April 1, 2016

The Honorable Peter Levine
Deputy Chief Management Officer
Department of Defense
9010 Defense Pentagon
Washington, DC 20301–9010

RE: **RIN 0720–AB65**

Dear Mr. Levine,

On behalf of the Parity Implementation Coalition (PIC), a coalition of mental health and addiction consumer and provider organizations, we thank you for the opportunity to comment on the proposed rule to update TRICARE mental health (MH) and substance use disorder (SUD) benefits, reduce administrative barriers to access to MH benefit coverage, and improve access to SUD treatment for TRICARE beneficiaries. The PIC applauds the Department of Defense (Department) for its commitment to ensure that service members and their families can access evidence-based MH and SUD treatment. We also applaud the Department's effort to de-stigmatize SUD treatment benefits by incorporating them into the general mental health provisions governing institutional benefits rather than separately identifying them as a limited special benefit.

The Parity Implementation Coalition is an alliance of addiction and mental health consumer and provider organizations. Members include the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, Depression and Bipolar Support Alliance, Hazelden Betty Ford Foundation, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, National Association of Addiction Treatment Providers, The Watershed Addiction Treatment Programs, Inc. and Young People in Recovery. In an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders, many of these organizations have advocated for more than nineteen years in support of parity legislation and issuance of regulations. We are committed to the prompt and effective implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) and we submit these comments and recommendations from that perspective and expertise.

The PIC supports the proposed elimination of quantitative and "qualitative" treatment limitations on MH and SUD benefit coverage and aligning cost-sharing for MH/SUD services with medical/surgical services

We support the Rule's proposal to eliminate the following:

- All inpatient mental health day limits, following the statutory revisions to 10 U.S.C. 1079;
- The 60-day partial hospitalization and substance use disorder residential facility (SUDRF) residential treatment limitations;
- Annual and lifetime limitations on SUD treatment;
- Presumptive limitations on outpatient services including the six-hours per year limit on psychological testing; the limit of two sessions per week for outpatient therapy; and limits for family therapy (15 visits) and outpatient therapy (60 visits) provided in free-standing or hospital based SUDRFs; and
- The limit of two smoking cessation attempts in a consecutive 12 month period and 18 face-to-face counseling sessions per attempt.

We agree that, despite waiver provisions in place to ensure access to medically or psychologically necessary services, the presumptive limitations have served as an administrative barrier to care. The removal of annual and lifetime limitations on SUD treatment, including limits on smoking cessation attempts, is consistent with the chronic, often relapsing nature of SUDs and the common need for multiple interventions and treatment over many years to achieve long-term recovery.

Additionally, we applaud the Department for making these changes to allow for coverage of "outpatient treatment that is medically or psychologically necessary, including family therapy and other covered diagnostic and therapeutic services, by a TRICARE authorized institutional provider or by authorized individual mental health providers without limits on the number of treatment sessions."

We likewise agree that differential cost-sharing requirements have served as a further disincentive for individuals seeking treatment, and agree that aligning cost-sharing requirements will reduce financial barriers for consumers on both inpatient and outpatient MH/SUD benefits while minimizing out-of-pocket risks for beneficiaries.

Based on the PIC's experience with the implementation of MHPAEA, we respectfully propose the following recommendations that we believe will further the intended goals of the Rule:

Recommendation: Define "qualitative" consistent with the Mental Health Parity and Addiction Equity Act's definition of non-quantitative treatment limitations

While we applaud the Department for proposing to eliminate "qualitative" treatment limitations, the Proposed Rule lacks a definition of the term. We recommend that the Final Rule define "qualitative" limits consistent with the definition in MHPAEA's Final Rule on non-quantitative treatment limitations (NQTLs). The MHPAEA Final Rule defines NQTLs as "limits on the scope or duration of treatment that are not expressed numerically (such as medical management techniques like prior authorization)."

The MHPAEA Final Rule also includes an illustrative list of NQTLs, which include:

> (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
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> (B) Formulary design for prescription drugs;
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> (C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
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> (D) Standards for provider admission to participate in a network, including reimbursement rates;
>
> (E) Plan methods for determining usual, customary, and reasonable charges;
>
> (F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
>
> (G) Exclusions based on failure to complete a course of treatment; and
>
> (H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

As recognized by the MHPAEA Final Rule, NQTLs, just like quantitative treatment limitations, limit the scope or duration of mental health and substance use disorder benefits. Defining "qualitative" will be critical to ensuring the intent of the Proposed Rule to increase access to care for service members and their families is realized. Additionally, examples that illustrate compliant and non-compliant use of qualitative treatment limits (as likewise set forth in the MHPAEA Final Rule for NQTLs) will be an important clarification for individuals receiving mental health and substance use disorder benefits covered by TRICARE and the providers providing those services.

Recommendation: Require issuers and plans to perform compliance testing and provide documentation that illustrates how the health plan has determined its compliance with the Department's requirements

Unfortunately, since the release of the MHPAEA Final Rule, our members still face considerable issues with plan disclosure requirements as well as noncompliance in the application of NQTLs in one or more of four specific areas:

1. Nondisclosure of how and to what degree NQTLs are being developed and applied comparably to both MH/SUD and medical/surgical benefits;

2. Refusal by plans and insurers to respond at all to requests for medical/surgical criteria and/or spending (in order to enable a comparability review by providers and consumers);

3. Statements by plans and insurers that they may apply an NQTL to any proportion or all of the MH/SUD benefit regardless of what proportion of the medical/surgical benefit that NQTL is applied to (e.g., an NQTL applied to 70% of the inpatient MH benefit, while only applied to 30% of the inpatient medical benefit); and

4. Unilateral statements by plans that an NQTL is justified based on the plan's internally recognized clinically appropriate standards, with no details or support provided.

Under MHPAEA, when a health plan imposes financial requirements or quantitative treatment limitations (QTLs), to both MH/SUD and medical/surgical benefits, a health plan must apply the appropriate regulatory test and determine whether they are in compliance with the law and its rules. The MHPAEA Final Rule provides tests that weigh whether the financial requirements or QTLs applied to MH/SUD benefits are "more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification."

With respect to NQTLs, the regulatory tests to be applied by health plans are different from the tests used to determine the compliance of financial requirements or QTLs. For NQTLs, there is a two-part test that weighs whether the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to the MH or SUD benefits are (1) comparable to, and (2) applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the same classification.

To ensure compliance with MHPAEA and its regulations, health plans must perform a compliance review of their financial requirements, QTLs, and NQTLs. This analysis does not have to be performed annually, but an analysis must be performed and must be revisited and revised (as necessary) in the event of a change to any such requirements or limitations.

Unless a consumer or provider knows how and to what extent a financial requirement, QTL or NQTL has been comparably developed and applied to the medical and surgical benefit, it is impossible to determine whether a violation of MHPAEA has occurred.

Summary of Recommendations

To address this concern and ensure service members and their families are able to access mental health and substance use disorder benefits at parity, we recommend that the Final Rule:

1. Explicitly requires issuers and plans to perform a compliance review of the financial requirements, QTLs and NQTLs applied by the plan or issuer
2. Requires plans and issuers to provide documentation that illustrates how the health plan has determined that the financial requirements, QTLs and/or NQTLs are in compliance in the event of a denial of benefit coverage. Specifically, this documentation should include any compliance testing performed by the plan showing that the plan meets the "predominant and substantially all" tests or the "comparability and stringency tests", as the case may be.

The PIC supports authorizing Intensive Outpatient Program treatment services for psychiatric and substance use disorders

The Proposed Rule would authorize Intensive Outpatient Program (IOP) treatment services by a new class of institutional provider, which will provide a less restrictive setting than an inpatient or partial hospital setting. As the rule identifies, SUD IOPs offer a level of care that has been endorsed by the American Society of Addiction Medicine (ASAM) and authorizing this level of care will potentially expand the volume of TRICARE participating providers and improve access to care.

The PIC supports the proposed expansion of MH and SUD benefits to include the full range of the continuum of care, including outpatient care and non-network providers.

We agree that the current restriction of SUD treatment to TRICARE-authorized SUD Rehabilitation Facilities (SUDRFs) and hospitals results in sub-optimal outcomes for patients due to care discontinuity and mismatches between the level of care a patient needs and the level of care accessible through TRICARE. As the Proposed Rule notes, office-based individual outpatient treatment is an effective, empirically-validated level of treatment for substance use disorder endorsed by ASAM Criteria, and its proposed inclusion among TRICARE benefits would close a critical gap in available care for our nation's service members and their families.

Moreover, the proposed expansion of the SUD treatment benefit for opioid use disorder to include office-based opioid treatment by TRICARE-authorized physicians and authorized opioid treatment programs will increase access to medication-assisted treatment (MAT) for opioid use disorder. MAT is an evidence-based treatment option and has proven life-saving for many patients with opioid use disorder. We believe this expansion of the TRICARE SUD benefit is critical at a time when our nation is facing an epidemic of opioid misuse and related overdose deaths.

The PIC Supports Streamlining Requirements for Institutional MH and SUD Providers to Become TRICARE Authorized Providers

We believe eliminating the administratively burdensome provider certification process and streamlining approval for institutional MH and SUD providers to become TRICARE-authorized providers will enhance access to care for TRICARE beneficiaries in regions where current providers meet industry quality assurance standards but do not meet current TRICARE certification requirements.

Conclusion

Thank you again for the opportunity to provide comments on this important Proposed Rule. Once implemented, the PIC believes this Proposed Rule will significantly increase access to MH/SUD treatment for our nation's service members and their families. We applaud the Department of Defense for proposing such comprehensive changes to TRICARE MH/SUD benefits that reflect the chronic, often relapsing nature of SUDs and support the full continuum of evidence-based care. We look forward to working with you in any way we can to ensure the swift and thorough implementation of these proposed and much needed regulatory changes.

Sincerely,

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Parity Implementation Coalition Co-Chair

Beth Ann Middlebrook
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