



Center for Medicaid & CHIP Services

Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP

Introduction

As the largest single source of funding for mental health (MH) and substance use disorder (SUD) services in the United States, Medicaid fills a critical role in supporting access to services and treatment for millions of individuals struggling with these conditions.ⁱ Nonelderly adult Medicaid enrollees are more likely to have MH conditions and SUDs than individuals with private or other forms of health insurance.ⁱⁱ This prevalence underscores the importance of providing robust coverage of prevention, treatment, and recovery supports for individuals enrolled in Medicaid.



Improving access to the full continuum of care for those with MH conditions and SUDs is likewise a high priority for the Children's Health Insurance Program (CHIP). MH conditions and SUDs often arise in childhood or adolescence,ⁱⁱⁱ and these conditions affect a significant number of children and adolescents.^{iv} As Medicaid and CHIP provide health care coverage for a large percent of children and adolescents in the U.S.,^v the Centers for Medicare & Medicaid Services (CMS) has prioritized working with state Medicaid and CHIP agency partners to ensure coverage of services to prevent, diagnose, treat, and provide recovery supports for a broad range of MH conditions and SUDs among child and adolescent enrollees.

Furthermore, racial and ethnic minority groups, who comprise a majority of Medicaid and CHIP enrollees, need improved access to MH and SUD treatment.^{vi} Rates of suicide and overdose deaths have been rising faster among racial and ethnic minority groups.^{vii} Moreover, individuals in these groups are often less likely to receive treatment for MH and SUDs; for example, Black enrollees with opioid use disorder are less likely to receive medication for opioid use disorder than White enrollees.^{viii} Additional populations who are at risk of having MH conditions and SUDs include people who identify as lesbian, gay, or bisexual (also referred to as sexual minorities)^x and people living in rural areas.^x Improving access to care for pregnant and postpartum women experiencing MH conditions and SUDs is also an important consideration.^{xi}

Ensuring compliance with federal parity requirements in Medicaid and CHIP is fundamental to improving access to care for enrollees who need MH and/or SUD treatment. Most provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)^{xii} apply to coverage provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and CHIP.^{xiii} Parity requirements were originally applied to Medicaid MCOs through the Balanced Budget Act of 1997^{xiv} that added section 1932(b)(8) to Title XIX of the Social Security Act. This provision incorporated requirements of the Mental Health Parity Act of 1996 into requirements for Medicaid MCOs.^{xv} MHPAEA, enacted as part of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008,^{xvi} expanded the 1996 parity requirements, and these expanded requirements also apply to Medicaid MCOs through section 1932(b)(8). Parity requirements that apply to CHIP were enacted in the Children’s Health Insurance Program Reauthorization Act of 2009.^{xvii} The Affordable Care Act included parity requirements for Medicaid ABPs.^{xviii} Parity requirements do not apply to MH or SUD benefits for enrollees who receive only Medicaid non-ABP fee-for-service (FFS) state plan services. However, CMS encourages states to comply with parity for all Medicaid and CHIP enrollees.

To strengthen implementation of parity in Medicaid and CHIP, CMS issued regulations in 2016 specifically focused on implementing the federal parity requirements that apply to Medicaid MCOs, CHIP, and Medicaid ABPs.^{xix} These Medicaid and CHIP parity regulations were informed by the 2013 MHPAEA final regulations that apply to private health insurance. Similar to those private insurance regulations, the Medicaid and CHIP parity regulations fundamentally require that financial requirements (e.g., coinsurance and copays) and treatment limitations (e.g., limits on the number of outpatient visits, inpatient days covered, or other similar limits on scope or duration of treatment) imposed on MH or SUD benefits may not be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical or surgical benefits in a classification of benefits. Benefit classifications used for assessing parity compliance include inpatient, outpatient, emergency care, and prescription drugs. Treatment limitations include both quantitative and non-quantitative treatment limitations (NQTLs). The Medicaid and CHIP parity regulations also state that NQTLs may not be imposed on MH or SUD benefits in any benefit classification unless, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical or surgical benefits in the same classification. Common NQTLs include, but are not limited to, prior authorization requirements, concurrent review requirements, medical management standards, formulary design for prescription drugs, and standards for provider admission to participate in a network.

To further support implementation of these Medicaid and CHIP parity regulations by State agencies, CMS issued a detailed **Parity Compliance Toolkit** and a **Parity Implementation Roadmap** as well as sets of **Frequently Asked Questions**. CMS also hosted several **webinars** and regularly provides in-depth individualized technical assistance to state Medicaid and CHIP agencies. CMS and SAMHSA along with other agencies also developed additional educational **materials**.

Unfortunately, research studies indicate that many individuals with MH conditions and SUDs struggle to access treatment and support.^{xx} A recent survey found that most individuals with MH conditions and SUDs have more difficulty accessing treatment for these conditions than they do accessing treatment for physical health conditions.^{xxi} In addition, reports show that the MH and SUD treatment needs of child and adolescent enrollees as well as enrollees from minority groups are often not being met.^{xxii} Furthermore, many Americans, including health care providers, are unaware of parity requirements.^{xxiii}



Current Processes for Ensuring Compliance with Parity in Medicaid and CHIP

CMS works with state Medicaid and CHIP agencies to ensure compliance with federal parity requirements in Medicaid managed care arrangements, Medicaid ABPs, and CHIP in accordance with Medicaid and CHIP parity regulations.^{xxiv}

Regarding application of parity requirements to Medicaid managed care arrangements, under the CMS regulations, states must provide documentation of compliance when benefits for MCO enrollees are split between the MCO and another managed care plan (e.g., a Prepaid Inpatient Health Plan [PIHP] or Prepaid Ambulatory Health Plan [PAHP]) or when some benefits are provided through the MCO and some through FFS. This documentation must be posted on the state Medicaid agency's website and submitted to CMS with the MCO contract for review and approval.

For MCO delivery systems with carved-out benefits (as described above), after states submit the initial round of required documentation to CMS, ensuring ongoing compliance with parity requirements is a component of CMS' Medicaid managed care contract review process. As part of that process, states are required to update documentation when benefit or operational changes occur that may affect compliance with parity requirements; otherwise, states are permitted to attest that there are no changes that affect compliance. Alternatively, when a state's contract requires an MCO to provide all benefits for a Medicaid enrollee population (without carving out benefits for delivery via FFS and other managed care entities), states are required to work with those managed care plans to ensure compliance, but submission of documentation of compliance with parity requirements to CMS is not required.

With regard to CHIP, states are required to submit state plan amendments (SPAs) and documentation to demonstrate compliance with parity requirements. When changes to CHIP coverage are made that may affect compliance with MHPAEA, states are required to update this documentation. States with a Title XXI (CHIP) Medicaid expansion that provide benefits through MCOs must meet the same parity requirements as Medicaid MCOs including the compliance documentation requirements summarized above.

States are responsible for ensuring Medicaid ABPs are in compliance with parity requirements through a SPA process. The ABP SPA template requires states to identify any benefit limitations, and states must provide descriptions of benefits that indicate compliance with parity requirements. An additional parity analysis is required from the state if any amendment would change elements of the benefit package that are considered as part of a parity compliance determination. States providing Medicaid ABP benefits through MCOs must meet the parity requirements for Medicaid MCOs including compliance documentation requirements summarized above.

Some recent statutory amendments to MHPAEA enacted as part of the Consolidated Appropriations Act, 2021^{xxv} require private sector group health plans and health insurance issuers that provide both medical and surgical benefits and MH or SUD benefits to perform and document comparative analyses of the design and application of any NQTLs applied to MH or SUD benefits to demonstrate compliance with MHPAEA. These health plans and insurance issuers are also required to make these analyses available to applicable Federal and state regulators upon request. These most recent amendments to MHPAEA do not directly apply to Medicaid and CHIP. On August 3, 2023, the Departments published proposed amendments to the 2013 MHPAEA final regulations and proposed new regulations implementing the NQTL comparative analyses requirements.^{xxvi} CMS will carefully consider those proposed regulatory changes and whether and to what extent they should inform parity requirements in Medicaid and CHIP, if finalized. Furthermore, CMS already requires states to provide the following information to demonstrate compliance with NQTLs in Medicaid managed care arrangements and CHIP benefits:

- The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH or SUD and medical or surgical benefits to which each such term applies in each respective benefits classification,
- The factors used to determine that the NQTLs will apply to MH or SUD benefits and medical or surgical benefits,
- The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH or SUD benefits and medical or surgical benefits,
- The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH or SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification, and
- The specific findings and conclusions reached by the plan or states, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

In light of recent updates to the underlying MHPAEA statutory provisions and proposed regulatory changes for private sector plans and issuers as well as concerns raised by various stakeholders including MH and SUD treatment advocates regarding barriers to accessing treatment and by state Medicaid and CHIP agencies regarding administrative burden of the current CMS parity compliance processes, CMS is requesting public comment on the following set of questions.

Comments must be submitted to the following email address by December 4th, 2023, to receive full consideration: MedicaidandCHIP-Parity@cms.hhs.gov.

Questions for Comment

1. What are some model formats (e.g., templates) and key questions to consider for improving efficiency and effectiveness of review of documentation of compliance with parity requirements in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?
2. What processes are states and managed care plans using to determine whether existing coverage policies are comparable for MH and SUD compared to medical and surgical benefits?
3. What are some key issues to focus on in reviewing policy or coverage documents that may indicate potential parity compliance issues including regarding NQTLs in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?
4. Which NQTLs and/or benefit classifications should be prioritized for review?
5. What should be the criteria for identifying high priority NQTLs for review?
6. What are some measures or datapoints or other information that could help identify potential parity violations in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?
 - For example, are the following measures effective for identifying coverage that may not be in compliance with parity requirements?
 - Comparison of rates of coverage being denied for MH and SUD benefits compared to rates of coverage being denied for medical and surgical benefits,
 - Comparison of average and median appointment wait times for MH and SUD providers compared to medical and surgical providers,
 - Comparison of payment rates for MH and SUD providers compared to payment rates for medical/surgical providers,
 - Comparison of prevalence rates of MH conditions or SUDs among certain groups of enrollees compared to the percent of enrollees from those groups who are receiving treatment for MH conditions or SUDs,
 - Comparison of the average time from receipt of a claim to payment of that claim for MH and SUD benefits compared to medical and surgical benefits, and
 - Comparison of the percentage of MH and SUD network providers actively submitting claims compared to the percentage of medical and surgical providers actively submitting claims.

- Are there any other measures that should be considered regarding provider network composition and standards for provider network admission including measures focused on –
 - Methods for determining reimbursement rates,
 - Credentialing standards, and
 - Procedures for ensuring a network includes an adequate number of each category of providers?
 - What terminology should CMS define to facilitate collection and evaluation of data regarding these or other recommended measures?
7. How should data on these or other recommended measures be collected?
 8. What are some potential follow-up protocols and corrective actions when measures indicate a potential parity violation in Medicaid managed care arrangements, ABPs, and CHIP?
 9. What additional processes should be considered for assessing compliance with Medicaid and CHIP parity requirements, e.g., random audits?
 10. Are there any MH conditions or SUDs that are more prevalent among enrollees in Medicaid MCOs, Medicaid ABPs, or CHIP? What are the most significant barriers to accessing treatment among enrollees with these conditions?
 11. Are there any particular MH conditions or SUDs or types of treatment that are at risk of not being covered in compliance with parity requirements for Medicaid managed care arrangements, Medicaid ABPs, or CHIP?

Please note, this is a request for comments only. In accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA), specifically 5 CFR 1320.3(h)(4), this general solicitation is exempt from the PRA. Facts or opinions submitted in response to general solicitations of comments from the public regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration, are not generally considered information collections and therefore not subject to the PRA. This request for comment is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This request for comment does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, we are not seeking proposals through this request for comment and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this request for comment; all costs associated with responding to this request for comment will be solely at the interested party's expense. In addition, this request for comment does not commit the Government to any policy decision, and CMS will follow established methods for proposing future policy changes. We note that not responding to this request for comment does not preclude participation in any future procurement or rulemaking, if conducted. It is the responsibility of the potential responders to monitor this request for comment announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this request for comment.

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- ii Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Detailed Tables 5.8B, 5.10B, 6.3B, 6.6B, 6.10B, 6.12B, 6.14B <https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables>. Table 5.9B indicates individuals with private insurance are more likely to have alcohol use disorder than Medicaid enrollees, but Medicaid enrollees are more likely to have drug use disorders and other substance use disorders see Tables 5.8B and 5.10B; Saunders, H., & Rudowitz, R. (2022). *Demographics and health insurance coverage of nonelderly adults with mental illness and substance use disorders in 2020*. KFF. <https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/>.
- iii Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustün TB. Age of onset of mental disorders: a review of recent literature. *Curr Opin Psychiatry*. 2007 Jul;20(4):359-64. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925038/>.
- iv Whitney DG, Peterson MD. US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. *JAMA Pediatr*,173(2):389-391 (2019). <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377>; Bitsko RH, Claussen AH, Lichstein J, et al. Mental Health Surveillance Among Children — United States, 2013–2019. *MMWR Suppl* 2022;71(Suppl-2):1–42 (Feb. 2022). https://www.cdc.gov/mmwr/volumes/71/su/su7102a1.htm?s_cid=su7102a1_w; Agency for Healthcare Research and Quality, 2022: National Healthcare Quality and Disparities Report. October 2022. https://www.ncbi.nlm.nih.gov/books/NBK587182/pdf/Bookshelf_NBK587182.pdf.
- v Alker J, Brooks T. Millions of Children May Lose Medicaid: What Can be Done to Help Prevent them from Becoming Uninsured. Georgetown University Health Policy Institute Center for Children and Families Report. Feb. 17, 2022. <https://ccf.georgetown.edu/2022/02/17/millions-of-children-may-lose-medicaid-what-can-be-done-to-help-prevent-them-from-becoming-uninsured/>.
- vi See CMCS Data Brief on Race and Ethnicity of the national Medicaid and CHIP population in 2020 <https://www.medicaid.gov/sites/default/files/2023-08/2020-race-etncity-data-brf.pdf>; Donohue JM, Cole ES, James CV, et a. The US Medicaid Program: Coverage, Financing, Reforms, and Implications for Health Equity. *JAMA*, 328(11):1085–1099 (2022). <https://jamanetwork.com/journals/jama/fullarticle/2796374>;
- vii Panchal N, Saunders H, Ndugga N. Kaiser Family Foundation Brief: Five Key Findings on Mental Health and Substance Use Disorders by Race/Ethnicity. Sept. 2022. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/five-key-findings-on-mental-health-and-substance-use-disorders-by-race-ethnicity/>.
- viii Donohue JM, Cole ES, James CV, et a. The US Medicaid Program: Coverage, Financing, Reforms, and Implications for Health Equity. *JAMA*, 328(11):1085–1099 (2022). <https://jamanetwork.com/journals/jama/fullarticle/2796374>.
- ix **Medley, G., Lipari, R. N., Bose, J., Cribb, D. S., Kroutil, L. A., & McHenry, G. (2016, October). Sexual orientation and estimates of adult substance use and mental health: Results from the 2015 National Survey on Drug Use and Health. NSDUH Data Review. <https://www.samhsa.gov/data/report/sexual-orientation-and-estimates-adultsubstance-use-and-mental-health-results-2015-national>**
- x Trust for America’s Health. Pain in the Nation: The Epidemics of Alcohol, Drug, and Suicide Deaths. May 2022. <https://www.tfah.org/report-details/pain-in-the-nation-2022/>
- xi SAMHSA Advisory. Evidence-Based, Whole-Person Care for Pregnant People Who Have Opioid Use Disorder. May 2023. <https://store.samhsa.gov/sites/default/files/pep23-02-01-002.pdf>
- xii MHPAEA was enacted on Oct. 3, 2008, as Title V, subtitle B (sections 511- 512) of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Pub. L. 110-343). <https://www.govinfo.gov/content/pkg/PLAW-110publ343/pdf/PLAW-110publ343.pdf>
- xiii Additional details on this legislative history are included in the Medicaid and CHIP parity final rules - Medicaid and Children’s Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans; Final Rule. 81 Fed. Reg. 18390 (March 30, 2016) (codified at 42 CFR Parts 438, 440, 456, and 457). <https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>
- xiv The Balanced Budget Act of 1997 (Pub. L. 105-33).
- xv The Mental Health Parity Act of 1996 (Pub. L. 104-204).

- xvi The Mental Health Parity and Addiction Equity Act (MHPAEA), enacted on Oct. 3, 2008, as Title V, subtitle B (sections 511- 512) of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Pub. L. 110-343). In 2013, the Departments of Labor, Health and Human Services, and the Treasury jointly issued final regulations implementing MHPAEA requirements for private health care coverage. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 FR 68240 (November 13, 2013) (codified at 26 CFR Part54, 29 CFR 2590, and 45 CFR Parts 146 and 147). <https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act>.
- xvii Children’s Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111-3).
- xviii The Patient Protection and Affordable Care Act (Pub. L. 111-148) enacted March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) enacted March 30, 2010 (collectively referred to as the “Affordable Care Act”).
- xix Medicaid and Children’s Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans; Final Rule. 81 Fed. Reg. 18390 (March 30, 2016) (codified at 42 CFR Parts 438, 440, 456, and 457). <https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>
- xx Medicaid and CHIP Payment and Access Commission. Access to Mental Health services for Adults Covered by Medicaid. Chapter 2 in Report to Congress on Medicaid and CHIP, June 2021. <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf>; **Medicaid and CHIP Payment and Access Commission. Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and CHIP. Chapter 3 in Report to Congress on Medicaid and CHIP, June 2021.** <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-3-Access-to-Behavioral-Health-Services-for-Children-and-Adolescents-Covered-by-Medicaid-and-CHIP.pdf>.
- xxi Mental Health Treatment and Research Institute. Equitable Access to Mental Health and Substance Use Care: An Urgent Need. July 2023. https://www.mhtari.org/Survey_Conducted_by_NORC.pdf.
- xxii **Medicaid and CHIP Payment and Access Commission. Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and CHIP. Chapter 3 in Report to Congress on Medicaid and CHIP, June 2021.** <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-3-Access-to-Behavioral-Health-Services-for-Children-and-Adolescents-Covered-by-Medicaid-and-CHIP.pdf>; Donohue JM, Cole ES, James CV, et a. The US Medicaid Program: Coverage, Financing, Reforms, and Implications for Health Equity. *JAMA*, 328(11):1085–1099 (2022). <https://jamanetwork.com/journals/jama/fullarticle/2796374>.
- xxiii Volk J, Schwab R, Kona M, et al. A Review of State Efforts to Enforce Mental Health Parity: Lessons for Policymakers and Regulators. Georgetown University Health Policy Institute, Center on Health Insurance Reforms. Oct. 2022. <https://www.rwjf.org/en/insights/our-research/2022/10/states-struggle-to-ensure-equal-access-to-behavioral-health-services-amid-mental-health-crisis.html>.
- xxiv Medicaid and Children’s Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans; Final Rule. 81 Fed. Reg. 18390 (March 30, 2016) (codified at 42 CFR Parts 438, 440, 456, and 457). <https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>.
- xxv Section 203 of Title II of Division BB of the Consolidated Appropriations Act enacted on December 27, 2020, as Pub. L. 116-260 amended MHPAEA.
- xxvi Requirements Related to the Mental Health Parity and Addiction Equity Act; Proposed Rules. 88 FR 51552 (Aug. 3, 2023). <https://www.federalregister.gov/documents/2023/08/03/2023-15945/requirements-related-to-the-mental-health-parity-and-addiction-equity-act>.