive utilization management practices to deny or curtail treatment.¹ Before the ACA, some health insurers could deny, cancel, or charge more for coverage for people with pre-existing conditions like MH/SUD and some health insurers were not required to provide MH/SUD coverage at parity. The ACA changed all of this. As a result, there was an extraordinary expansion of MH/SUD coverage, critical to reducing inequities, and improving the quality and affordability of MH/SUD treatment.

On paper, the requirement that individual and small group plans cover MH/SUD services as one of ten EHB was game-changing, intended to rectify the longstanding history of discriminatory practices by insurers against individuals with MH/SUD. In practice, while the MH/SUD category for EHB has ensured basic coverage of many MH/SUD services (and importantly triggers protections of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)), CMS's

¹ Uberoi, N.K. (2015). *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)* (CRS Report R44163). Washington, DC: Congressional Research Service.

Willison, C.E., Singer, P.M., & Grazier, K.L. (2020). Double-edged sword of federalism: variation in essential health benefits for mental health and substance use disorder coverage in states. *Health Economics, Policy, and Law*, 16(2), 170-182. doi:10.1017/S1744133119000306

Barry, C.L. (2006). The political evolution of mental health parity. *Harvard Review of Psychiatry*, 14(4), 185-194. doi: 10.1080/10673220600883168

benchmark approach to define the services in the EHB categories has failed to require sufficient coverage of MH/SUD services. While studies have shown that the ACA has increased access to mental health services, the impact on SUD treatment is less clear. For example, studies of the ACA's impact on SUD treatment show that the addiction treatment gap has remained unchanged since the law took effect.² For moderate to severe MH disorders, it is estimated the average treatment gap in the U.S. is approximately 65%.³ This is unacceptable, especially given record rates of drug overdoses devastating our nation and significantly higher mental health needs in the wake of the COVID-19 pandemic. We believe that changes to the benchmark approach can help eliminate discriminatory and inadequate coverage of MH/SUD treatment and disparities in the level of services offered among States. Further, we believe there are ways that benchmark approach can be modified to improve effectiveness, transparency, oversight and enforcement.

We appreciate CMS's invitation to provide feedback on the EHB benchmark plans and process. While we offer specific feedback on the questions posed by CMS in the RFI and detailed recommendations to improve the benchmark approach and coverage of MH/SUD benefits, these are the changes that CMS could make that would be particularly impactful for individuals with MH/SUD and their families:

1. Establish a federal definition in the MH/SUD benefit category that establishes the minimum level of benefit coverage required for EHB. This would eliminate ambiguity in how the benefit is currently defined and variation in the benefits covered across states, close coverage gaps, reduce discriminatory insurance coverage practices, and increase access to affordable, life-saving care for individuals with MH/SUD. This minimum federal definition should ensure that all levels of MH/SUD care are covered benefits and that key services – including for MH/SUD emergencies (“crisis”) – to treat MH/SUDs are covered.
2. Require states to demonstrate that their benchmark plans are fully compliant with MHPAEA. As described below, many states benchmark plans were never parity compliant, which has had the effect of permitting MHPAEA non-compliance among qualified health plans (QHPs) and other state-regulated plans.
3. Establish an enforcement structure and process for ensuring that the benchmark plans, and QHPs that are based on the benchmark plans, are compliant with all legal coverage requirements, including, but not limited to parity, EHB, network adequacy and provider directory accuracy.

² Tomko, C., Olfson, M., & Mojtabai, R. (2022). Gaps and barriers in drug and alcohol treatment following implementation of the affordable care act. *Drug and Alcohol Dependence Reports*, 5. <https://doi.org/10.1016/j.dadr.2022.100115>

³ Kohn, R., Ali, A.A., Puac-Polanco, V., Figuero, C., López-Soto, V., Morgan, K., Saldivia, S., & Vicente, B. (2018). Mental health in the Americas: an overview of the treatment gap. *Revista Panamericana de Salud Pública [Pan American Journal of Public Health]*, 42, e165. <https://doi.org/10.26633/RPSP.2018.165>

A. Benefit Descriptions in EHB-benchmark Plan Documents

Problems Created by Benchmark Approach

We agree with CMS that the benchmark approach has created a number of concerns.

We echo CMS's concerns that the EHB-benchmark approach creates a "patchwork" and "disparate coverage nationwide." Reviews of benefits in the benchmark plans have identified significant variation in the MH/SUD benefits offered across the states.⁴ While we appreciate the unique needs of individual states, this level of variation is an unacceptable outcome for a federal law that is intended to improve health care access across the country. More importantly, the variety of coverage means that individuals do not receive the MH/SUD care they need and deserve. As we explain in more detail throughout this letter, we believe CMS should take a more proactive role in establishing minimum standards of coverage for the MH/SUD EHB category, permitting states to vary coverage requirements only to the extent that the proposed requirements exceed the federal standard.

We agree with CMS that the descriptions of the MH/SUD benefits in the EHB-benchmark plans lack detail and transparency and that this creates "ambiguity in defining EHB in a particular State." In order to define EHB and serve as a reference plan, plan documents for EHB-benchmark plans must be thorough and comprehensive and provide easily understood information about the scope of benefits and cost-sharing information. The vast majority of the 2017 EHB-benchmark plans – plans that are still in effect as the benchmark plans in many states – do not meet these requirements.⁵

In addition to the concerns outlined by CMS, we would add that the benchmark approach has perpetuated non-compliance with parity requirements. QHPs must both offer MH/SUD benefits and cover those benefits at parity with medical and surgical benefits within the relevant classifications of care. The insurance plans selected to serve as the states' 2017 EHB-benchmark plans (the benchmark plans still in effect in many states) did not meet MHPAEA requirements, and litigation to enforce MHPAEA has addressed benefit coverage that should now be incorporated and reflected in benchmark plans. While parity compliance cannot be fully

⁴ The National Center on Addiction and Substance Abuse. (2016). Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans. *Drugfree.org*. Retrieved from <https://drugfree.org/reports/uncovering-coverage-gaps-a-review-of-addiction-benefits-in-aca-plans>

Smith, B.T., Seaton, K., Andrews, C., Grogan, C.M., Abraham, A., Pollack, H., Friedmann, P., & Humphreys, K. (2018). Benefit requirements for substance use disorder treatment in state health exchanges. *The American Journal of Drug and Alcohol Abuse*, 44(4), 426-430. <https://doi.org/10.1080/00952990.2017.1411934>

Willison, C.E., Singer, P.M., & Gazier, K.L. (2020). Double-edged sword of federalism: variation in essential health benefits for mental health and substance use disorder coverage in states. *Health Economics, Policy, and Law*, 16(2), 170-182. doi:10.1017/S1744133119000306

⁵ Partnership to End Addiction's review of the 2017 EHB-benchmark plans found that plan documents for 88% of the plans lack sufficient detail to fully evaluate compliance with the ACA requirements and/or adequacy of benefits.

The National Center on Addiction and Substance Abuse. (2016). Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans. *Drugfree.org*. Retrieved from <https://drugfree.org/reports/uncovering-coverage-gaps-a-review-of-addiction-benefits-in-aca-plans>

determined from a review of plan documents, Partnership to End Addiction’s review found a significant number of facial and likely parity violations in the 2017 EHB-benchmark plans.⁶ Although plans modeled on those benchmark plans must comply with parity, Partnership to End Addiction again found many instances of facial and likely parity violations in QHPs sold to consumers in 2017.⁷ Specifically, the Partnership identified:

- A plan offered in Utah in 2017 limited coverage for SUD transitional residential recovery services to three series of treatment, while skilled nursing facility care was limited to 30 days per calendar year.
- Plans offered in New Mexico and D.C. in 2017 covered intermediate medical care in a skilled nursing facility, but excluded comparable intermediate SUD care in a residential treatment facility.
- Mississippi offered a plan in 2017 that explicitly covered partial hospitalization for ; however, as long as the 2017 plan is used as a benchmark, Utah’s EHB will not provide MH/SUD services at parity, and thus have ripple effects on coverage through the state. standards for SUD services that did not exist for medical/surgical services.
- Vermont offered a plan in 2017 that contained an ongoing concurrent review requirement for SUD services that did not appear to exist for medical services.
- Five states offered plans in 2017 that excluded court-mandated services for SUD only.⁸
- Fourteen states offered plans in 2017 that covered methadone for the treatment of pain but excluded coverage of methadone for opioid use disorder (OUD).⁹

⁶ The National Center on Addiction and Substance Abuse. (2016). Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans. *Drugfree.org*. Retrieved from <https://drugfree.org/reports/uncovering-coverage-gaps-a-review-of-addiction-benefits-in-aca-plans>

⁷ Center on Addiction. (2019). Uncovering Coverage Gaps II: A Review and Comparison of Addiction Benefits in ACA Plans. *Drugfree.org*. Retrieved from <https://drugfree.org/reports/uncovering-coverage-gaps-ii-a-review-and-comparison-of-addiction-benefits-in-aca-plans/>

⁸ In 2016, the U.S. Department of Labor (DOL) clarified that examples of NQTLs include exclusions for court-ordered care that would otherwise be medically necessary. Court-ordered treatment exclusions are not permissible under the Parity Act if the exclusion applies only to court-ordered treatment for SUDs.

United States Department of Labor. (2016, October 27). *FAQs about Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation*. Dol.gov. <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf>

⁹ In its Self-Compliance Tool, the Department of Labor clarified that if a plan covers methadone for pain but excludes coverage of methadone for OUD, it must “demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for [OUD] are comparable to and applied no more stringently than those used for medical/surgical conditions.”

United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*. Dol.gov. <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool-2018.pdf>

In 2019, the Department of Health and Human Services (HHS) clarified that excluding a treatment/medication for OUD while covering the treatment/medication for other conditions may also violate the ACA’s prohibition on discrimination, unless supported by clinical guidelines or medical evidence.

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 227, 285 (Jan. 24, 2019).

See also: Vuolo, L. (2019, April 25). The Federal Government Needs To Take Stronger Action To Prevent Discriminatory Coverage Of Methadone. *Health Affairs Forefront*. <https://www.healthaffairs.org/doi/10.1377/forefront.20190418.164447/full/>

A cursory re-review of these states' current benchmark plans indicates many of these parity issues still exist today. Indeed, Utah's benchmark plan – its state employee plan – is currently opted out of MHPAEA and contains blatantly discriminatory MH/SUD coverage provisions. Thankfully, the recently enacted *Consolidated Appropriations Act, 2023* is ending the ability of self-funded non-federal government plans to opt out of MHPAEA; however, as long as the 2017 plan is used as a benchmark, Utah's EHB will not provide MH/SUD services at parity and thus have ripple effects on coverage through the state.

CMS's questions:

1. CMS seeks public comment on its understanding that the ambiguity of covered benefits and limitations in the EHB-benchmark plan documents has not resulted in "overt consumer harm" and "States have generally proven to be effective enforcers of the EHB requirement in ensuring that benefits are still treated as EHB in instances where the EHB-benchmark plan is ambiguous or lacking in detail."
2. To what extent may States require additional guidance to ensure plans are interpreting EHB-benchmark plan documents in a manner that provides EHB

In response to Question 1, we note that you observe that you "do not necessarily believe" that the ambiguity of covered benefits and limitations in the EHB-benchmark plan documents has caused consumer harm because of a lack of consumer complaints. We strongly disagree with this understanding. Using lack of consumer complaints as evidence for lack of consumer harm fails to take into account the reality of consumers who are experiencing MH/SUD challenges. Consumers are often unaware of requirements for health plans to cover MH/SUD benefits and therefore unaware that the health plan may be violating their rights when it denies benefits. In addition, consumers and providers are often not aware of the complaint process or how to file a complaint.

Putting aside the fact that many people do not understand their rights, filing an appeal to challenge their insurer's denial of treatment is challenging, complicated, expensive, and time-consuming. Most importantly, these denials occur during times of crisis when individuals and their families are trying to access life-saving care and unable to engage in a complicated (and often, ineffective) complaints process. We know from our work on parity compliance and enforcement that the lack of consumer complaints is not indicative of the lack of consumer harm. Due to pervasive stigma against individuals with MH/SUDs and historically discriminatory benefit coverage, consumers are less likely to challenge denials of MH/SUD benefits as compared to other medical benefits, in part because consumers are conditioned to expect poor MH/SUD coverage.¹⁰

¹⁰ A 2019 survey of consumers in five states found that while a majority of those surveyed encountered barriers from their health plan when trying to access MH/SUD care, very few filed a complaint with federal or state regulators.

Parity at 10 Campaign. (2019). *Consumer Health Insurance Knowledge and Experience Survey: Report of Findings*. Parityat10.org. <http://parityat10.org/wp-content/uploads/2019/03/Consumer-Health-Insurance-Knowledge-ExperienceSurvey-Report-030719.pdf>

Therefore, we do not believe it is valid for CMS to conclude that no harm has occurred for consumers by relying on consumer complaints as the main mechanism for evaluating EHB compliance and enforcement. This strategy places consumers at risk for illegal and discriminatory denials of life-saving care and shifts enforcement responsibility from CMS and state regulators to consumers who are least able to execute this responsibility, creating an undue and unreasonable burden.

In response to Question 2, we believe States require additional guidance from CMS on (1) redefining EHB and (2) EHB requirement compliance and enforcement. Our specific recommendations are detailed below.

Guidance on Redefining EHB

To address both problems with the current benchmark plans and the concerns created by the benchmark process, we recommend that CMS issue guidance/requirements on redefining EHB by (1) requiring selection of new benchmark plans that are parity compliant; (2) clarifying that any benefits added to the benchmark plans to achieve parity compliance are not subject to the generosity limit or defrayal and (3) establishing a federal definition for the MH/SUD benefit category. We believe the most appropriate way this can be effectuated would be through updated regulations. However, in the event that rules cannot be finalized before the end of the administration, we encourage CMS to have a plan to issue sub-regulatory guidance to state policymakers.

Specifically, absent updated regulations, we recommend that CMS provide guidance to states requiring them to adopt new benchmark plans, that are compliant with parity requirements. As part of this guidance, CMS should make clear that the agency will reject any benchmark plan proposal that fails to demonstrate compliance with parity requirements.

As previously discussed, many states are still relying on the 2017-EHB benchmark plans to define EHB, and many of these plans are non-compliant with ACA and parity requirements and inadequately define EHB. As CMS notes in the RFI, it was not anticipated that “the language used in [the EHB-benchmark plan] plan documents would be used to define the EHB for a state indefinitely.” Therefore, we strongly believe it’s paramount for CMS to articulate the need for states to adopt new benchmark plans.

CMS previously recognized that non-parity-compliant EHB-benchmark plans would not provide a sufficient template for future QHPs but that time constraints precluded states from selecting an MHPAEA-compliant plan.¹¹ Given that this selection occurred nearly a decade ago, it is well past time for states to select benchmark plans that are parity compliant. We recommend that CMS require all states to select a new benchmark plan and demonstrate the benchmark plans are parity compliant. Below, we recommend that CMS establish a process to evaluate

¹¹ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,813 (Feb. 27, 2015).

compliance with parity and other legal requirements in the benchmark plans and QHPs modeled on the benchmarks.

We are aware of a number of instances in which states have considered improving MH/SUD coverage gaps in their state-regulated commercial plans (including QHPs) to help ensure parity, yet are confronted with the question of whether, in fixing MH/SUD coverage gaps that result in discriminatory coverage of MH/SUD for their residents, they will incur costs to the state associated with defrayal. Discriminatory benchmarks and worries about the potential of defrayal have stalled efforts to promote parity compliance and improve coverage in states. Furthermore, states should not find themselves potentially running afoul of the generosity limit by adding benefits that are necessary for parity. As such, we urge CMS to advise states that new benefits added to comply with parity or other federal requirements would not count towards the generosity limit, just as they would not count as new mandates for defrayal purposes.

In addition to requiring states to update their benchmarks to comply with parity requirements and rejecting benchmarks that do not demonstrate such compliance, CMS should establish a federal definition for the MH/SUD benefit category that delineates minimum services that all plans must cover regardless of MH/SUD coverage in the benchmark plan. CMS notes that it “may be unreasonable to expect a State to exhaustively describe all covered benefits and limitations in their EHB-benchmark plan documents.” As such, for the reasons described above, we are concerned that a benchmark plan may be insufficient for defining EHB, necessitating a federal definition. Creating a federal definition is particularly important for the MH/SUD benefit category as these benefits have been poorly defined by the benchmark process, with entire levels of care and core evidence-based services not covered in benchmark plans, and issuers frequently offer benefits that are inconsistent with medically accepted standards.

Further, the requirement for MH/SUD benefits to be covered at parity necessitates the need for CMS to be more prescriptive in defining the benefits that must be covered in this category. The failure to cover the continuum of MH/SUD services in benchmark plans is rampant with no benchmark requiring coverage of all the levels of care described in the American Society of Addiction Medicine’s (ASAM) Criteria or the American Association of Community Psychiatrists’ Level of Care Utilization System (LOCUS). As noted above, the failure to cover intermediate MH/SUD services given coverage of physical health skilled nursing facility coverage is a common parity violation. Each level of care is indispensable within the MH/SUD services continuum, though EHB and the benchmarks do not even acknowledge their existence. This is in large part because CMS set EHB and benchmarks at a time when coverage discrimination against MH/SUD was blatant and endemic.

Several other examples of key services that are not currently required by EHB / benchmark plans include:

- Coordinated specialty care (CSC), which is the evidence base intervention for individuals experiencing early psychosis. CMS, the National Institutes of Health, and SAMHSA

published an information bulletin in 2015 extolling CSC¹², which has been heavily studied as part of the National Institute on Mental Health’s RAISE Study.¹³ Yet, because no benchmark plans cover CSC services, individuals experience devastatingly long periods of untreated psychosis, dramatically increasing their risk of disability and other adverse outcomes. No core evidence-based intervention for youth experiencing the onset of a serious physical health illness (e.g., diabetes) would be systematically denied in the same manner.

- Behavioral health emergency (“crisis”) services. Federal policymakers – including Congress, the Biden Administration, and HHS – have dedicated enormous effort to standing up the 988 Suicide and Crisis Lifeline and expanding behavioral health emergency services, which help people get the help they need and avoid needless, and often tragic, encounters with law enforcement. Yet, while every benchmark includes EMS and emergency transport services, none includes appropriate emergency services for behavioral health. This failure to include behavioral health emergency services under EHB means that many people do not have appropriate coverage of these services. Thankfully, the State of Washington has required its state-regulated plans to cover behavioral health emergency services in order to ensure plans are compliant with MHPAEA requirements. Massachusetts has implemented a similar requirement for mobile crisis services, and the Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc, for 2022 explicitly includes coverage of mobile crisis services¹⁴, yet the 2014-2016 benchmark plan information on CMS’s website does not include such coverage. CMS should require behavioral health emergency services to be covered both to fulfill the promise of EHB and to ensure small group and individual plans are compliant with their MHPAEA responsibilities not to limit coverage of MH/SUD emergency services more stringently than they do for physical health emergency services.

Additionally, among other examples of MH/SUD benefits that should be included in the federal definition are: crisis intervention services (including mobile crisis services and crisis stabilization services, consistent with SAMHSA’s National Guidelines for Behavioral Health Crisis Care¹⁵), intensive case management for coordination of behavioral health services, Assertive Community Treatment, peer support services, supported employment, housing-related activities and services, including individual housing transition services, individual housing, and tenancy sustaining services, Methadone Maintenance Therapy for OUD, all services and levels of care that make up the continuum of MH/SUD care under The ASAM Criteria and Level of

¹² Centers for Medicare and Medicaid Services, National Institute of Mental Health, & Substance Abuse and Mental Health Services Administration. (2015, October 16). *Coverage of Early Intervention Services for First Episode Psychosis* [Joint Informational Bulletin]. Medicaid.gov. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf>

¹³ National Institute on Mental Health. (2022, October). *Recovery After an Initial Schizophrenia Episode (RAISE)*. Nih.gov. <https://www.nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/recovery-after-an-initial-schizophrenia-episode-raise>

¹⁴ Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. (2022). *Schedule of Benefits*. Bluecrossma.com. https://www.bluecrossma.com/common/en_US/ContractAndRiderInformation/pdfs/hseled2000SoB-0123sng.pdf (p. 52)

¹⁵ Substance Abuse and Mental Health Services Administration. (2020). *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*. Samhsa.gov. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

Care Utilization System (LOCUS), including all levels of inpatient, residential, partial hospitalization, intensive outpatient and outpatient. We urge CMS to require that plans have standards in place to ensure these services are always provided in the least restrictive setting possible and that sufficient number of community-based providers are available for all services at all times. In addition, plans' coverage for MH/SUD should be more encompassing for minors because of how vulnerable and susceptible this population is to the risks of behavioral health conditions. We suggest an approach similar to Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, whereby plans would cover all services that are necessary to correct or ameliorate an MH/SUD regardless of whether the plan would otherwise have covered the service.

Guidance on EHB compliance and enforcement

Both the lack of detail in plan documents and CMS' reliance on consumer complaints – or lack thereof – as evidence of EHB compliance hinder an effective compliance and enforcement strategy that is inconsistent with CMS's mission to provide high quality health care and improve health. We strongly urge CMS to adopt the following processes to proactively review benchmark plans and issue guidance to States to ensure they are properly enforcing EHB requirements.

First, CMS should establish a process to review any new benchmark plans selected by the states (or other vehicle to define EHB) to ensure they comply with all applicable requirements. CMS should issue guidance to States on how to apply this process to all plans modeled on the benchmark plans. This process should include a requirement that states submit a robust parity compliance review of each benchmark plan to demonstrate that all benchmark plans, and all plans modeled on the benchmark plans, are parity compliant. As part of this analysis, CMS should not allow any quantitative treatment limitation for MH or SUD benefits within a classification of care that is more restrictive than the quantitative treatment limitation placed on physical health benefits within that classification of care. CMS's process should also include ensuring the benchmark plans contain sufficient benefit descriptions to define EHB (based on the aforementioned federal definition). CMS should establish a review process to ensure that the EHB data collected adequately describes benefits and to require States or plans to submit additional information before plans are modeled on the benchmark. All plans modeled on the benchmark plans should similarly be reviewed by States to ensure plan documents adequately and unambiguously describe covered benefits.

CMS must also develop guidance to ensure States are properly enforcing health plan compliance with all coverage requirements, including EHB, parity, network adequacy and provider directory accuracy (see discussion below). Relying on consumer complaints is an insufficient strategy. CMS must adopt – or require states to adopt – a prospective enforcement and compliance strategy that ensures plans that are sold to consumers comply with the law and prohibit insurers from selling plans that do not meet coverage requirements.

B. Typical Employer Plans

Changes in the scope of benefits offered by employer plans since 2014

CMS's questions:

1. What is the relative generosity of the plans defined as “typical employer plans” in the regulations and whether they are reflective of the scope of benefits provider under employer plans offered in more recent plan years, or whether employer plans offered since 2014 are more or less generous?
2. Are there other employer plans commonly sold in States that are not in the current definition of “typical employer plan”?
3. Have there been changes in State markets since 2014 that warrant changes to

We caution CMS not to interpret the “typical employer plan” as a limiting provision and recommend that it should be read as a minimum number of benefits that plans cover, rather than a ceiling. In the context of MH/SUD benefits, many “typical employer plans” do not adequately cover these services. Given the extraordinary rise in MH/SUD conditions because of the COVID-19 pandemic, the “typical employer plan” of 2014 cannot be compared to the needs of employers in 2023. For example, almost 50% of large employers report an increase in the share of workers using mental health services and approximately 30% of workers are requesting for family leave due to mental health issues.¹⁶ Additionally, 43% say they’re somewhat concerned about the growth of SUD conditions among their workers.¹⁷ Troublingly, one-third of large employers say their networks do not have enough behavioral health providers to ensure timely access to care.¹⁸ It is important for CMS to go beyond the offerings of a typical employer plan in defining EHB. If the benefits covered by a typical employer plan become less generous over time, the benefits offered under EHB should not become less generous as well.

We believe this interpretation of the statutory language is essential for the EHB requirement to be meaningful. In passing the ACA, Congress intended for gaps in coverage to be closed, particularly for benefits that had been traditionally excluded from insurance coverage, such as MH/SUDs. Using typical employer plan coverage as a ceiling would disrupt this intention and would continue to leave individuals with MH/SUDs at risk. CMS has already recognized as such when, in the last iteration of the benchmarking process rules, it established typical employer coverage as the floor or minimum required coverage for States seeking to change their benchmark plans.¹⁹ A similar approach should be used when considering typicality at the federal level.

¹⁶ Claxton, G., Rae, M., Wager, E., Young, G, Whitmore, H., Kerns, J., Shmavonian, G., & Damico, A. (2022). *Employer Health Benefits: 2022 Annual Survey*. Kaiser Family Foundation. <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf>

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ 45 C.F.R. § 156.111(b)(2)(i) (2023).

C. Review of EHB

1. Barriers of accessing services due to coverage or cost

CMS's question:

1. Are there significant barriers for consumers to access MH/SUD services, including behavioral health services that are EHB?

There are significant barriers for consumers to access MH/SUD services that are EHB. There are many studies that point to barriers to access for MH/SUD services. National data consistently shows that 40 percent of all people with untreated mental health problems say they did not get treatment because they could not afford it, while another 22 percent said their insurance plans either did not cover mental health treatment at all or offered insufficient coverage.²⁰ Similarly, approximately 25 percent of people with untreated SUD say they did not receive care because they did not have health coverage and could not afford cost, and 12% said their plan did not cover SUD treatment or offered insufficient coverage.²¹ As previously discussed, the benchmark process contributes to this lack of access by not sufficiently defining the specific benefits that need to be covered in this category (see prior discussion on benefit description). In addition, consumers face barriers related to prior authorization requirements and other utilization management requirements, restrictive medical necessity criteria that are not based on generally accepted standards of care and inadequate provider networks, based on low reimbursement rates, contract standards and network admission practices which cause consumers to self-ration care because of higher out-of-network costs.

A 2019 Milliman report²² examined in network use and provider reimbursement for MHSUD versus physical health and found staggering disparities including:

- 85% increase in how often behavioral inpatient facilities are utilized out of network relative to medical/surgical providers in a 5-year study period.
- Out of network utilization rate for behavioral health residential treatment facilities was over 50%.

²⁰ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2021). *2020 National Survey on Drug Use and Health, Table 8.33B Detailed Reasons for Not Receiving Mental Health Services in the Past Year: Among People 18 or Older with a Perceived Unmet Need for Mental Health Services in the Past Year; by Receipt of Past Year Mental Health Services, Percentages, 2019 and 2020*. Samhsa.gov. <https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/NSDUHDetTabs8-33pe2020.pdf>

²¹ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2023). *National Survey on Drug Use and Health, 2021: Table 5.41B Detailed Reasons for Not Receiving Substance Use Treatment in Past Year: Among People Aged 12 or Older Classified as Needing But Not Receiving Substance Use Treatment at a Specialty Facility and Who Perceived a Need for Substance Use Treatment in Past Year; Percentages, 2021*. Samhsa.gov. <https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect5pe2021.htm#tab5.41b>

²² Melek, S., Davenport, S., & Gray, T.J. (2019). *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*. Milliman. <https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx>

- Primary care reimbursement rates were 23.8% higher than behavioral health reimbursements.
- A behavioral healthcare office visit for a child was 10.1 times more likely to be out of network than a primary care office visit.
 - This is more than twice the disparity seen for adults.

We appreciate CMS’ work to improve access to MH/SUD as seen in the Notice of Benefit and Payment Parameters for 2023 final rule, which seeks to apply distance metrics and wait time for appointments for MH/SUD and reviews will begin in 2024; however, we also encourage guardrails around adequate reimbursement, ensuring any guardrails also apply to third-party administrators (TPAs), and takes into consideration all levels of care.

2. Telehealth

CMS’s questions:

1. How has utilization of telehealth impacted access to behavioral health services that are EHB, particularly during the COVID-19 pandemic?
2. How could telehealth utilization better address gaps in consumer access to EHB for behavioral health or other health care services?
3. What strategies have plans implemented to broaden access to telehealth services?

We believe that telehealth holds significant promise in terms of expanding access to MH/SUD benefits in the context of QHPs. Telehealth is a growing, effective way to provide MH/SUD care when patients and providers are in different physical locations. Virtual access to MH/SUD services continues to fill a great need and improve access to care for individuals without transportation, individuals in communities where there are no local treatment options for specialized care, individuals residing in areas with inclement weather, and for individuals with co-occurring conditions that make it feasible to participate in treatment from home whereas their condition would normally result in a no-show appointment. For MH conditions that need specialty care such as eating disorders, studies show in-person versus virtual therapy in outpatient eating disorder treatment find short-term clinical outcomes (i.e., eating symptoms, levels of weight gain (as applicable), and patient satisfaction with services) were comparable.²³ In some populations, like children and adolescents, it may also create a better experience than traditional therapy sessions. Additionally, telehealth can increase access to culturally competent and clinically specific clinicians for underserved individuals.

However, the National Association of Insurance Commissioners (NAIC) found that while telehealth has the greatest potential to increase access to care for disadvantaged, underserved and rural communities who face barriers to care due to geography (patients isolated from

²³ Steiger, H., Booij, L., Crescenzi, O., Oliverio, S., Singer, I., Thaler, L.; St-Hilarie, A., & Israel, M. In-person versus virtual therapy in outpatient eating-disorder treatment: A COVID-19 inspired study. *International Journal of Eating Disorders*, 55(1), 145-150. <https://doi.org/10.1002/eat.23655>

providers) and transportation, such communities disproportionately face barriers to telehealth including lack of broadband access and digital literacy limitations.²⁴

Telehealth has played a critical role in helping people with MH/SUD continue to get care over the course of the COVID-19 pandemic. Importantly, unless guidance from the agency is given, we are concerned that service modality will become an additional way care is denied or delayed. As the Public Health Emergency is expected to end in April, we have started to see payers pulling back coverage for telehealth in discriminatory ways. For example, one payer in Massachusetts decided to cut telehealth reimbursement rates for medical nutrition therapy by 20% for conditions the company deemed a non-chronic condition. All eating disorder subtypes, celiac disease, and irritable bowel syndrome did not make the list. This stunning decision fails to account for the patient and provider relationship, especially in the context of a pandemic. Currently, telehealth sessions are more “face-to-face” than in-person, masked sessions. Via video, patients and providers can see each other’s facial expressions to aid in support and communication, critical for the work dietitians do. This is absent in so called face-to-face, masked in-person encounters, which are being preferentially covered. This arbitrary policy also fails to consider the medical needs of providers that are still providing care but may be immunocompromised and prefer telehealth visits.

It is important to note that telehealth is a platform for service delivery, not a discrete benefit. Plans should maintain a hybrid model in which all methods of service delivery, including in-person and telehealth, should be covered allowing consumers to elect how to receive services, in consultation with their provider. CMS should also ensure that any standards related to coverage for telehealth conform to other proposed regulatory standards, such as those proposed by SAMHSA on Medications for the Treatment of Opioid Use Disorders, 42 CFR Part 8, including initiation of buprenorphine treatment by audio-visual and audio-only telehealth and methadone treatment by audio/visual telehealth. The benchmark plans, and QHPs based on benchmark plans, should clearly describe the services that are available via telehealth and any limitations that may exist (e.g., providers, telehealth platforms, access to in-person network services and any gatekeeping through telehealth first).

Some plans have implemented strategies to broaden access to telehealth services by offering “telehealth only” or “telehealth first” coverage, which bars or limits access to in-person care. As CCIO noted in its Benefit and Payment Parameter standards for 2023 plans, telehealth should supplement not replace in-person services and more analysis is required to assess whether telehealth services should be counted to “satisfy” network adequacy requirements. We greatly appreciate CMS’s acknowledgement of this dynamic and continue to strongly support the agency’s Notice of Benefit and Payment Parameters final rule that ensures that telehealth services do not displace the availability of in-person care and that to count towards the standards, providers must have in-person services available.

²⁴ Edmiston, K.D., & AlZuBi, J. (2021). *An Overview of Telehealth and Its Implications for Health Disparities*. National Association of Insurance Commissioners.
https://content.naic.org/sites/default/files/national_meeting/Telehealth%20and%20Health%20Disparities.pdf

3. Cost-Controlling Measures

CMS's questions:

1. What strategies have consumers and providers seen plans implement to reduce utilization and costs, such as use of prior authorization, step therapy?
2. Are these strategies to reduce utilization and costs applied broadly or targeted to a specific area?
3. Are there geographical differences in strategies plans use to reduce utilization and costs within a State?
4. Are these tools effective or ineffective?
5. Do these tools curb or complicate access to medically necessary care?

As organizations that represent consumers and providers, we have seen plans implement a number of strategies to reduce utilization with the goal of controlling costs, not improving health. Some of the most common strategies include: prior and continuing authorization requirements, step therapy, restrictive medical necessity criteria, narrow and restrictive networks (also “ghost” networks). While these tools may be “effective” for plans seeking to control costs and utilization of services, they inhibit access to medically necessary care and harm patients by delaying or prohibiting patients from obtaining oftentimes life-saving care.

Despite the routine use **prior authorization and continuing authorization requirements**, these hurdles create oftentimes insurmountable barriers for individuals seeking MH/SUD treatment. Prior authorization requirements can delay the initiation of care at the critical moment a patient needs treatment and continuing authorization requirements can disrupt ongoing care. Engaging and retaining patients in MH/SUD treatment can be difficult because MH/SUDs can affect insight, motivation and decision-making, creating narrow and shifting windows in which a patient is motivated to engage in treatment. Requesting and obtaining prior and continuing authorization can impose delays and disruptions of care, which can lead to serious consequences for patients, including failing to return for subsequent appointments, stopping the use of medications, resuming substance use, medical complications, overdose and death. Health plans impose prior and continuing authorization requirements on a range of MH/SUD services, particularly services that are more intensive, such as residential treatment and inpatient psychiatric hospitalizations.²⁵ Notably, MHPAEA prohibits health plans from imposing prior and continuing authorization requirements on MH or SUD benefits that are more restrictive than those requirements imposed on comparable medical benefits. Partnership to End Addiction found that a majority of the 2017 EHB-benchmark plans required prior authorization for SUD services.²⁶

²⁵ Becker, J., Accordino, R., & Hazen, E. (2020, October 23). Prioritizing The Elimination Of Prior Authorizations For Inpatient Psychiatric Care. *Health Affairs Forefront*. <https://www.healthaffairs.org/doi/10.1377/forefront.20201020.957372/full/>

²⁶ The National Center on Addiction and Substance Abuse. (2016). Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans. *Drugfree.org*. Retrieved from <https://drugfree.org/reports/uncovering-coverage-gaps-a-review-of-addiction-benefits-in-aca-plans>

Recognizing the harms that these requirements impose on patients seeking MH/SUD care, a number of states have prohibited or restricted the use of prior and/or continuing authorization for a range of SUD services and medications in both Medicaid and state-regulated private health plans.²⁷ Many MH/SUD providers are out of network, because they find these plan processes burdensome; therefore, addressing them is critical to addressing the overall workforce shortage problem. Ideally, CMS should prohibit the use of prior authorization for MH/SUD benefits in the QHPs under its authority to define EHB. At a minimum, CMS should urge states to remove prior authorization for MH/SUD through the benchmarking process while emphasizing that doing so would not count against the generosity limit when done to comply with parity. CMS and State regulators should evaluate continuing authorization requirements during the aforementioned parity compliance review and ensure that any continuing review requirements imposed by plans on MH/SUD benefits are parity compliant.

Health plans' use of **step therapy** also prevents patients from being able to access the treatments they need in a timely manner that can paradoxically increase costs. Step therapy results in insurers requesting or requiring patients to demonstrate unsuccessful treatment on one or more insurer-preferred medications before they receive coverage for the medication that their physician recommends. This practice, also known as "fail first," can be a danger to the health and well-being of the person taking the medication. One study of Maine's Medicaid program found that the state's prior authorization and step therapy policy for second-generation antipsychotics was associated with a 29% greater risk of treatment discontinuity, and no associated cost savings for patients with schizophrenia.²⁸ Step therapy contributes to medication access problems that greatly risk patient safety, and are ultimately associated with greater health care services utilization and costs, the social services sector, and criminal justice sector.²⁹ We recommend that CMS and State regulators ensure that any step therapy requirements imposed on mental health or substance use disorder coverage are reviewed for parity compliance.

Health plans also use **restrictive medical necessity criteria** to reduce utilization and costs, denying patients access to affordable, life-saving care. Health plans have significant discretion in selecting and applying medical necessity criteria for MH/SUD benefits, which has allowed for significant variation in how plans make medical necessity determinations for these services. Frequently, health plans use medical necessity criteria that are inconsistent with generally accepted standards of care (GASC). When health plans make utilization review decisions based on flawed medical necessity criteria that place plans' economic self-interest ahead of enrollees' needs, enrollees are denied critical coverage that put services out of reach. Such criteria –

²⁷ Partnership to End Addiction, & the Legal Action Center. (2020). *Spotlight on Legislation Limiting the Use of Prior Authorization for Substance Use Disorder Services and Medications*. Drugfree.org. <https://drugfree.org/reports/spotlight-on-prior-authorization/>

²⁸ Soumerai, S.B., Zhang, F., Ross-Degnan, D., Ball, D.E., LeCates, R.F., Law, M.R., Hughes, T.E., Chapman, D., & Adams, A.S. (2008). Use of atypical antipsychotic drugs for schizophrenia in Maine Medicaid following a policy change. *Health Affairs*, 27(Supplement 1). <https://doi.org/10.1377/hlthaff.27.3.w185>

²⁹ West, J.C., Wilk, J.E., Rae, D.S., Muszynski, I.S., Stipek, M.R., Alter, C.L., Sanders, K.E., Crystal, S., & Regier, D.A. (2009). Medicaid prescription drug policies and medication access and continuity: findings from ten states. *Psychiatric Services*, 60(5), 601-610. <https://doi.org/10.1176/ps.2009.60.5.601>

either developed by health plans or purchased/licensed from third-party for-profit vendors – are used by plans to inappropriately restrict access to covered benefits that enrollees need simply by declaring that such services are “not medically necessary.” These criteria are inconsistent with GASC and frequently limit coverage to services to reduce acute symptoms only, denying coverage of ongoing treatment that is necessary to treat enrollees’ often chronic condition. These criteria are also inconsistent with criteria from nonprofit professional associations, which reflect GASC, such as The ASAM Criteria from the American Society of Addiction Medicine and the Level of Care Utilization System from the American Association of Community Psychiatrists.

Plans also “limit covered MH/SUD services to a subset of MH/SUD diagnoses or may require a level of need that exceeds the need required under most accepted MH/SUD standards of care.”³⁰ Health plans have often failed to disclose their medical necessity criteria and reasons for denial of services, even though federal regulatory standards establish disclosure requirements. These practices make it difficult for patients and providers to challenge denials for service authorizations or claims based on medical necessity. Some states require health plans to use specific medical necessity criteria, and in some cases, level of care assessment tools when applying the medical necessity criteria.³¹ CMS should require that MH/SUD medical necessity criteria align with GASC and require plans to use The ASAM Criteria, LOCUS and CALOCUS-CASII (for children and adolescents) when making levels of care determinations for MH/SUD care.

Plans also use **narrow provider networks** to reduce costs and utilization of services. Although the ACA requires QHPs to maintain adequate provider networks,³² many QHPs have closed or narrow networks, which forces enrollees to seek much more expensive services out of network or go without treatment altogether.³³ This is particularly problematic given that many MH/SUD providers do not participate with insurance.

We appreciate that CMS has issued federal standards for 2023 with time and distance and wait time requirements. These standards, however, must be enforced to be effective and compliance must be based on accurate data. CMS’s current auditing of network adequacy includes secret shopper and audits of a few plans with no penalty for non-compliance. Plans are incentivized to continue including providers who are not actually seeing patients because the benefits outweigh the risks. A recent analysis of network adequacy policy efforts concluded that state laws and regulations regarding provider directories and network standards without strong enforcement has been unsuccessful in changing plan behavior.³⁴

³⁰ See *Wit v. United Behavioral Health*, Brief amicus curiae of Nat’l Health Law Prog., et al., 26 May 2021, <https://healthlaw.org/resource/wit-v-united-behavioral-health-care-u-s-court-of-appeals-ninth-circuit/>.

³¹ Partnership to End Addiction, & the Legal Action Center. (2020). *Spotlight on Medical Necessity Criteria for Substance Use Disorders*. Drugfree.org. <https://drugfree.org/reports/spotlight-on-medical-necessity-criteria-for-substance-use-disorders/>

³² 45 C.F.R. § 156.230(a) (2022).

³³ Pollitz, K. (2022, February 4). *Network Adequacy Standards and Enforcement*. Kaiser Family Foundation. <https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/>

³⁴ Burman, A. (2021). Laying ghost networks to rest: combatting deceptive health plan provider directories. *Yale Law & Policy Review*, 40, 78-148. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3869806

Recent studies have found that behavioral health providers listed in Medicaid directories and counted toward network adequacy have not billed claims. In Oregon, for example, researchers found that 67% of mental health prescribers and 60% of non-prescribers in the network directories had not billed five claims and were not seeing Medicaid patients.³⁵ CMS should require verified information, either audited by an independent entity or verified as having filed a minimum number of claims under the plan.

Within CMS's current enforcement work, we strongly recommend MH/SUD should be its own category and penalties for non-compliance and transparency should be increased. The current CMS report on **provider directory accuracy** does not indicate which plans were found non-compliant and does not specifically report on MH/SUD. Looking over the five years of auditing, plans continue to have low rates of compliance with less than half the providers (47%) having accurate and up to date information in 2021.³⁶ Given other secret shopper surveys, we can predict that the rate of accuracy is worse for MH/SUD. Given that plans have been required to have accurate data for over five years, CMS needs to revise its enforcement strategy to specifically address MH/SUD and ensure that plans are incentivized to comply through greater requirements for audited or verified by claims data, transparency of which plans have been audited, and penalties.

CMS is also piloting transparency measures for acute hospital and primary care.³⁷ Given the importance of MH/SUD in driving mortality rates and the high percentages of the population affected by these conditions, MH/SUD should be added, and CMS should look to the share of all providers, not just those in the QHP, and include out-of-network providers billing to private insurers. CMS should also require plans to have sufficient number of community-based providers to ensure appropriate care in the coverage area, better define network adequacy standards and enforce requirements for plans to maintain adequate networks and accurate provider directories.

³⁵ Zhu, J., Charlesworth, C.J., Polsky, D., & McConnell, J.K. (2022). Phantom networks: Discrepancies between reported and realized mental health care access in Oregon Medicaid. *Health Affairs*, 41(7). <https://doi.org/10.1377/hlthaff.2022.00052>

³⁶ Department of Health and Human Services, Centers for Medicare & Medicaid Services, The Center for Consumer Information and Insurance Oversight (CCIIO). Machine-Readable Provider Directory Review Summary Report Plan Years 2017-2021. March 22, 2022. <https://www.cms.gov/files/document/2017-2021mrpdsummaryreportfinal508.pdf>

³⁷ Pollitz, K. (2022, February 4). *Network Adequacy Standards and Enforcement*. Kaiser Family Foundation. <https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/>

4. *Changes in medical evidence and scientific advancement*

CMS questions:

1. Does EHB need to be modified or updated to account for changes in medical evidence or scientific advancement?
2. What changes in medical evidence and scientific advancement have occurred since 2014 that are not reflected in the current EHB-benchmark plans?
3. Are there benefits widely covered as EHB that are not supported by current medical evidence?
4. Are there other barriers to incorporating changes in medical evidence and scientific advancement into EHB?
5. How can EHB better track with changes in medical evidence and scientific advancement?
6. What steps should be taken to address EHB that are not supported by current medical evidence?

Overall, there needs to be better alignment of MH/SUD benefits with medical/scientific evidence. As described above, few plans cover the full continuum of care (particularly intermediate services) or core evidence-based services such as methadone for OUD, coordinated specialty care for early psychosis, or crisis services for MH/SUD emergencies.

In addition, the science around treatment for MH/SUDs is rapidly evolving. To ensure that CMS accounts for these changes, Congress gave the agency explicit authority and responsibility to periodically review and update EHB coverage.³⁸ To our knowledge, CMS has not conducted such a review and submitted a report to Congress to date. We believe doing so is essential in order to pursue policies that improve health equity and expand access to affordable MH/SUD coverage and care.

Because of the evolving nature of MH/SUD treatment, CMS should establish a consistent framework for periodically reviewing and updating EHBs that involves a standard review process to ensure benefits that align with medically accepted standards of care are covered as well as a new benefit analysis to determine whether to add new benefits based on changes in medical evidence or scientific advancement. This is not only a statutory requirement but also sound public policy. The process for review of the EHB must be transparent, with mechanisms in place to allow for regular and meaningful public review and comment. The EHB review and updating process should be consumer-focused and data-driven to identify and address EHB coverage gaps and close health disparities. This approach implements the ACA's commitment to "protect and strengthen Medicaid and the ACA and to make high-quality healthcare accessible and affordable for every American," and "advance equity for all, including people of color and others who have been historically underserved."

³⁸ 42 U.S.C. § 18022(b)(4)(H) (2021).

5. Changes in medical evidence and scientific advancement and health equity

CMS questions:

1. How could changes in medical evidence or scientific advancement inform CMS' health equity and nondiscrimination efforts w/r/t EHB (e.g., Lack of coverage for treatment informed by scientific advancements in certain areas of health care resulting in disproportionate impact on consumers)?
2. How can EHB adapt to more quickly address pressing public health issues (including the overdose epidemic)?
3. What are the barriers for third-parties (family members and caregivers) to obtain naloxone?
4. How should EHB advance health equity by taking into consideration economic, social, racial or ethnic factors that are relevant to health care access?
5. How could EHB better address health conditions that disproportionately affect underserved populations or large parts of the American population?

MH/SUD services are considerably underutilized by BIPOC communities, LGBTQ+ individuals, and other individuals of non-dominant identities, underscoring significant gaps in access to effective services. This indicates that updating EHB requirements to improve access to important MH/SUD services is key to addressing health disparities. CMS should use EHB as a vehicle to achieve behavioral health equity. CMS should ensure meaningful stakeholder engagement, including participation of representatives from underserved and disenfranchised populations, to assist in reviewing and updating EHB, including BIPOC, persons with disabilities, members of tribal communities, LGBTQ+ persons, and other underrepresented communities. In addition, CMS should ensure that States are consistently collecting data with regards to demographics and utilization of MH/SUD services among individuals with EHB-compliant plans. Collection of such data is key for CMS and States to make meaningful changes to their EHB coverage and address remaining gaps.

In response to question 2, emergency services should explicitly include evidence-based services for the treatment of SUD and OUD, including screening and diagnostic assessment, offer of opioid agonist medication for individuals in opioid withdrawal and untreated moderate to severe OUD and facilitated referral to treatment in the community, along with naloxone. Delivery of evidence-based services will help address racially disparate rates of utilization of MOUD.³⁹

In response to question 3, the barriers for third-parties (family members and caregivers) to obtain naloxone include: denial and misconceptions about a loved one's risk for overdose;

³⁹ Weber E., & Freidman, S. (2021). *Emergency: Hospitals Can Violate Federal Law by Denying Necessary Care for Substance Use Disorders in Emergency Departments*. Legal Action Center. <https://www.lac.org/resource/emergency-hospitals-can-violate-federal-law-by-denying-necessary-care-for-substance-use-disorders-in-emergency-departments>

stigma and confidentiality concerns; lack of knowledge about how to obtain naloxone; and out-of-pocket costs.⁴⁰

In response to question 5, EHBs can help advance health equity and better address the MH/SUD needs of underserved populations by supporting crisis services, as we further outline in the following section. Our current emergency response system is not designed to meet the needs of those experiencing an MH/SUD crisis, and unlike medical conditions, our response to mental health, substance use or suicide crisis is rooted in law enforcement and criminal justice. This is particularly true for communities of color, and too often leads to avoidable, tragic outcomes. Black people with a mental health diagnosis are more likely to be incarcerated than any other race, and racial/ethnic minority youth with behavioral health issues are more readily referred to the juvenile justice system than to specialty primary care, compared with white youth.⁴¹ These encounters further highlight longstanding racial discrimination and a need to apply an equity lens to crisis response. Crisis response systems work to decriminalize mental illness and create new points of entry to care that are not reliant on law enforcement.

6. Address gaps in coverage

CMS questions:

1. Are there examples of benefits that are essential to maintaining health, including behavioral health, that are insufficiently covered as EHB but that are routinely covered by other specific health plans or programs, such as employer-sponsored plans, Medicare and Medicaid?
2. Does EHB cover screening, consultative, and treatment modalities that supports the integration of both mental health and substance use disorder services into primary care?
3. Is there sufficient coverage as EHB of emergency behavioral health services, including mobile crisis care and stabilization services?
4. Is there sufficient coverage as EHB for other levels of care, such as crisis prevention and care coordination for behavioral health services?
5. Do plans that provide EHB include peer and recovery support services for behavioral health services?
6. How can CMS balance state flexibility with statutory requirement to ensure sufficient coverage for a diverse population, including those living in rural areas who may have limited provider types available?
7. What other strategies could be implemented to modify EHB to address gaps in coverage or changes in the evidence base?

⁴⁰ Slocum, S., Ozga, J.E., Joyce, R. Walley, A.Y., & Pollini, R.A. (2022). If we build it, will they come? Perspectives on pharmacy-based naloxone among family and friends of people who use opioids: a mixed methods study. *BMC Public Health*, 22, 735. <https://doi.org/10.1186/s12889-022-13078-z>

⁴¹ American Psychiatric Association. *Mental Health Disparities: Diverse Populations*. Psychiatry.org. <https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts>

Emergency Behavioral Health Services

As described above, a glaring coverage gap, particularly given the priority that HHS is rightfully placing on the 988 Suicide and Crisis Lifeline and behavioral health crisis (i.e., emergency) services, is EHB's failure to cover services that make up the behavioral health emergency services continuum of care.

Effective July 2022, 988 became available nationwide as an easy-to-remember number to help people in a mental health, substance use or suicide crisis. But 988 is only the first step to fulfilling an ideal vision to help people in crisis. That vision also includes mobile crisis teams offering an in-person MH/SUD crisis response and crisis stabilization options that provide short-term de-escalation and care, per SAMHSA's National Guidelines. Ensuring that QHPs offer these services will help ensure that all people in a MH/SUD crisis receive a MH/SUD response, regardless of where they live.

The full continuum of crisis response services is often funded through a patchwork of dedicated local (state/county) funds and federal grant dollars. Thankfully, states now have an option to use Medicaid, at an enhanced matching rate, to reimburse for mobile crisis teams. State Medicaid programs can also provide coverage of crisis stabilization services. Medicare will also start paying for mobile crisis psychotherapy at an enhanced rate. Unfortunately, QHPs as a general rule do not provide robust coverage of these services, leaving a large hole in financing to scale up services to meet large need. Even where the No Surprises Act's (NSA) strong coverage mandate now exists for behavioral health crisis and stabilization services (which are provided in "independent freestanding emergency departments" that are providing "emergency services," as defined by the NSA), coverage is not yet a reality despite clear federal requirements. This seems, at least in part, because health plans do not see these services listed in state benchmarks, even though they are required covered benefits under the NSA.

Despite promising coverage in state Medicaid programs, health plans are also systematically failing to cover mobile crisis response services, a critical part of the behavioral health emergency services continuum. Mobile crisis response services are critical to preventing unnecessary law enforcement encounters, involvement in the criminal legal system, emergency department visits, and hospitalizations. Notably, while every benchmark plan includes EMS/emergency transport, none includes mobile crisis response services. To ensure appropriate coverage, CMS should specify that EHB for MH/SUD services includes both mobile crisis response and crisis receiving/stabilization services. We also urge CMS to take steps to eliminate enrollee cost-sharing burdens for mobile crisis response services, which can be significant, either through EHB rules or by supplementing QHP coverage with federal funding sources for these services.

Furthermore, CMS should require that, to ensure parity between physical health emergency services and behavioral health emergency services, states must cover behavioral health emergency services using the same standards as for physical health emergency services. This includes requiring coverage based on a prudent layperson standard and without regard to

provider network status, limiting enrollee cost-sharing to the same amount as for physical health emergency services, and prohibiting prior authorization. The State of Washington Insurance Commissioner recently issued a memo explaining why Washington’s new coverage requirement for behavioral health emergency services ensures that plans are meeting their obligations under MHPAEA.⁴²

Care Integration

Integrating MH/SUD and physical health care is essential to improving access and outcomes, yet key evidence-based models are frequently not covered. For example, the Collaborative Care Model (CoCM), which has shown to be effective in treating common mental health conditions such as depression and anxiety by more than 80 randomized controlled trials, is underutilized.⁴³ Set in primary care settings, the CoCM has a three-person care team, including the primary care provider, a psychiatric consultant, and a behavioral health care manager. Unfortunately, we are not aware of any benchmark plans that require coverage of this model. We urge CMS to include in EHB a requirement that the CoCM be covered. By expanding reimbursement for this model, CMS can help reach more people who need MH/SUD services and more efficiently utilize the existing workforce.

Peer support services

With respect to coverage of peer support services, a recent publication by the Behavioral Health Excellence Technical Assistance Center (BHE-TAC) on billing practices for peer support services concluded, “Behavioral Health-centered Peer Support services are now generally accepted practice among public payers, and becoming more accepted by private, third-party payers.”⁴⁴ The BHE-TAC document gives examples of how coverage is expanding in private plans with in-person and virtual options.⁴⁵ We are unaware of any study looking specifically at ACA plans within the private market and urge the federal government to fund such a study.

Peer support services are an evidence-based service delivered by individuals and family members with lived experience of recovery from a mental health and/or substance use condition or lived experience as a parent of a child with emotional, developmental, substance use and/or mental health concerns. Peer support providers are trained in skills that enable them to use their lived experience to engage individuals and families with these conditions in developing goals and choosing services and supports to meet those goals.⁴⁶ Peer support

⁴² Beyer, J. (2022, May 6). *Behavioral Health Emergency Services Under E2SHB 1688 (Chap. 263, Laws of 2022)* [Memorandum]. Office of the Insurance Commissioner, Washington State. <https://www.insurance.wa.gov/sites/default/files/documents/e2shb-1688-mhpaea-memo.pdf>

⁴³ AIMS (Advancing Integrated Mental Health Solutions) Center. University of Washington. “Collaborative Card.” <https://aims.uw.edu/collaborative-care>.

⁴⁴ Behavioral Health Excellence Technical Assistance Center. (2022). *Peer Support Billing Pathways*. National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2022-10/HRSA_Peer_Support_Billing_Pathways_2022_08_FINAL.pdf

⁴⁵ Id. at 17.

⁴⁶ See id. for further definitions of peer support providers and peer support services.

providers are credentialed providers and must have state certification after completing training and supervised practice as a peer support provider for mental health, substance use or both conditions.

Medicaid has covered peer support services for over a decade. CMS and SAMHSA have strongly encouraged states to offer these services through the Medicaid program and jointly issued a 2007 Dear State Medicaid Director letter on peer support services.⁴⁷ According to a recent GAO study, 37 states offer SUD peer support services as part of their Medicaid programs.⁴⁸ Medicare has recently expanded access to peer support providers as part of integrated care and crisis teams and by clarifying that they can bill as auxiliary personnel incident to other providers.⁴⁹

A comprehensive report by Optum indicated strong outcomes from state Medicaid peer support programs.⁵⁰ After implementing a whole health peer coaching program in Michigan, average medical outpatient services for the population served declined by 17.56 visits and an average reduction in costs of \$3,191. Average inpatient admits also declined by 1.87, with a demonstrated cost reduction of \$19,283. Another peer program targeted at individuals who had been hospitalized or were currently hospitalized demonstrated a 66% reduction in behavioral health acute inpatient admissions six months pre- or post-engagement. There was an average cost savings of \$280 per admission. The program also achieved significant reductions in physical health/medical admissions and costs.

The Administration should take several steps to ensure effective peer support services across payers including carefully defining the scope of the services provided by peer support providers, developing training for supervisors, clarifying the ability of peers to be supervisors, and eliminating barriers such as prior authorization processes that deny peer support services for many who need them. Taking these steps while continuing to expand coverage across payers will increase access to this cost-effective service and improve outcomes.

⁴⁷ Smith, D.G. (2007, August 15). *SMDL #07-011* [State Medicaid Director Letter from the Centers for Medicare and Medicaid Services]. Centers for Medicare and Medicaid Services. <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf>

⁴⁸ United States Government Accountability Office. (2020). *Substance Use Disorder: Medicaid Coverage of Peer Support Services for Adults*. Gao.gov. <https://www.gao.gov/products/gao-20-616>

⁴⁹ Seshamani, M., & Jacobs, D. (2022, November 1). Strengthening Behavioral Health Care for People with Medicare. *Centers for Medicare and Medicaid Services Blog*. <https://www.cms.gov/blog/strengthening-behavioral-health-care-people-medicare-0>
The Appropriations bill for FY'23 required CMS to conduct outreach and education of providers on how to bill peers in integrate care and crisis settings.

⁵⁰ Optum. (2020). *Peer Support: Its Impact on Behavioral Health Recovery*. Optum.com. <https://www.optum.com/content/dam/optum4/resources/pdf/peer-support-its-impact-on-behavioral-health-recovery-white-paper.pdf>

D. Coverage of Prescription Drugs as EHB

CMS questions:

1. What are the risks and benefits of replacing United States Pharmacopeia Model Guidelines with another drug classification system?
2. Should CMS use another drug classification system such as USP Drug Classification?

The current federal minimum standard for EHB prescription drug coverage is inadequate. We strongly recommend that CMS use its authority to require QHPs to cover a minimum of two drugs per USP category and class (rather than one) and “all or substantially all” drugs in the six protected classes as required through Medicare Part D. Medicare Part D requirements have been critical in ensuring access to anti-psychotics and anti-depressants and given the Administration’s strong support for ensuring access, this would be a critical and impactful change for beneficiaries with these conditions.

Medications used for the treatment of opioid use disorders (MOUD) and opioid reversal agents (e.g., naloxone) should be added to the list of protected classes of drugs and QHPs should be required to cover all of these medications. In the Notice of Benefit and Payment Parameters, CMS suggested that QHPs should cover all forms of MOUD⁵¹ but we strongly encourage CMS to go further and require coverage of MOUD and opioid reversal agents, without limitations (such as prior authorization, step therapy, concurrently counseling, etc.) under the prescription drug or MH/SUD EHB requirement.

In selecting a new drug classification system, CMS should be careful to ensure that there is a requirement to cover methadone for OUD, either under the prescription drug or MH/SUD EHB as methadone has been widely excluded in the QHPs.⁵²

⁵¹ HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 227, 285 (Jan. 24, 2019).

⁵² Vuolo, L. (2019, April 25). The Federal Government Needs To Take Stronger Action To Prevent Discriminatory Coverage Of Methadone. *Health Affairs Forefront*. <https://www.healthaffairs.org/doi/10.1377/forefront.20190418.164447/full/>

Thank you again for recognizing the need to collect information on how the current process for establishing essential health benefits is impacting people across the country. We believe CMS has an important opportunity to update regulations and increase access to desperately needed MH/SUD services. We hope you have found these comments helpful. If you would like to discuss these comments, please contact David Lloyd (David@thekennedyforum.org) and he will coordinate on behalf of all the undersigned organizations.

Sincerely,

2020 Mom (Policy Center for Maternal Mental Health)
American Foundation for Suicide Prevention
The Carter Center
Community Catalyst
Eating Disorders Coalition for Research, Policy & Action
Faces & Voices of Recovery
Inseparable
The Kennedy Forum
Legal Action Center
Mental Health America
National Alliance on Mental Illness
National Association of Addiction Treatment Providers
National Association of Peer Supporters
National Council on Alcoholism and Drug Dependence – Maryland Chapter
National Health Law Program (NHeLP)
Partnership to End Addiction
REDC Consortium