From:	Leah Newkirk
To:	EBSA MHPAEA Request for Comments
Subject:	Proposed Relevant Data Requirements for NQTLs: Kaiser Permanente Comments
Date:	Friday, October 6, 2023 4:04:11 PM
Attachments:	Kaiser Permanente Comment_MHPAEA Technical Release_Final.pdf

Kaiser Permanente offers the attached comments on the Proposed Relevant Data Requirements for NQTLs Related to Network Composition and Enforcement Safe Harbor, published August 3, 2023.
Please contact me with any question.
Thank you.

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October 6, 2023

The Honorable Julie Su
U.S. Secretary of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

Submitted electronically to: mhpaea.rfc.ebsa@dol.gov

RE: Request for Comment on Proposed Relevant Data Requirements for Nonquantitative Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act

Dear Secretaries Su, Becerra and Yellen:

Kaiser Permanente offers the following comments on Proposed Relevant Data Requirements for NQTLs Related to Network Composition and Enforcement Safe Harbor, published August 3, 2023 (the Technical Release).[1]

Kaiser Permanente[2] is the largest private integrated health care delivery system in the United States, with more than 12.7 million members in eight states and the District of Columbia. Kaiser Permanente's mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Overarching Comments

The Technical Release relates to the Departments' *Notice of Proposed Rulemaking CMS-9902-P Requirements Related to the Mental Health Parity and Addiction Equity Act* (the Proposed Rule).[3]

[1] Departments of the Treasury (Treasury Department), Labor (DOL), and Health and Human Services (HHS), Technical Release 2023-01P (July 25, 2023), https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/23-01.

[2] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., one of the nation's largest not-for-profit health plans, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and more than 600 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

[3] 88 Fed. Reg. 51552 (Aug. 3, 2023).

The Proposed Rule requires plans and issuers to include relevant data in the comparability and stringency analysis for each NQTL type in the "type, form, and manner" to be specified by the Departments in sub-regulatory guidance (referred to herein as "Relevant Data"), unless they qualify for an exception.[4]

Kaiser Permanente supports the Mental Health Parity and Addiction Equity Act (MHPAEA). We support the Departments' efforts to provide specific measures for the Relevant Data requirement and encourage the Departments to continue to revisit the measures and technical specifications for all NQTL types going forward. We appreciate the Departments' consideration of a Safe Harbor for Provider Network Composition NQTLs and encourage the Departments' development of safe harbors for all NQTL types that have been identified as priorities for enforcement.

Kaiser Permanente's greatest concern with the four categories of data proposed – out- of-network utilization, percentage of in-network providers actively submitting claims, time and distance standards, and reimbursement rates – is with the application of the "Special Rule" for NQTLs related to network composition. If Relevant Data shows "material differences" in access to in-network MH/SUD benefits as compared to in-network M/S benefits in a classification, that is *per se* noncompliance. The example provided by the Departments in the Proposed Rule to illustrate the application of the Special Rule suggests that a health plan must collect and evaluate in-network and out-of-network utilization rates, network adequacy metrics, and provider reimbursement rates—the categories of data contemplated by the Technical Release.[5] We dispute the conclusion that differences in these data, by themselves, demonstrates discrimination under MHPAEA.

The Technical Release focuses on data collection for "NQTLs related to network composition." We urge the Departments to define the specific NQTL types for which plans must collect data. In future guidance focused on Relevant Data, we ask the Departments to define those NQTLs. The final Technical Release should provide a specific list of NQTLs related to network composition that health plans must analyze, explain how to analyze them jointly, and clarify how to determine whether the data metrics from the Technical Release will be applicable to each separate network NQTL.

Kaiser Permanente asks the Departments to consider permitting plans to rely on multiple categories of network composition data and to evaluate that data together. While complex, experts recommend "[u]sing multiple types of standards and a layered approach to standards based on high-priority behavioral health provider types and treatment needs" to ensure access to care.[6]

We appreciate the Departments' consideration of the following specific comments on the four proposed categories of data:

Out-of-Network Utilization

Plans can and do collect and evaluate out-of-network data for purposes of improving access to care for members and patients. However, there are serious limitations to the data, and we disagree with the conclusions that the Departments intend to draw from it. As such, Kaiser Permanente does not

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[4] Proposed 26 CFR 54.9812-1(c)(4)(iv)(A) and (C), 29 CFR 2590.712(c)(4)(iv)(A) and (C), and 45 CFR 146.136(c)(4)(iv)(A) and (C), and as referenced in subsequent sections.

[5] Example 8 at 88 Fed. Reg. 51662.

[6] See https://aspe.hhs.gov/sites/default/files/documents/792ca3f8d6ae9a8735a40558f53d16a4/behavioral-health-network-adequacy.pdf and https://www.brookings.edu/wp-content/uploads/2017/09/regulatory-options-for-provider-network-adequacy.pdf

believe it is reasonable for out-of-network utilization data to be a *per se* basis for determining noncompliance.

The Departments state a belief that high usage of out-of-network MH/SUD providers, as compared to out-of-network M/S providers, is evidence that MH/SUD providers may be available in the relevant geographic areas but joining provider networks is not sufficiently appealing to them. The implication is that plans have the ability to persuade MH/SUD providers to be part of their networks. Kaiser Permanente believes MH/SUD providers' reasons for staying out of networks are, in fact, multifactorial and complex, and we support research to evaluate MH/SUD providers' participation in and perspective on plan networks. However, at this time, and with the information presently available, we do not believe the Departments can reasonably tie out-of-network utilization to disparate treatment of MH/SUD and M/S by health plans or plans' NQTLs.

Should the Departments proceed with the intended direction, however, Kaiser Permanente is concerned about health plans' ability to capture accurate and relevant data on out-of-network utilization. Health plans do not have data on our members' interactions with "cash only" private practices, which may be the providers of most interest. The Departments request comment on how they might control for treatment received from MH/SUD providers where no claim for benefits was made (i.e., because the participant, beneficiary or enrollee did not submit a claim for services furnished by an out-of-network provider). We do not see a way to control for this, as health plans generally do not have this data and have no mechanism for acquiring it.

Increasingly, mental health services are delivered at new access points (e.g., at schools and through crisis care delivery systems) that are out-of-network. Kaiser Permanente and many other stakeholders, including policymakers, view this development positively. These new access points are designed to improve access for vulnerable populations, and some states are requiring coverage by plans. The Technical Release's focus on out-of-network utilization as evidence of health plans' misuse of NQTLs would penalize plans for a positive trend that clearly benefits patients where and when they need MH/SUD services.

As described in Kaiser Permanente's comments on the Proposed Rule, we seek a clear definition of "material differences" with respect to out-of-network utilization (and other Relevant Data). The definition should identify and rely upon clear metrics and seek to minimize false red flags by ensuring that only statistically significant differences (calculated at a 95 percent confidence interval) are flagged as material differences.

The Departments propose collection of data over a two-year time frame. We recommend limiting the time frame to the previous rolling 12 months, which will be easier to administer and can be important if improvement opportunities were identified and corrective actions taken in the past year.

Percentage of In-Network Providers Actively Submitting Claims

Kaiser Permanente appreciates the Departments' concern with the inclusion of providers in a network directory who are not actively furnishing services to plan members. However, we do not believe that this metric is an appropriate Relevant Data metric for use in considering MHPAEA compliance.

As far as we know, measuring the percentage of in-network providers who are actively submitting claims is not used by federal or state regulators and has not been tested in any way to determine network adequacy or strength, so its relevance for assessing health plan members' access to care

is unknown. Until the usefulness of this metric is established by research, we strongly discourage including it as a Relevant Data metric.

The combined impact of this proposed metric and the Special Rule on Network Composition data would encourage health plans to *remove* providers who are not actively seeing members from their networks; even more perversely, these requirements would encourage plans to remove providers who are seeing fewer than five health plan members during the specified period. Given the current mental health provider shortage, this will further reduce access to care. Providers have limited panels and often contract with multiple plans. When there is an opening for a patient, that opening should be utilized. If the Departments establish rules that encourage pruning of networks, patients may lose access to care.

Kaiser Permanente and other health plans contract with health care organizations that manage networks of behavioral health providers. These contracts can be vital to ensuring access to needed mental health services. However, we do not have control over how these groups allocate their networks in a given geography or how they may prune their networks to manage providers who are not accepting patients or accepting few patients.

The Departments propose collecting this data over six months, which we believe is too narrow a window (and contrasts with the two-year window proposed for out-of-network use). Kaiser Permanente recommends a 12-month period for data collection.

Time and Distance Standards

Time and distance standards are an industry approach taken by regulators across many markets and by issuers and plans themselves to establish a minimum benchmark for a network. However, there are well-recognized limitations on time and distance standards to evaluate network adequacy, including that they do not reflect actual access to care (rather they only show where health plan members could potentially be able to receive care), they do not ensure high-quality care, and they do not take into account that a large and growing proportion of services are delivered via telehealth. Given these drawbacks, regulators are increasingly moving toward multi-factored measurement and acknowledging the importance of virtual care or telehealth in ensuring access to timely and high-quality care. We believe that measuring the timeliness of care, rather than focusing on geographic availability of providers, as time and distance standards do, is moving standards in the right direction (although there are limitations on the ability to accurately measure timeliness).

Should time and distance standards remain part of the Departments' evaluation, Kaiser Permanente strongly recommends metrics be adjusted to account for access to providers who offer telehealth services (for example, federal and state regulators have offered a "credit" toward meeting time and distance standards if care from certain provider types is made available via telehealth). At Kaiser Permanente, most outpatient mental health visits are now provided via video and phone, in accordance with patients' preferences.[7] Patients report a high-level of satisfaction with this mode of delivery and research indicates that it is safe and effective.[8] Crediting telehealth is also important to health equity, as it increases the numbers, diversity and language capabilities of the available

[7] Kaiser Permanente's outpatient mental health visits for July 2023 included 55.43% video, 22.66% telephone, and 21.91% in-person visits.

[8] See, e.g., Kaiser Permanente Division of Research: Telemedicine Gets Boost From Pandemic-Era Study (ajmc.com)

MH/SUD workforce in provider shortage areas. Equity requires acknowledgement of telehealth in network metrics, including in time and distance standards.

Reimbursement Rates

Reimbursement as an NQTL would be particularly challenging to implement given the lack of a clear definition for the NQTL type. There is a wide variety of reimbursement methodologies across the range of health care benefits. We also question whether provider reimbursement methodologies should be an NQTL, as they do not constitute a limit on the scope or duration of benefits. Treating in-network reimbursement as an NQTL type shifts the analysis of MHPAEA from being a patient-protection, anti-discrimination law into a law focused on defending the economic interests of providers, without regard to the potential adverse impact (through premiums and cost-sharing) on patients.

There is likely to be justifiable variability of payment methodologies for M/S services and MH/SUD services. As we describe in our comments on the Proposed Rule, Kaiser Permanente is particularly attuned to this issue as an integrated delivery system, in which we provide care through two care delivery models: (1) within a self-contained delivery system where providers operate within the same organization, allowing care to be delivered with very few NQTLs, and (2) with a contracted network of community providers ensuring adequate access. To meet the growing demand for mental health services in recent years, Kaiser Permanente has increased its reliance on a contracted network of mental health providers.

We reimburse our integrated medical group providers and contracted providers differently: our medical group providers are essentially salaried, while contracted providers are paid fee-for-service. We see the same complication with the inpatient classifications. Kaiser Foundation Hospitals are a part of our integrated delivery system and the site for most M/S inpatient care. Most inpatient MH/SUD services are delivered at contracted facilities. The reimbursement methodology is fundamentally different.

We expect that value-based payment programs are also likely to have a higher proportion of M/S providers. M/S providers are more likely to be in larger groups, with the administrative capacity and size to take on risk arrangements or population-based payment. The Proposed Rule should encourage value-based payment arrangements by permitting separate comparative analyses, including separate evaluations of data, for these groups.

We question whether the metrics proposed are helpful in evaluating the comparability of network NQTLs overall and reimbursement methodology in particular. Billed charges are not a meaningful metric, as they are not consistent, standard, or reliable. Rather, we recommend that the proposal require collection and evaluation of in-network payments and "allowable amounts" for inpatient MH/SUD and M/S benefits. We also recommend the Departments refrain from using the CPT-code comparison measures. The CPT-code metrics contemplated in the Technical Release provide a very narrow and arbitrary picture of negotiated reimbursement. In particular, the CPT codes referenced in the Technical Release represent only a tiny subset of office-based services.

Instead, the Departments should focus on negotiated allowed amounts as a percentage of an external benchmark (such as Medicare rates) for the same service to the extent that the benchmark source covers the service. Comparing the weighted average of negotiated rates against a benchmark rate for the same service is more likely to represent a meaningful picture of the

comparability of the network negotiation methodologies for MH/SUD versus M/S services. We also recommend the comparison be for all provider types, physicians and non-physicians.

Should the Departments move forward with the existing proposal, we suggest adding initial evaluation codes, given the focus on access.

The Departments propose performing the analysis on sub-classifications of providers that differ from the classifications of benefits provided by MHPAEA. This runs contrary to the broader structure of MHPAEA regulations and, if adopted as a required Relevant Data metric, would materially complicate MHPAEA compliance. For this reason, we recommend that any future metrics on reimbursement methodologies be developed at the classification level as such classifications are defined in regulation.

Alternatives

The Departments ask what other types of measures should be considered that are not addressed in the Technical Release. With the caveat that the application of the Special Rule for Network Composition would be misguided with any metrics (and noting that we encourage the evaluation of multiple metrics), we recommend the Departments explore how timely access to care can be appropriately and reliably measured and reported. State regulators and the Medicaid program are increasingly focused on these metrics, which, when combined with other metrics, would provide more meaningful measures of the impact of network NQTLs on patient access to MH/SUD services.

Aggregation of Data

Kaiser Permanente recommends data be collected for a health plan or issuer's book of business by product. We define "product" to mean a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity). Any set of plans that share a network type and a set of benefits is a product**.** This would streamline administrative work for health plans and ensure statistically valid data. As an alternative, we support the proposal in the Technical Release that all data be collected in the aggregate for all plans or policies, as applicable, that use the same network of providers or reimbursement rates.

Safe Harbor for NQTLs Related to Network Composition

Kaiser Permanente supports the development of a safe harbor for NQTLs related to network composition (and for all NQTLs). More time is needed to identify appropriate standards, consistent with the goals of the potential enforcement safe harbor, for each of the data elements described in the Technical Release.

We recommend the Departments extend the timeline for development of safe harbors.

Additional Comments

Kaiser Permanente requests that the measures selected and technical specifications that are adopted preempt state data collection requirements for MHPAEA compliance purposes. Aligning federal and state requirements directs enforcement activity to the highest priority areas and reduces administrative burden and operational costs.

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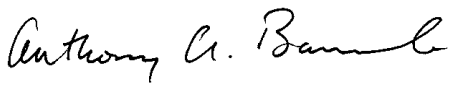
KP appreciates the Departments' consideration of these comments. Please contact Leah Newkirk at leah.g.newkirk@kp.org if we may provide additional information or answer any questions.

Sincerely,



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