

The Honorable Xavier Becerra  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

The Honorable Lisa M. Gomez  
Assistant Secretary  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20002

The Honorable Douglas W. O'Donnell  
Deputy Commissioner for Services and Enforcement  
Internal Revenue Service  
U.S. Department of the Treasury  
1111 Constitution Avenue, NW  
Washington, DC 20224

Re: 0938-AU93  
1210-AC11  
1545-BQ29  
Requirements Related to the Mental Health Parity and Addiction Equity Act

Dear Secretary Becerra, Assistant Secretary Gomez, and Deputy Commissioner O'Donnell:

I write to you today on behalf of The Council of Autism Service Providers (CASP) regarding the Department of Health and Human Services, Employee Benefits Security Administration, and the Internal Revenue Service's (the Departments) proposed rule, Requirements Related to the Mental Health Parity and Addiction Equity Act (2023 Proposed Rule).

CASP is a non-profit association of organizations committed to providing evidence-based care to individuals with autism. CASP represents the autism provider community to the nation at large, including government, payers, and the general public. We provide information and education and promote standards that enhance quality of care. We are also home to the clinical practice guidelines for applied behavior analysis, "Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2nd ed.)"<sup>1</sup> (Practice Guidelines).

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<sup>1</sup> Council of Autism Service Providers. 2020. *Applied Behavior Analysis Treatment of Autism Spectrum Disorders: Practice Guidelines for Healthcare Funders and managers (2<sup>nd</sup> ed.)*  
<https://casproviders.org/asd-guidelines/>.

The Mental Health Parity and Addiction Equity Act (MHPAEA) final rule<sup>2</sup> states that mental health conditions are defined by the terms of the plan or health insurance coverage and "in accordance with applicable and federal state law...consistent with generally recognized independent standards of current medical practice (e.g., the most current version of the DSM, ICD or state guidelines.) Autism Spectrum Disorder is consistently defined in all three, thus ensuring protection under MHPAEA.

Preventing plans and issuers from using NQTLs to place greater limits on access to mental health and substance use disorder benefits as compared to medical/surgical benefits is of great importance to our organization and the autistic consumers that our member organizations serve. We appreciate and strongly support the efforts of the Departments to ensure access to care. We also applaud the requirements for plans to follow generally accepted standards of care (i.e., our previously referenced Practice Guidelines) in making decisions related to medical necessity.

We appreciate your consideration of our comments on the 2023 Proposed Rule:

**29 CFR § 2590.712, 45 CFR § 146.136, AND 26 CFR § 54.9812-1 – PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS**

**Purpose – (a)(1)**

Ensuring access to mental healthcare, at parity with healthcare provided in the medical/surgical care realm, is of utmost importance. Unfortunately, our member organizations report experiencing ongoing disparities, particularly when providing applied behavior analysis, including limits based on the following:

- Behaviors or skills;
- Age;
- Service delivery models, such as telehealth;
- School enrollment;

According to one of our CASP member organizations, "We encounter non-quantitative treatment limitations (i.e., the child **being in a full day school program is used as criteria** when determining whether or not they qualify for medically necessary comprehensive treatment). This applies to two specific funders."

- Service locations;

As an example, one CASP member organization reports, "Upon requesting information on their NQTL Analysis (attached), we found that the analysis did not adequately identify the factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL. Nor did it clarify which benefits, including both mental health/substance use disorder benefits and medical/surgical benefits, are subject to the NQTL

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<sup>2</sup> 78 FR 68240

concerning *the location of care*. Furthermore, we believe the analysis does not provide sufficient explanation as to whether certain factors were given more weight than others and the reasons for such weighting, including a review of any specific data used in the decision-making process.”

Additionally, denials are frequently given due to:

- Lack of progress;
- Co-occurring condition or co-morbid diagnosis;
- Concurrent service delivery (i.e., a Board-Certified Behavior Analyst's supervision of a Registered Behavior Technician in accordance with the Practice Guidelines);

Requirements unique to autism spectrum disorder are frequently imposed upon relevant services, including:

- Parental involvement;

One CASP member organization reports, “We also have seen a significant increase across a number of funders on the monitoring of parent training hours provided and whether or not they will continue authorizing direct ABA Therapy if parent training hours are not increased.”

Another states, “Parent/Caregiver/Guardian Participant Requirements BCBS has imposed a requirement stipulating that a caregiver must participate in 80% of scheduled treatment sessions and complete interim homework assignments to maintain therapy.”

- Specific assessment tools;
- Evidence of progress;
- Authorization of a fixed number of treatment hours for all consumers instead of individualization of treatment intensity according to the Practice Guidelines;

One CASP member organization reports, “We encounter quantitative limits (i.e., the plan only provides 200 days of ABA per year) and providers saying their policy is 25 hours max/week due to medical necessity (and their opinion of the child) the most.”

- Imposition of cumbersome credentialing requirements that result in excessive delays.

### **Substantially All / Predominant Test for NQTLs – (c)(4)(i)**

MHPAE clearly states that “MH/SUD treatment limitations are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits.” We strongly support the 2023 Proposed Rule’s requirement that if an NQTL is not applied to “substantially all” (i.e., two-thirds) medical/surgical benefits within a classification of care, plans may not apply the NQTL to mental health and substance use disorder benefits within that classification.

Again, our member organizations report experiencing ongoing disparities related to the “substantially all/predominant test” for NQTLs, particularly when providing applied behavior analysis, including limits according to:

- Behaviors or skills;
- Age;
- Physical disabilities;
- Service delivery models, such as telehealth;
- School enrollment and
- Service locations.

Additionally, denials are frequently given due to:

- Lack of progress;
- Co-occurring condition or co-morbid diagnosis;
- Required rediagnosis, even though autism is a lifelong condition;
- Concurrent service delivery (i.e., a Board-Certified Behavior Analyst's supervision of a Registered Behavior Technician in accordance with the Practice Guidelines),

Requirements unique to autism spectrum disorder are frequently imposed upon relevant services, including:

- Parental involvement;

*One of our member organizations reports, “Parent/Caregiver/Guardian Training & Support in the payer’s current policy stipulates that community-based training can only occur for goals previously mastered by technicians in safe and analog settings. This is not in alignment with standard care protocols. According to the Clinical Practice Guidelines for Autism Spectrum Disorder (ASD), it is not necessary for goals to be mastered in one specific setting before being implemented in another. For children to attend school, go grocery shopping, and meet their daily life requirements, they must be able to function in their community on a regular basis. Denying treatment in a community setting could potentially endanger the child's health and safety, such as failing to heed adult instructions in parking lots. Moreover, caregiver training cannot replace the treatment provided by a trained, professional registered behavior technician. It is inappropriate to expect parents to fulfill the role of a provider for their child; such a requirement may potentially violate federal mental health parity laws. Parents are generally not expected to carry out medical procedures for their child's physical health conditions when a trained professional is required. By enforcing this requirement solely for mental health treatments, the payer is placing an undue burden on families seeking mental health treatment, as compared to those seeking physical health treatment.”*

- Specific assessment tools;

- Evidence of progress;
- Authorization of a fixed number of treatment hours for all consumers instead of individualization of treatment intensity according to the Practice Guidelines;
- Imposition of cumbersome credentialing requirements that result in excessive delays.

Another of our CASP member organizations reports the following:

*"I am from a smaller company. We encounter hour limits on the parent training code (97156) the most, with some insurances having limits on all of the codes that we utilize. Some of our funders allow for BTs to work on cases, and some do not. We have also encountered similar issues with trainees being able to bill for supervision services. Lastly, we have had one specific payer that says our clients only have 25 hours of service per year. Thank you!"*

An example from another CASP member organization states:

*"Most frequently, we see upfront limitations to the number of hours allowed; for example, we are never allowed to ask for more than 8 hours of 97151 for a funder, or 25/week for 97153 for another funder—these cases are forwarded immediately to denial and need to be appealed. In addition, we sometimes see limitations on location."*

**"Independent Professional Medical or Clinical Standards" Exception to NQTL Requirements – (c)(4)(i)(E), (c)(4)(ii)(B), (c)(4)(iv)(D), and (c)(4)(v)(A)**

As home to the Applied Behavior Analysis Practice Guidelines, we strongly support the Departments' desire to ensure that plans/issuers follow *"independent professional medical or clinical standards (consistent with generally accepted standards of care)"* when imposing NQTLs.

However, we are concerned that the proposed exception, which is intended to be narrow, could weaken rather than strengthen existing regulations.

In 2013, the Departments correctly determined that rather than operating as an exception, clinical appropriateness was most properly placed squarely within the framework of the regulations' NQTL requirements. Furthermore, MHPAEA's statutory text requires that treatment limitations applicable to mental health and substance use disorder benefits be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits and includes no exceptions to this standard.

An increasing number of states have adopted a strong definition of *"generally accepted standards of care"* for MH/SUDs. Strong definitions have been enacted in [Illinois](#), [California](#), [Georgia](#), and [New Mexico](#). We support the following version of these states' definitions for *"independent professional medical or clinical standards,"* which we view as synonymous with *"generally accepted standards of care"*:

*“Independent professional medical or clinical standards” mean standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting independent professional medical or clinical standards are peer-reviewed scientific studies and medical literature, recommendations of federal government agencies, drug labeling approved by the United States Food and Drug Administration, and recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines.”*

The Departments should adopt a definition of “independent professional medical or clinical standards” that is tied to criteria/guidelines developed by the relevant nonprofit clinical specialty associations. Tying this definition to nonprofit clinical specialty association guidelines and criteria is essential because they are:

- **Fully transparent and accessible.** Consumers, providers, and other stakeholders can readily access the criteria being used to determine whether specific MH/SUD services are, in fact, appropriate to meet individual patient needs.
- **Developed through a consensus process that protects against conflicts of interest.** The authors and reviewers of nonprofit criteria are publicly identified. Credentials, expertise, and potential conflicts of interest can be evaluated by the public.
- **Externally validated.** Nonprofit clinical criteria are subject to rigorous peer review validation studies in real-world clinical settings and are reviewed in professional and scholarly journals.

Once a strong definition is in place that is tied to nonprofit clinical professional association criteria/guidelines, we urge the Departments to put in place the following requirements:

- The Departments should require plans/issuers to analyze how any MH or SUD criteria/guidelines they use diverge from “independent professional medical or clinical standards.” Such an analysis would also be done for M/S benefits within the classification of care and would be subject to the NQTL comparability and stringency test.
- **Require specific data reporting for the medical necessity/appropriateness.** The special rule should require specific data collection and analysis requirements relating to medical necessity/appropriateness.
- **Prohibit plans/issuers from withholding their criteria/guidelines for MHPAEA review.** Our member organizations report frequent claims from payers that their medical necessity criteria are proprietary. The Departments should explicitly require that plans/issuers make available any criteria/guidelines they use to federal and any applicable State authorities as well as to

participants/beneficiaries, without any exceptions for purported “*proprietary*” or “*confidential*” criteria/guidelines.

By removing the “*independent professional medical or clinical standards*” exception, creating a strong definition for this term that is tied to nonprofit professional association criteria/guidelines, and putting in place the above requirements, we believe that the Departments can advance this important issue without allowing plans/issuers to continue practices that will inhibit access.

CASP member organizations report barriers to care related to the reliance of payers on “*confidential and proprietary*” medical necessity criteria, including denials based on:

- Behaviors or skills;
- Age;
- Service delivery models, such as telehealth;
- Co-occurring condition or co-morbid diagnosis;
- Parental involvement;
- Specific assessment tools;
- Evidence of progress;
- Authorization of a fixed number of treatment hours for all consumers instead of individualization of treatment intensity according to the Practice Guidelines;
- Caseload and supervision requirements.

As an example, one CASP member reports, “*We often see they will not approve an auth if the patient is not available for the full recommendation of hours, limits on 91751, and specific treatment plan templates, which often is close to 100 pages long.*”

#### **Meaningful Benefits of Treatment of a Mental Health Condition or Substance Use Disorder – (c)(2)(ii)(A)**

We support the provision requiring that if any MH or SUD benefits are provided in any classification of care, both MH and SUD benefits must be provided in all classifications of care, and the scope of covered MH and SUD benefits in each classification must be “*meaningful*.”

It is important that the Departments not only define “*meaningful*” but also identify “*scope of covered services*” as an NQTL in the non-exhaustive NQTL list. This would remove any ambiguity that a plan/issuer must identify, for any excluded service, the “*factor*” and “*evidentiary standard*” that the plan used for M/S exclusions within the classification of care and determine whether the MH/SUD exclusion met the NQTL comparability and stringency test. A “*scope of covered services*” NQTL should also be subject to the 2023 Proposed Rule’s requirements relating to outcomes data and actions to address access disparities. CASP member organizations report ongoing challenges related to reimbursement for:

- Services for patients with intense behavioral presentations;
- Services for patients with profound autism;

- Services for adults with autism.

#### **Prohibition on Discriminatory Factors and Evidentiary Standards – (c)(4)(ii)(B)**

The CPTO codes for adaptive behavior/ABA services have not yet undergone procedures to establish standard Medicare valuation units. Because of this, plans consistently set rates that are unsustainable for our member organizations nationwide, particularly related to the provision of services under Medicaid.

Plans commonly justify discriminatory reimbursement rates by citing the Medicare Fee Schedule. Medicare is not subject to MHPAEA and has long undervalued MH/SUD services. Given how frequently the Medicare Fee Schedule is used to justify discriminatory MH/SUD reimbursement, we urge the Departments to specify that utilizing the Medicare PFS to justify reimbursement rates will fall within the proposed prohibition of (c)(4)(ii)(B).

#### **Required Use of Outcomes Data & Actions to Address Material Differences in Access – (c)(4)(iv)(A-B)**

We strongly support the provision to require a plan/issuer to collect and evaluate relevant data to assess the impact of the NQTL on MH/SUD and M/S benefits and to tie the *“type, form, and manner of collection and evaluation”* of data to guidance that can be periodically updated. By requiring plans/issuers to collect and assess outcomes data and to address disparities in access, the Departments are appropriately bringing the focus of NQTL analyses back to the fundamental purpose of MHPAEA – addressing disparities in access to MH/SUD care.

We urge the Departments to clarify that outcome data must be separately reported for MH and SUD services to conform to the statutory standard.

Without a definition, plans/issuers will be left to determine whether the differences in access shown by the data are *“meaningful.”* Such a situation will make it extraordinarily difficult for the Departments or any applicable State authority to hold plans accountable. Consistent with the statute’s *“no more restrictive”* standard, we urge the Departments to require plans to take action whenever the data shows any difference in access.

#### **Special Rule for NQTLs Related to Network Composition – (c)(4)(iv)(C)**

We believe that inadequate networks are one of the most significant barriers to individuals accessing needed MH/SUD care. Our member organizations report being told that networks are full, all while families languish on waiting lists, attempting to access medically necessary applied behavior analysis.

We strongly support the new proposed rules relating to *“network composition,”* which would address many of these access issues. The special rule relating to network composition NQTLs is particularly powerful because a plan/issuer would fail to meet the requirements of (c)(4)(i) and (c)(4)(ii) *“if the relevant data show material differences in access to in-network mental health and substance use disorder benefits*



as compared to in-network medical/surgical benefits in a classification.” This strong requirement should be maintained.

#### **Effect of Final Determination of Noncompliance – (c)(4)(vii)**

For too long, there have been no meaningful consequences when plans/issuers have violated MHPAEA. Through widespread inaction and the lack of meaningful consequences for violations of MHPAEA’s requirements, state and federal regulators have prioritized plans/issuers’ interests and profits over the ability of individuals to receive needed MH/SUD care. We strongly support the provision that gives the Secretaries the ability to direct that a plan/issuer not impose an NQTL after a final determination of noncompliance and urge the Departments to change the “may” to a “shall” to indicate that the plan will not be permitted to apply a non-compliant NQTL.

#### **Examples Relating to Prohibited Exclusions of Autism and Eating Disorder Coverage – (c)(2)(ii)(C)**

Our member organizations provide medically necessary services to children and adults diagnosed with autism spectrum disorder nationwide. We strongly support the addition of new examples in the 2023 Proposed Rule, which would make clear that exclusions of key services for autism spectrum disorder violate MHPAEA.

#### **Meaning of Terms – (a)(2)**

The proposed changes to definitions of “mental health benefits” and “substance use disorder benefits” would ensure that the placement of benefits is consistent with “generally recognized independent standards,” which are tied to the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the mental, behavioral and neurodevelopmental disorders chapter of the International Classifications of Disease (ICD). The 2023 Proposed Rule would also ensure that any state laws that define MH/SUDs in a manner that conflicts with “generally recognized independent standards” do not reduce plan members’ protections under MHPAEA. This has particularly been an issue where autism spectrum disorder (ASD) benefits have been defined as M/S benefits, even though this is contrary to generally recognized independent standards as reflected by the DSM and ICD. Where this has occurred, individuals with ASD have been denied MHPAEA protections.

We also strongly support the Departments’ proposed definitions for key terms relating to NQTLs – “evidentiary standards,” “factors,” “processes,” and “strategies.” The lack of definitions for these terms, which are foundational to MHPAEA’s NQTL requirements, has hindered efforts to hold health plans accountable for discriminatory NQTLs due to frequent disagreements about their meaning.

Our member organizations in North Carolina report an ongoing lack of access to services due to the exclusion of autism spectrum disorder as a mental disorder benefiting from the protections of MHPAEA. Autism Spectrum Disorder is clearly defined in the DSM-V as well as the ICD-10 and ICD-11. Allowing states to exploit ambiguity perpetuates discrimination by health plans and leaves consumers with no access to care.

### Non-Exhaustive List of NQTLs – (c)(4)(iii)

We support the revisions to the list of NQTLs, including those relating to “network composition,” and the clarification that this list is “non-exhaustive.” As referenced above, we urge the Departments to add “scope of covered services” as an identified NQTL.

### Provisions of Other Law – (d)(3)

We urge to add the following sentence, with any adjustment for code-specific terms, to make clear that no part of the comparative analyses or other application information required by 29 CFR § 2590.712-1 / 45 CFR § 146.137 / 26 CFR § 54.9812-2 may be withheld: “All requested plan information shall be made available to claimant and may not be withheld as proprietary or commercially protected information.”

### 29 CFR § 2590.712-1, 45 CFR § 146.137, AND 26 CFR § 54.9812-2 – NONQUANTITATIVE TREATMENT LIMITATION COMPARATIVE ANALYSIS REQUIREMENTS

We strongly support the addition of new requirements relating to plans/issuers’ NQTL comparative analyses that they are required to conduct under amendments to MHPAEA enacted as part of the CAA, 2021. These detailed requirements are necessary to ensure there is clarity on what plans/issuers’ analyses must contain and to hold plans accountable for following these requirements.

We also appreciate language relating to providing participants/beneficiaries with information summarizing changes the plan/issuer “has made as part of its corrective action plan following the initial determination of noncompliance, including an explanation of any opportunity for a participant or beneficiary to have a claim for benefits reprocessed.” We strongly urge the Departments to place an affirmative obligation on plans/issuers, as part of the corrective action plan, to identify affected participants/beneficiaries, reprocess any claims, and notify those who they determine have been impacted by the non-compliant NQTL.

Finally, in (b), we urge the Departments to explicitly reference “any applicable State authority” to ensure clarity that plans’ comparative analysis must be made available to state regulators upon request. While this statutory requirement is referenced in (e), some insurers have refused to provide the required parity compliance analysis to the applicable State authority upon request if the relevant Secretary has not also requested the analysis. This change will help prevent such false claims by preventing selective citation of the proposed regulations.

### 45 CFR § 146.180 – TREATMENT OF NON-FEDERAL GOVERNMENT PLANS

We support the language implementing the elimination of self-funded non-federal government plans’ ability to opt out of MHPAEA. Hundreds of thousands of public employees and their family members

have for too long been denied critical MHPAEA protections as their public-sector employer affirmatively opted-in to discriminating against individuals needing MH/SUD services.

We urge the Department of Health and Human Services to prioritize robust MHPAEA compliance reviews of these plans as soon as their opt-out is no longer valid. This is particularly important given that many of these public sector plans opted out of MHPAEA specifically because they wished to continue discriminatory treatment limitations on MH/SUD benefits. The Department should immediately request plans' NQTL compliance analyses to ensure they are taking the necessary steps to comply with MHPAEA.

## OTHER ISSUES

### Third-Party Administrators (TPAs)

Rather than "*incentivize*" TPAs to comply with MHPAEA, we urge the Departments to use all possible avenues to hold both self-funded plan sponsors and TPAs accountable for MHPAEA compliance.

### Provider Directory Requirements

We urge the Departments to require periodic independent third-party testing of provider directories to assess the accuracy of the information and ensure that a sufficient percentage of providers are accepting new patients. HHS has already put forward strong proposed standards for Medicaid managed care and the Children's Health Insurance Program (CMS-2439-P), which establish maximum appointment wait time standards for routine outpatient MH/SUD services of 10 business days and require such independent secret shopper surveys. This proposed rule should be a model for the Departments in individual and group plans.

Additionally, plans/issuers should be required to identify providers who are available via telehealth. Finally, the Departments should ensure that participants/beneficiaries who cannot access in-network services on a timely basis can access out-of-network services, with their out-of-pocket costs no greater than the amounts that they would have paid for the same services received from an in-network provider.

### Claims Procedure Requirements

The Departments have requested feedback on how the ACA and ERISA's existing claims procedure requirements can facilitate access to MH/SUD benefits. Most fundamentally, HHS and DOL must strengthen enforcement with existing claims procedure requirements, which, in our experience, are frequently not followed with little apparent consequence. To strengthen participants/beneficiaries' ability to challenge inappropriate denials of MH/SUD care, HHS and DOL should, at minimum, make clear that plans/issuers' NQTL compliance analysis must be made available upon request, with no restrictions for purported "*proprietary*" or "*confidential*" information. While we believe this is HHS and DOL's interpretation of existing law, making this explicit in the claims procedure requirements is important.

HHS and DOL should also require that, for any adverse benefit determination relating to MH/SUD, the adverse benefit determination and explanation of benefits should contain clear instructions on how to request and receive any NQTL compliance analysis(es) related to the determination. The requirements should include a phone number, email, and address where such a request could be submitted, including on an expedited basis, to enable the submission of meaningful urgent appeals and requests for expedited external reviews.

We also support the Departments' suggestion that should a plan/issuer deny authorization for a specific level of care, the plan/issuer must identify a lower level of care that it believes would be more appropriate, along with information related to the coverage of such service in the plan and the availability of network providers to deliver the lower level of service. We also support the Departments' suggestion that the plan/issuer provide an explanation of how a particular NQTL was applied to particular benefits.

Finally, HHS and DOL should put in place meaningful enforcement mechanisms to ensure that plans/issuers fulfill their obligation to provide participants/beneficiaries with legally required information upon request. We believe meaningful consequences must include automatic reversal of any adverse benefit determination associated with the request. A potential mechanism is directing independent review organizations (IROs) to automatically reverse adverse benefit determinations when plans fail to provide claimants with any information requested during the internal and/or external appeals process. Otherwise, the claims' procedure requirements to provide information are toothless, and the external appeal process is a meaningless alternative to litigation.

Additionally, the Proposed Rule makes reference to "*claims*" data throughout; however, the term captures a limited set of information, action steps, and determinations made in the context of a request for coverage.

It should be made clear that the data expected is not limited to those requests that have been entered into a claims processing system and processed as claims. Specifically, reporting related to claims should explicitly include any service requests that trigger any engagement with the plan or issuer, such as pre-claim utilization review assessments, peer-to-peer reviews, and other pre-service determinations that are utilized to manage the services that are ultimately given a determination (adverse or otherwise). Following this definition, NQTL Analyses should include in-operation comparisons of pre-payment reviews, clawbacks, and audits.

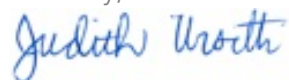
### **HHS Must Propose and Finalize MHPAEA Rules for Medicaid**

While we appreciate the 2023 Proposed Rule, which affects individual and group health plans, it is imperative that HHS move quickly to propose and finalize rules for Medicaid managed care, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans (ABPs) without delay after the finalization of this proposed rule. The Administration must not allow a strong set of MHPAEA rules for individuals in individual and group plans but a weaker set of rules for individuals in Medicaid-managed care, CHIP, and ABPs. This is particularly critical given that these plans serve lower-income individuals

and families who are disproportionately Black, Latino, Native American, and from other marginalized and underserved communities. Many of the entities that serve as Medicaid MCOs also operate in the state-regulated insurance markets and serve as TPAs for employer-sponsored plans. HHS must also finally hold state Medicaid agencies accountable for strong oversight, given most states' deeply inadequate MHPAEA enforcement efforts.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Judith Ursitti at [jursitti@casproviders.org](mailto:jursitti@casproviders.org).

Sincerely,



Judith Ursitti

Vice President of Government Affairs