ABHW
Advancing Health Care Policy
for Mental Health and Addiction

March 31, 2022

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Re: Additional guidance necessary for parity compliance pursuant to the Consolidated Appropriations Act of 2021

Dear Mr. Khawar, Ms. Turner, Ms. Rivers, Mr. Ackerman, Mr. Knopf and Ms. Levin,

The Association for Behavioral Health and Wellness (ABHW) appreciates the Department of Labor (DOL), U.S. Department of Health and Human Services (HHS), and Department of Treasury's (collectively, "the tri-Departments") 2022 Mental Health Parity and Addiction Equity Act (MHPAEA) Report to Congress published on January 25, 2022 ("Report"). The purpose of this letter is two-fold: (1) to respond to the findings and recommendations in the Report, and (2) to make recommendations to the tri-Departments regarding the content of the forthcoming rulemaking and additional guidance scheduled for release later this year.

I. ABHW Response to Findings of the Report

A. *ABHW agrees with the determinations of noncompliance for blanket exclusions and blanket pre-certification requirements for mental health/substance use disorder (MH/SUD) benefits that are cited in the Report*

ABHW agrees with a number of the specific findings related to substantive non-compliance identified in the 2022 Report. For example, we agree that blanket exclusions for specific treatments and services such as applied behavior analysis (ABA) therapy, medication-assisted treatment for opioid use disorder, nutritional counseling for MH/SUDs, urine testing for MH/SUD conditions, as well as plan limits which require blanket pre-certification for all MH/SUD benefits, generally create clear violations of the parity law. ABHW members generally recommend to their customers that they remove such exclusions from their products and services, and we agree that enforcement is generally appropriate where plans and issuers continue to apply such facially prohibitive exclusions.

B. *Guidance is needed to define minimum standards for the adequacy of compliance documentation*

The specific, clear-cut examples of *substantive* non-compliance stand in sharp contrast to the lack of clearly defined, objective definitions and standards for determining the adequacy of parity compliance documentation that is required under the Consolidated Appropriations Act of 2021 ("CAA"). We appreciate the high-level guidance provided in FAQ 45, but significant, fundamental questions remain unanswered about the appropriate scope and design of documentation for many aspects of the comparative analysis. This ambiguity is demonstrated by the Report's finding by the DOL that <u>not one submitted analysis was sufficient to meet the tri-Departments' largely unarticulated standards</u>.

We eagerly await the scheduled rulemaking to implement the CAA documentation requirements to provide greater clarity regarding the form and the level of detail and necessary documentary evidence required to be deemed sufficient by the tri-Departments. This is crucial in light of the Report's findings of insufficiency across the population of responses reviewed by the DOL.

We also strongly urge the tri-Departments to consider our previous requests to provide model comparative analyses that would illustrate the minimum standards for fulfilling the comparative analysis and documentation requirements. Issuance of standardized examples of comparative analyses would save tremendous resources and guesswork on the part of the health plans and employers, ensure the documentation submitted to regulators is correct, diminish the time auditors spend on an audit, and help to maintain consistency in enforcement.

C. *Enforcement discretion regarding adequacy of documentation should be exercised until guidance is released to define minimum standards for compliance*

While we await the requested guidance, our members are devoting considerable resources to providing all documentation that is requested by investigators in various parity audits and exams. However, prospective guidance is needed to ensure efficiency for all stakeholders in these exams and audits, including regulators and beneficiaries. In this context, where regulators find that 100% of the comparative analyses that they review are inadequate, and where regulators have not identified a single model example of a fully satisfactory comparative analysis, we suggest it would be arbitrary and capricious to exercise enforcement against a limited number of arbitrarily-selected plans or issuers on the basis of the asserted inadequacy of their comparative analyses. We therefore respectfully request that you continue to exercise enforcement discretion with regard to making final determinations of non-compliance based on the adequacy of documentation under the CAA until final regulations have been issued to clarify the precise scope of information, level of detail, and form of analysis and documentation that must be provided to satisfy the five-step requirements for key nonquantitative treatment limitation (NQTL) types.

D. *Enforcement should focus on limits that demonstrably impact members' access to services*

We also request that you provide greater clarity regarding the substantive problems to be solved—i.e., the specific aspects of plan design and operations that directly impact member access to services—and focus enforcement more narrowly on these problems. We believe that an enforcement strategy that focuses primarily on these identified problems, and that offers safe harbors for enforcement in the absence of identified problems, will significantly enhance plan compliance and the efficacy of enforcement.

II. ABHW requests that the tri-Departments adopt the following recommendations for guidance

We applaud the tri-Departments for including a proposed rule for MHPAEA on the HHS regulatory agenda and we look forward to its publication this summer. In light of the Report and our comments above, as you are drafting these new rules, we urge you to adopt the following recommendations:

A. *Develop a strategy for enforcement that specifically targets identified forms of disparities or discrimination in the design and application of the plan's limitations*

ABHW's members provide value to their beneficiaries by designing and implementing plan benefits and limits to serve the triple aim for health care delivery by reducing the cost per member of health care, ensuring that health care services are high quality and well-coordinated, and improving population health through the efficient use of limited resources. We are fully committed to ensuring that these design and implementation

strategies do not create limits on access to MH/SUD benefits that are incomparable to or more stringent than the limits on medical/surgical (M/S) benefits. However, the current strategy for enforcement is unnecessarily burdensome on regulators, plans, and issuers and is misaligned with consumer interests because it fails to focus on the aspects of plan design and operation that that are different from their medical corollaries and that create a greater burden on access to MH/SUD services as a result of such difference.

Accordingly, we urge the tri-Departments to consider the recommendations included below in the context of certain key principles:

1. **Most forms of substantive disparities or discrimination can be easily identified and corrected.**

Where thresholds for compliance are clearly defined or the lack of parity is facially evident, our members have generally taken swift action to ensure their compliance. For example, prior to MHPAEA, it was a common plan feature to require prior authorization for all MH/SUD benefits but not for medical benefits and now this is not the case. A large majority of the initial determinations of non-compliance that are cited in the 2022 Report relate to benefit exclusions or other limits that are specifically targeted to MH/SUD conditions. For these types of limits, as in other contexts where a substantive compliance concern is clearly articulated, it is generally easy to understand the threshold for compliance, the scope and depth of details that are material to the identified concern and therefore necessary to address in the comparative analysis. It is also relatively straightforward for plan compliance officials to identify such concerns, especially when highlighted in enforcement reports and guidance, and to rectify them.

We request that the tri-Departments continue to provide details on the specific benefit designs or limits that are found to be disparate or discriminatory in current investigations as well as future investigations to ensure that these benefit designs or limits are eliminated consistently across our members' plans and operations.

2. **Our members are unable to react where regulators' concerns are unclear.**

Our members have remained unsure of what action, if any, to take with regard to guidance that does not clearly establish a threshold for compliance. For example, FAQ 45 states, "If the plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits." This guidance presents a number of ambiguities: "expert" is an ambiguous term that could be defined narrowly to include only external clinical consultants or could be defined broadly to include essentially all plan staff that are involved in plan design or operations (who are all hired due to their expertise

with regard to their assigned roles); "qualifications" is an ambiguous term that could be defined narrowly to address only education, licensure, and/or certifications, or can be defined broadly to include all reasons for hiring or contracting with the expert; and, it is unclear what conclusions to draw for compliance in situations where reliance on expert opinions is non-formulaic and varies by context.

Moreover, in addition to the very wide range of reasonable interpretations of the scope and quantity of detail that would be sufficient to respond to this ambiguous guidance, the ultimate impact of such analysis, however lengthy and detailed, on the stringency or appropriateness of limits on health plan benefits seems to be extremely attenuated at best. Even to the extent that a regulator may identify a difference in expert qualifications, there is no reason to believe that this difference has caused a disparity in the design of the limit in question, or that the substitution of an expert with different qualifications would result in a different outcome in the design of the limit or its application to any given member, especially where no substantive disparity or specific concern has been identified in the design or application of the underlying limit itself.

This specific statement from FAQ 45 is noted merely as an example, and we have similar concerns with much of the guidance that is set forth in FAQ 45 and the NQTL sections of the DOL's Self-Compliance Tool for MHPAEA.

3. **The current approach to documentation, review, and enforcement is not cost-effective for plans or regulators.**

The compliance documentation requirements of the CAA involve significant work. Our members estimate that it takes anywhere from 50-250 hours of staff time to develop each new NQTL analysis under the current guidance, depending on the complexity of the specific NQTL type, among other factors. The fees that are charged to health insurance issuers by state departments of insurance to cover the costs of market conduct exams focused on parity—which typically run between $500,000 - $750,000 per exam (not including any fines or penalties)—demonstrate the burden on regulators to review such documentation and make compliance determinations. Many of these market conduct exams have focused on the same types of NQTLs, comparative analyses, and supporting documentation that are currently required by federal regulators.[1] Federal and state regulatory agencies have also been forced to hire and train dedicated staff to review the vast reams of documentation that are being produced to comply with regulator requests.

4. **Most of the current work by plans and regulators to document and enforce compliance is not targeted to specific identified concerns.**

[1] States that have recently conducted market conduct exams focused on parity include Illinois, Minnesota, Pennsylvania, and West Virginia, among others.

In practice, most of the substantive examples of noncompliance in the 2022 Report and previous guidance relate to limits that specifically target MH/SUD conditions and that are generally straightforward to analyze. Unfortunately, most of plans and regulators' current efforts are devoted to developing and reviewing lengthy comparative analyses in the absence of any identified concern that a given limit is in fact a disparate limitation on MH/SUD benefits.

We recognize that work remains to ensure true parity of benefit design and administration. However, the current approach of requiring plans and issuers to document *all* aspects of the design and operation of "all" NQTL types in order to comprehensively *prove the absence* of any possible disparity creates a very low "return on investment" for both plans and investigators. A large majority of the reams of minutiae about each plan's administrative structure and operations that are being currently produced and investigated in the absence of a specifically identified parity compliance concern has no real bearing on access to benefits.

5. **Compliance and enforcement efforts will be more effective if they are targeted to specifically identified forms of disparities or discrimination.**

To be efficient and effective, enforcement strategies must focus on identified problems for which the solution would materially benefit plan members. Similarly, reporting requirements must be limited to the details that are material to the identified problem. Prospective guidance to articulate the specific problems to be solved would substantially enhance compliance even in the absence of oversight. Common concerns for standard reporting could be identified in sub-regulatory guidance and continuously updated as findings evolve. In addition to these prospectively identified common concerns, investigations could continue to include any plan-specific concerns that are identified. This would contrast with the current approach of focusing on the comprehensiveness of compliance documentation even in the absence of identified concerns or thresholds for compliance.

A more targeted enforcement strategy would greatly enhance the efficiency and effectiveness not only of compliance efforts by plans and issuers but also of enforcement efforts by regulators, to the ultimate benefit of plan members and beneficiaries. In each of the following sections of this letter, we propose specific forms of guidance and enforcement strategies that we believe will significantly enhance compliance while reducing the current burden on both plans and regulators.

B. *Establish safe harbors for enforcement with regard to the adequacy of compliance documentation*

The most helpful change for stakeholders as well as investigators would be for the tri-Departments to identify and define certain safe harbors for compliance with regard to widely accepted practices that do not pose a material risk of violating parity. These safe harbors would create a presumption of compliance in the absence of clear evidence of noncompliance. The application of safe harbors would limit the burden on plans and investigators in instances where compliance can be readily assessed without extensive documentation and would provide investigators with methodology for targeting more comprehensive oversight to the issues for which such oversight is most likely to matter.

We recommend that, at minimum, the tri-Departments issue guidance to establish that where the plan or issuer provides data that demonstrate comparability or lesser stringency of application of the NQTL to MH/SUD benefits for a set of operations measures defined by the tri-Departments for a given NQTL type, and where the regulator has not identified any specific disparity or particularized suspicion of noncompliance:

1. **If all of the MH/SUD and M/S benefits in a classification are subject to the NQTL, it is not necessary for the plan or issuer to provide information on the factors, sources, and evidentiary standards used to determine whether to apply the NQTL to a given benefit in the classification.**
    - Example: all inpatient MH/SUD and M/S benefits are subject to a limit (e.g, concurrent review every 7 days). No documentation is needed for Steps 2 and 3 of the comparative analysis, or for the "as written" portion of Steps 4 and 5 of the comparative analysis, though analysis "in operation" may still be necessary in Steps 4 and 5.

2. **For any factor, evidentiary standard, source, process, or other information that is the same for MH/SUD and M/S benefits, it is sufficient for the plan or issuer to affirm that this information is the same with no further discussion or supporting documentation.**
    - Example: a factor for determining which benefits are subject to a limit, and the evidentiary standard and sources used to define and apply that factor, are all the same for both MH/SUD and M/S benefits. No further documentation beyond this affirmation is needed for this factor in Step 2 or for the evidentiary standards and sources associated with this factor in Step 3.
    - Example: all of the same factors, evidentiary standards, and sources are used to determine which benefits to subject to a limit. No further documentation beyond this affirmation is needed for Steps 2 and 3.
    - Example: the same committee is used to determine which benefits to subject to prior authorization, regardless of whether the benefits are for MH/SUD or

M/S conditions. No further documentation is needed beyond this affirmation regarding the committee's composition, operations, in Step 4.

- Example: all of the processes to design and implement an NQTL type are the same for MH/SUD and M/S benefits. No further documentation is needed beyond this affirmation for Step 4.

To reiterate, these safe harbors would be inapplicable where the identified operations measures fail to demonstrate that the NQTL is in fact being applied comparably and no more stringently in operation, or where the investigator identifies any particularized concern. For example, if expert review of the set of benefits subject to prior authorization determines that a plan is applying prior authorization to a MH/SUD service that is not typically subject to prior authorization in the industry, or otherwise identifies evidence of incomparability or greater stringency of application of the factors, sources, and/or evidentiary standards that are used to determine whether to apply prior authorization to MH/SUD benefits relative to those used for M/S benefits, then the investigator could request full documentation for these steps of the analysis. However, where no evidence exists to support a particularized suspicion of noncompliance, the suggested safe harbors represent areas where regulators are very unlikely to find substantive parity compliance issues, yet where significant resources are currently being expended by regulators and plans alike to ensure that compliance documentation is adequate.

C. *Define a core set of NQTLs*

The MHPAEA regulations can be paraphrased to state that an NQTL is any "limit" on the scope or duration of treatment benefits that is not "expressed numerically." [2] The regulations provide a non-exhaustive list of examples, but the 2021 Report to Congress identifies a number of new NQTL types, and it appears to be clear that the tri-Departments intend to retain discretion to interpret ***any*** aspect of a plan's design or operation to constitute an NQTL if it can be found to have the effect of limiting the scope or duration of benefits in any way. Given this expansive interpretation, it is not possible for plans and issuers to develop 5-step analyses for "all" NQTLs proactively—i.e., in advance of a specific request and available on demand.

The current definition of an NQTL can conceivably involve almost any aspect of plan design and operations. The final rules define "Treatment limitations" to be "limits on the scope or

[2] In practice, this definition does not seem to be workable: some treatment limits, such as quantity limits on prescription drugs, are expressed numerically, but would be unreasonable to subject to the "predominant" and "substantially all" tests required for quantitative treatment limits. We raise this concern about the definition of an NQTL merely to emphasize the impossibility of even identifying (let alone preparing comparative analyses for) "all" NQTL types that could be reasonably identified as being applied by a plan's design and operations.

duration of treatment," and define NQTLs somewhat circularly to be treatment limits that "otherwise limit the scope or duration of benefits for treatment under a plan or coverage."[3]

ABHW members appreciate that FAQ 45, Q8 clearly identifies four specific NQTLs to focus on for the near future as areas of specific concern. ABHW urges regulators to do the same in the long term by using the upcoming MHPAEA proposed rule to define a core set of NQTLs on which issuers and plans are expected to have documented analyses prepared for submission upon request.[4] Defining such a list will facilitate plans' responsiveness to regulator requests for information relating to the core NQTLs, particularly upon short notice, but would in no way prevent regulators from requesting documentation on other non-core NQTLs should a complaint or specific compliance concern arise.

Specifically, we propose the following list of core NQTLs:

1. Prior Authorization
2. Concurrent Review
3. Retrospective Review
4. Formulary/Prescription Drug List (PDL) Tiering
5. Step Therapy Requirements
6. Medical Necessity Criteria Development/Selection Process
7. Determinations that a Treatment or Service is Experimental/Investigational
8. Blanket Exclusions of Specific Provider Types
9. In-Network Provider Fee Schedule Development Methodology
10. Out-of-Network Provider Reimbursement Rate-Setting Methodology

Defining a core set of NQTLs for which to develop and maintain comparative analyses will ease the administrative burden on plans, streamline the enforcement process for the tri-Departments, and most importantly, move closer to equitable coverage for patients. The standard list can be created in sub-regulatory guidance, and can be reviewed and updated as needed as plan designs and operations evolve, and as parity compliance programs and enforcement initiatives mature.

D. *Publish NQTL-specific guidance for the comparative analysis for each core NQTL type*

[3] "Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition." 29 CFR § 2590.712(a), 45 CFR § 146.136(a), and 26 CFR § 54.9812-1(a).

[4] *See* Implications of parity documentation requirements and examination processes and standards under CAA, ABHW, March 3, 2021.

For each NQTL type designated as a "core NQTL" for reporting purposes, we again ask the tri-Departments to develop:

- A reporting template that provides detailed instructions for each step of the comparative analysis as applied to the given NQTL type, including the minimum set of required issues or concerns to be addressed for each step, on a point-by-point basis, for that particular NQTL type;
- A minimum set of required operations measures and technical specifications for the NQTL; and
- At least one de-identified example of a complete 5-step comparative analysis that demonstrates the minimum set of informational elements, data points, or other details that are necessary to constitute a sufficient analysis for that NQTL type.

If the tri-Departments are unable to create a model analysis for each standard NQTL type, then we ask regulators to convene a technical expert panel to create them, and to include industry representation on the panel in order to ensure that the model analyses provide clarity on the thresholds for compliance and adequacy of documentation with regard to common industry practices.

E. *Develop guidance regarding thresholds for compliance*

Ambiguity remains regarding how the tri-Departments will make final determinations of compliance on a number of key issues that have arisen in the course of the tri-Departments' investigations. We request that the tri-Departments issue guidance, subject to notice and comment, with regard to the following specific issues:

- Guidance should be clear that any finding of noncompliance must be based on a reasonable determination that the identified disparity of plan design or operations has in fact caused a disparity in beneficiary or member access or coverage, as substantiated by a finding that:
    - Identified claims were denied pursuant to the noncompliant aspect of plan design or operations; or
    - Identified claims were reimbursed at a lower level than they would have been but for the disparity.
- A reasonable determination that an identified MH/SUD service would have been delivered but for the noncompliant aspect of plan design or operations. Where a plan decides to apply an NQTL to all MH/SUD and M/S benefits in the same classification, this is *per se* evidence that the factors, sources, and evidentiary standards that were relied upon to make that decision were designed in a manner that was comparable and no more stringent for MH/SUD benefits than for M/S benefits (i.e., for the "as written" prong of the NQTL analysis).

- Where a plan uses the same committee or process to decide whether to apply an NQTL to both MH/SUD and M/S benefits and the processes are the same for all benefits, this is *per se* evidence that the processes were designed ("as written") in a manner that is comparable and no more stringent for MH/SUD benefits than for M/S benefits.
- Plans have flexibility to determine the nature and scope of documentation and level of detail that they will maintain to memorialize decision-making for all aspects of plan design and operations. Any new requirement that the tri-Departments wish to impose on plan documentation and level of detail requirements and practices outside the scope of the 5-step comparative analyses required under the CAA must be promulgated in rulemaking that is subject to notice and comment, and must be supported by a reasonable estimate of the administrative cost of creating and maintaining such documentation under the Paperwork Reduction Act. This would include, for example, a requirement for plans and issuers to create documentation to support decision-making with regard to the application of every cited factor to every covered service for each NQTL type.
- Data comparisons for operations measures such as denial rates, reimbursement rates, formulary tiering proportions, or other measures may be interpreted to prompt inquiry into the reason for any material difference that appears to support a suspicion that a limit may be applied more stringently to MH/SUD benefits than to M/S benefits. However, any final determination of noncompliance must be based on an identified disparity in the processes, strategies, evidentiary standards, or other factors that are used to apply the NQTL and not on the data comparison.

F. *Clearly define protocols for investigations*

In addition to the need for a set of defined NQTLs and accompanying guidance, we believe that clearly defined protocols for investigations would be beneficial to all stakeholders. To that end we submit the following requests:

- Provide at least 60 days for payers to respond to requests for any information or reporting that has not been clearly identified as necessary and required in published guidance. The current timeframes that are generally allotted to respond to requests for additional information (generally 7-14 days) rarely provide enough time to collect and analyze the requested information, given that investigators often request information that is distributed across multiple teams and data systems.
- Define a protocol for the submission and approval of requested comparative analyses that includes differentiated steps for:
    - Submission and approval of a corrective action plan (CAP) following an initial determination of non-compliance;

    - Completion of the approved CAP; and
    - Submission and approval of comparative analyses that have been revised to reflect the completed actions of the CAP
- Ensure that any requests for additional information following an initial documentation request identify the specific concerns regarding substantive non-compliance that prompted the request and that must be rebutted or resolved through the response.

G. *Establish an appeals process for findings of non-compliance*

The inherent subjectivity of determinations of "comparability" and "stringency" and the ambiguity of the current guidance regarding the threshold for compliance across a wide range of key questions make it clear that appropriate safeguards for due process are necessary, including a right to appeal any findings of noncompliance.

This subjectivity of findings has been demonstrated in the inconsistency of process and findings that ABHW's members have observed with regard to the tri-Departments' investigations to date. For example, one third party administrator (TPA) that was subject to simultaneous investigations by two different regional offices (pursuant to their services to multiple health plans in different states) erroneously listed an outdated exclusion for an MH/SUD benefit in the Summary Plan Description. The TPA explained in response to the initial document request that this was merely a copy-editing error and provided evidence of paid claims to demonstrate that the benefit was covered in practice along with revised language for the next year's benefit booklet. One regional office accepted this explanation with no further questions, but a different regional office acting on the exact same information made an initial determination of non-compliance and initiated the 45-day clock for compliance.

In addition, our members have also noted widely differing approaches to the scope of requests for supporting documentation, even in identical or nearly-identical contexts, and the level and scope of detail requested. These requests are often made without identifying any particularized concern or rationale. For example, one TPA noted that investigators requested no further supporting documentation with regard to the processes by which certain TPA committees undertook decision-making, whereas other investigators responding to essentially the same comparative analysis requested an extensive range of supporting documentation, including committee member qualifications, meeting minutes, evidence relied upon by the committee members, etc. Although no final determinations of compliance have yet been reached in these cases, the potential for significant inconsistency of enforcement determinations is high, and the need for an appeals process is clear.

We request that the appeals process include standard procedural safeguards, including the tolling of the 45-day timeframe for remediation of the alleged violation while the appeal is pending.

H. *Promulgate guidance to ensure alignment of state parity investigations and enforcement with federal practices*

It is also critical to keep in mind that some state parity policies and compliance approaches differ significantly from federal policies and enforcement even when based upon federal parity standards, creating confusion for issuers and plans in understanding how to achieve and demonstrate compliance at the state level even if federal requirements are clarified. In fact, our members have identified wide discrepancies in how essentially identical NQTL analyses have been interpreted between federal and state regulators, between different states, and even between different regulators in the same state.[5]

Given that no NQTL analyses were deemed compliant at the federal level, the need for closer alignment at the state level is even more urgent to allow recent and upcoming federal changes to have meaningful impact. During our meeting on March 17, 2021 with the tri-Departments, the regulators agreed that uniformity with the states would be beneficial for all involved parties. As such, we urge the tri-Departments to continue prioritizing state and federal uniformity by establishing recommended guidance that states can adopt for mental health parity reporting and investigations.

III. **Update the DOL Self-Compliance Tool.**

We appreciate that DOL allowed a comment period for the Self-Compliance Tool (Tool) in 2020. Given that the Tool has gained importance with the CAA provisions, we reiterate and resubmit our previous comments and recommendations for the Tool as you begin the process to update it for 2022.

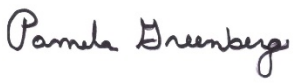
IV. **Conclusion**.

ABHW believes that consumers have the right to non-discriminatory mental health and substance use disorder coverage. We hope to work closely with the tri-Departments to identify gaps and develop clarity on the issues discussed within this letter. We would appreciate a meeting with you to discuss this content and address any questions you may have. We will reach out under separate cover to offer scheduling information. Please do not hesitate to contact Deepti Loharikar at loharikar@abhw.org or 202-505-1834 with any

[5] *See*, *e.g.*, Medicaid and CHIP Payment and Access Commission, *Implementation of the Mental Health Parity and Addiction Equity Act in Medicaid and CHIP*, p. 13, January 29, 2021, slide 14: "Some interviewees noted that non-quantitative treatment limitations were assessed and interpreted differently both within and across states." https://www.macpac.gov/wp-content/uploads/2021/01/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf, last visited May 21, 2021.

concerns in the meantime. We appreciate your time and efforts on this important issue and look forward to continuing to be a strong partner as we all move forward.

Sincerely,



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