MARYLAND PSYCHIATRIC SOCIETY

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Ms. Judy Behm
Standards Coordinator, CHQI
326 First Street, Suite 29
Annapolis, MD 21403
MHPaccred@chqi.com

To Clear Health Quality Institute:

Thank you for sending your "**DRAFT MENTAL HEALTH PARITY ACCREDITATION PROGRAM STANDARDS AND GUIDE, VERSION 1.0**." As President of the Maryland Psychiatric Society, representing 700 psychiatrists, I am submitting comments in response to the Clear Health Quality Institute (CHQI) request for feedback. We are concerned that adoption of these standards would ultimately undermine patient care and the progress on mental health parity that has been achieved to date.

1. **The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is an anti-discrimination statute that sets forth specific legal tests that require legal judgement in their application and, as such, accreditation standards cannot achieve the goals of the law.**

In its essence, MHPAEA is a non-discrimination/consumer protection law. The parity law is complex, and identification of parity violations is not always clear cut because the non-discrimination tests under the parity law are not always readily measurable. We question the wisdom of permitting an extra-legal entity to judge whether a plan meets the legal tests that are embedded in these standards.

Furthermore, we are concerned about the effects of a "seal of approval" achieved through accreditation. We are concerned that over time Maryland regulators will look no further than accreditation status in determining parity compliance. The Maryland Insurance Administration is currently wrapping up its third market conduct study on parity. We want to preserve the impetus for state-level scrutiny of plans' adherence to parity requirements.

In fact, the insurance industry has recommended accreditation as a solution to achieving compliance and has argued that it should be recognized as such by federal and state regulators. Because the draft standards are predicated on the Federal Self Compliance Tool, in some respects, the proposed accreditation process is redundant. Any health plan that wishes to be transparent and demonstrate compliance can already do so by simply following and documenting the process outlined in this newly issued Compliance Tool and publicly posting the results.

In the long run, patients are better served by having the entities vested with legal authority review plan compliance and actions under MHPAEA, e.g. insurance commissioners and attorneys general, rather than an entity that is engaged directly by the plans.

2. **Even if an accreditation program were appropriate, it would be essential that the standards and their review maintain absolute fidelity to the parity law, regulations and guidance. The standards as drafted do not reflect established federal requirements.**

It appears that the insurance industry, which participated in the CHQI Parity Standards Committee developing the draft accreditation standards, has not agreed to essential elements of parity such as network adequacy standards and parity in payment. Full data on denial rates and out-of-network utilization are essential metrics in analyzing the "in operation" component of the respective NQTLs. Although the industry opposes network adequacy as a relevant NQTL, federal guidance has been clear. The options proposed are vague and deficient in many respects and in our view not consistent with the federal guidance.

Apparently, the industry has also not agreed to full disclosure regarding the source information and/or evidentiary standards used to define the factors upon which NQTLs are based and/or triggered. The draft would give up what we have fought hard to attain. The Department of Labor's guidance on parity requires plans to be transparent with participants and beneficiaries about what their standards are, how they are created, and how they are applied to mental health care as compared to medical/surgical care. Transparency is required and needs enforcement.

3. **Even if the draft standards achieved the high bar of fidelity to the law, we are not confident that the infrastructure and personnel with qualified parity experience will be in place to review applicants.**

We have concerns about whether CHQI will be able to put in place the essentials for independently and verifiably evaluating plans' compliance. For example, it is unknown: 1) how any beta testing of any eventual standards will be done and especially whether it will be independently validated; 2) whether there will there be independent validation of any data that plans may be required to submit to prove compliance with a particular standard; 3) whether there will be any transparency as to the basis for a plan's achievement of accreditation status; and 4) what methodology will be used for plan documentation review and scoring and interrater reliability. These are just a few examples. It seems incumbent on CHQI to demonstrate in advance its capacity to render judgement on a very complex set of legal tests. Appropriate standards would only be as good as the processes and expertise necessary to validate them. There remain far too many unanswered questions.

4. **It is also unclear to whom and to what the status of any accreditation would apply**.

There is a vast array of health plans in the marketplace: commercial arrangements, self-insured plans, etc., many with subcontractor functions built in. Every component is integral to a parity compliance evaluation. It would be necessary to clarify who the applicant is and the scope of what their accreditation status means. This would become very confusing to all parties, including employers, patients, regulators and others.

We think the foregoing considerations call into question whether CHQI's Mental Health Parity Accreditation Standards are a solution that promotes compliance and enforcement of the law and achieves the nondiscriminatory protections for consumers of mental health and substance use disorder services, which are the very purpose of the law.

Thank you for your consideration of our views.

Sincerely,

Patrick Triplett, M.D.
President