PREMIER TRANSFORMING HEALTHCARE TOGETHER®

October 13, 2023

The Honorable Julie A. Su
Acting Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20710

The Honorable Janet L. Yellen
Secretary
U.S. Department of Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
1600 Pennsylvania Avenue NW
Washington, DC 20500

File Code 1210–AC11
Submitted electronically to: http://www.regulations.gov

Re: Requirements Related to the Mental Health Parity and Addiction Equity Act

Dear Acting Secretary Su, Secretary Becerra, and Secretary Yellen:

Premier Inc. appreciates the opportunity to submit comments to the Departments of Labor, Treasury and Health and Human Services regarding the proposed rules updating requirements related to the Mental Health Parity and Addiction Equity Act (MHPAEA). This proposed rule represents a positive step towards ensuring parity for patients struggling with behavioral health challenges through integrated, equitable care. Premier supports the Departments' efforts to improve access to high-quality care, particularly through the proposed implementation of the nonquantitative treatment limitation (NQTL) comparative analyses requirements. In our comments, Premier specifically recommends that the Departments:

- Finalize proposals to help improve commercially insured patient access to medically-necessary behavioral health services through improved NQTL analysis monitoring and reporting;
- Commit to working across federal agencies and with Congress to develop solutions to the critical behavioral health workforce shortage;
- Improve federal oversight and monitoring of employee access to Family and Medical Leave Act (FMLA) and other benefits for behavioral health-related illnesses;
- Develop incentives for payers to include behavioral health integration in value-based care models; and
- Dedicate federal resources to educating and equipping behavioral health providers to succeed in outcomes-focused quality measurement.

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,350 hospitals and approximately 300,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,400 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier

operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

Contigo Health, LLC, a subsidiary of Premier, creates new ways for all stakeholders to work together to optimize employee health benefits. At its core, Contigo Health, with 900,000 network providers across 4.1 million U.S. locations, and claims repricing technology, helps improve access to care, and provides health plan payors, and their health plan members, medical claims savings through pre-negotiated discounts with network providers. Contigo is committed to eliminating gaps in substance use disorder (SUD) treatment and recovery services through a its Substance Use Disorder Centers of Excellence program, which provides in-person and virtual services.

Premier's PINC AI™ Applied Sciences (PAS) is a trusted leader in accelerating healthcare improvement through services, data, and scalable solutions, spanning the continuum of care and enabling sustainable innovation and rigorous research. These services and real-world data are valuable resources for the pharmaceutical, device and diagnostic industries, academia, federal and national healthcare agencies, as well as hospitals and health systems. Since 2000, PAS researchers have produced more than 1,000 publications which appear in 264 scholarly, peer-reviewed journals, covering a wide variety of topics such as population-based analyses of drugs, devices, treatments, disease states, epidemiology, resource utilization, healthcare economics and clinical outcomes.
.
A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. REVISING NQTL COMPARATIVE ANALYSES REQUIREMENTS

The U.S. has made significant progress in providing access to mental health (MH)/SUD services since MHPAEA was enacted in 2008. Utilization increased more in MH/SUD services compared to medical and surgical services (M/S) between 2008 and 2013. More recently, largely due to the COVID-19 pandemic, health plans have seen overall MH services increase by 38.8 percent between 2019 and 2022. Despite increased utilization, more needs to be done to ensure all Americans have access to medically-necessary behavioral health treatment and recovery support services.

As such, ***Premier supports the Departments' aim to ensure that individuals who seek care for covered MH/SUD treatment needs do not face greater barriers to accessing benefits than they would face when seeking coverage for the treatment of a physical medical condition or for a surgical procedure.*** In this rulemaking, the Departments seek to implement provisions of the Consolidated Appropriations Act of 2021, which required plans and issuers to conduct meaningful comparative analyses to measure the impact of NQTLs. This includes evaluating standards related to network composition, out-of-network reimbursement rates and prior authorization NQTLs. Further, the Departments propose to implement the sunset provision for self-funded, non-federal governmental plan elections to opt out of compliance with MHPAEA, adopted in the Consolidated Appropriations Act of 2023.

Premier has long supported federal efforts to streamline administrative burden for providers, allowing them to focus on high-quality patient care, and we support the Departments' proposals to require plans to set network composition standards, collect outcomes data and address differences in MH/SUD and medical/surgical services. Premier also supports ending the ability of non-federal government plans to opt out of federal parity requirements, ensuring that public servants in all levels of government have access to coverage for medically-necessary behavioral healthcare.

While Premier applauds the Departments' efforts to improve access to high-quality care, the proposed rule does not address the larger problem of dire shortages in the behavioral health clinical workforce. ***Premier urges the Departments to work with Congress, other federal agencies (e.g., the Health Resources and Services Administration and Substance Abuse and Mental Health Services Administration) and with industry stakeholders to ensure a coordinated federal effort to strengthen and grow a critically understaffed area of healthcare.*** Premier has recommended a multi-pronged approach, and a mix of both near term and longer-term solutions, to address pressing healthcare workforce issues.

III. LEVERAGING FEDERAL GOVERNANCE TO IMPROVE COVERAGE OF MENTAL HEALTH AND SUBSTANCE USE BENEFITS

As part of the proposed rule, the Departments seek comment on whether there are ways to improve the coverage of MH/SUD benefits through other provisions of federal law. One area of consideration that is within the purview of the Department of Labor is employee access to job-protected leave under the FMLA. Per FMLA requirements, eligible employees of covered employers are entitled to 12 work weeks of FMLA leave each year, with continued coverage under the employee's group health benefits, with a guarantee that the employee be restored to the same or virtually identical position at the end of the leave period. FMLA and related leave policies play a critical role in ensuring that patients are able to receive medically-necessary behavioral health treatment, particularly higher-acuity care that supersedes the individual's ability to perform their role at work.

However, it is critical to reiterate that FMLA leave, while affording job protection, is not the same as paid leave. Unlike nearly all other industrialized nations, the U.S. does not have national standards on paid family or sick leave. To the extent practicable, ***Premier strongly encourages the Department of Labor to provide incentives and technical assistance to employers - as well as state and local governments that have passed family and medical leave requirements - to ensure that such policies ensure equal treatment of MH/SUD and medical/surgical medical treatment needs. Premier also urges the Departments to continue to monitor and enforce compliance with parity requirements for patient financial liabilities such as copayments.*** Attention to patients' out-of-pocket costs is critical, as inability to afford the cost of care continues to be the leading reason for unmet treatment need for both mental illness and substance use disorders.

IV. IMPROVING QUALITY IN BEHAVIORAL HEALTHCARE

Premier is concerned with a key policy assumption underlying many of the proposals in the rule that *more* care equals *better* care, which is not always the case. Although unmet treatment needs remain significant, particularly among individuals with SUDs and co-occurring MH and SUD concerns, even individuals who are actively engaged in treatment are not always receiving high-quality care. Only one in four residential facilities that treat adolescents in the U.S. for opioid use disorder offer buprenorphine, which is the only medication for adolescents ages 16 to 18 approved by the Food and Drug Administration. Additionally, only a handful of states, including New York and Massachusetts, require that licensed addiction treatment centers follow clinical best practices such as offering medication-assisted treatment for opioid use disorder.

Premier strongly encourages the Departments to continue developing incentives for payers to include behavioral health integration in value-based care models. Even if the proposals in this NPRM succeed in reducing payers' disproportionate use of NQTL tools such as prior authorization for behavioral health services, bridging the fraught relationships between health plans and behavioral health providers will require a significant paradigm shift. About 40 percent of psychiatrists in the U.S. operate cash-only private practices and do have in-network agreements with any health plans. Even more troubling from a health disparities perspective, only about 35 percent of psychiatrists accept Medicaid.

One well-documented reason for low in-network participation by behavioral health providers is the disproportionately low reimbursement rates that payers offer. A recent GAO report found that exceedingly low reimbursement rates for MH service providers are contributing to ongoing access issues that covered consumers' experience. In order to earn the trust of providers who have been subjected to these low reimbursement rates, value-based payment models in the behavioral health space must have simple, meaningful measures. Only about 14 percent of MH providers use standardized treatment progress measures, despite clear evidence that when providers track symptoms and therapeutic alliance data regularly, outcomes improve substantially. ***Premier urges the Departments to dedicate resources to educating providers and incentivizing payers to use objective, standard outcomes measure sets, suffusing the national behavioral health infrastructure with quality improvement capabilities.*** In addition to improving uptake of treatment progress measures among providers and payers, Premier also recognizes the need for substantial additional resources fund research on what interventions produce the most positive treatment outcomes. Therefore, ***Premier encourages the Departments to allocate additional funding to study the impacts of promising treatment interventions on patient outcomes and healthcare expenditures, and to enable the rapid deployment of any new evidence-based interventions.***

V. CONCLUSION

Premier appreciates the opportunity to comment on the Departments' proposed rules updating requirements related to MHPAEA. If you have any questions regarding our comments, or if Premier can serve as a resource on these issues to the Administration in its policy development, please contact Mason Ingram, Director of Payer Policy, at Mason_Ingram@premierinc.com or 334.318.5016.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.