From:	Ellen Weber
To:	EBSA MHPAEA Request for Comments
Subject:	Legal Action Center Comments - Technical Release 2023-01P
Date:	Friday, October 13, 2023 3:40:50 PM
Attachments:	Outlook-tncrjrr3.png Legal Action Center Comments Technical Release 2023-01P 10.13.23.pdf

Employee Benefits Security Administration:

Thank you for the opportunity to submit comments on the Proposed Relevant Data Requirements for Nonquantitative Treatment Limitations Related to Network Composition and Enforcement of Safe Harbor for plans subject to the Mental Health Parity and Addiction Equity Act.

We would appreciate confirmation that you have received the attached comments, if possible.

Thanks very much and enjoy the weekend.

Ellen

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October 13, 2023

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: Technical Release 2023-01P

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

The Legal Action Center appreciates the opportunity to submit comments on the Department of Health and Human Services, Department of Labor, Employee Benefits Security Administration, and the Internal Revenue Service's (the "Departments") Technical Release 2023-01P on data requirements related to network composition and enforcement of a safe harbor for group health plans and insurance issuers (hereafter "plans/issuers") under the Mental Health Parity and Addiction Equity Act (hereinafter "Parity Act" or "MHPAEA").

The Legal Action Center is a non-profit law and policy organization that fights discrimination, builds health equity, and restores opportunity for people with substance use disorders, arrest and conviction records, and HIV and AIDS. We have worked extensively on the enforcement of the Parity Act at the national and state levels, and Legal Action Center convenes state parity coalitions in both Maryland and New York. In New York, the Legal Action Center also assists consumers with parity-related barriers to substance use disorder treatment through the Consumer Health Access to Addiction and Mental Healthcare Project (CHAMP). On behalf of the Maryland Parity Coalition, we led advocacy efforts by substance use disorder (SUD) mental health (MH) consumer

and provider stakeholders to secure enactment of a Parity Act compliance law in 2020 and develop strong regulatory and data standards referenced in the Technical Release. We also led advocacy efforts on Maryland's recently updated network adequacy regulations,[1] which address many of the issues raised in the Technical Release.

We commend the Departments for adopting standardized data outcomes metrics for network composition and other non-quantitative treatment limitations (NQTL) and requiring plans/issuers to submit such data to demonstrate compliance with the NQTL "in operation" standards. For many NQTLs, the "in operation" analysis is incomplete without a comparative analysis of outcome data, and, as the Departments have observed in the proposed rule and MHPAEA Comparative Analysis Report to Congress, plans/issuers rarely provide meaningful outcome data unless mandated by regulators. **Nearly 15 years after the enactment of the Parity Act, consumers cannot wait any longer for equitable coverage and access to the SUD and MH services they pay for and have a right to receive.**

Based on our work, we urge the Departments to:

- Develop and require the use of standardized definitions, methodologies and templates for calculating and reporting outcomes data to ensure meaningful data collection, analysis and reporting across all plans/issuers.
- Require separate reporting and analysis of MH benefit data and SUD benefit data to accurately capture different levels of disparity for the respective benefits compared to medical/surgical benefits.[2]
- Ensure that measures and benchmarks are adjusted, as needed, for SUD benefits to accurately reflect service delivery models, which are frequently facility-based as opposed to office-based, and reimbursement models, which are often bundled rates as opposed to CPT code billing.
- Ensure that outcomes data reports are readily available to the public as non-proprietary plan/issuer plan documents and reported in a transparent form that consumers can use for cross-plan comparisons and plan selection.

These elements are essential for regulatory oversight and enforcement.[3] They will also facilitate enforcement of parity rights by consumers and providers. Plans/issuers routinely impose contract clauses, as a condition of contracting, that bar communications among providers about reimbursement rates and other contract provisions, precluding them from effectively negotiating fair standards of network participation and reimbursement. Data transparency will shine a light on plan/issuer practices, allow for a more level playing field in network

[1] Legal Action Center, Building Better Networks and Improving Access to Substance Use Disorder and Mental Health Providers: Lessons From Maryland (June 14, 2023).

[2] Milliman, "Addiction and Mental Health vs. Physical health: Widening Disparities in Network Use and Provider Reimbursement," at 19 - 20 (Nov. 19, 2029) (out-of-network utilization for SUD care "especially stark" and increased between 2013-2017 compared to med/surg services; SUD out-of-network utilization nearly four times the out-of-network utilization rate of MH services delivered in outpatient facilities and nearly double for office visits; relative SUD reimbursement declined over five-year period while MH reimbursement increased based on Medicare-allowed level); Wendy Yi Xu, et. al, "Cost Sharing Disparities for Out-of-Network Care for Adults with Behavioral Health Conditions," JAMA NETWORK OPEN (Nov. 6, 2019) doi:10.1001/jamanetworkopen.2019.14554 (patients with drug use and alcohol use disorders had higher utilization of and cost-sharing payments for out-of-network care than individuals with MH conditions or other chronic health conditions).

[3] In Maryland, for example, regulators did not impose uniform definitions and methodologies for quantitative data gathering and analysis in the first set of network adequacy regulations. This significantly hampered their review of insurer submissions and enforcement and precluded cross-plan comparisons.

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credentialing (network admission), and potentially result in more favorable contract standards that incentivize network participation by MH and SUD providers. As the Departments have recognized, MH and SUD providers are available to deliver care, but are either excluded from or not willing to join networks based on restrictive reimbursement, contracting or administrative standards.

While we fully support the data outcome metrics identified in the proposed rule and technical release, we do not support the adoption of the "material difference" standard as the threshold for a violation or the proposed safe harbor for network composition. As fully explained in our proposed rule comments, the "material difference" standard is inconsistent with the statutory requirements of "no more restrictive" and "no more stringent" application of NQTLs for MH and SUD benefits. 29 U.S.C. § 1185a(a)(3)(A)(ii) and (a)(8)(3)(A)(ii); 42 U.S.C. § 300gg-26(a)(3)(A)(ii) and (a)(8)(A)(iv). **A threshold that is more consistent with the statutory standard would be a "de minimis" variation – with any difference above such a mark constituting a Parity Act violation.** As discussed below, we also believe that it is premature to establish a "safe harbor." We urge the Departments to fully assess, over a multi-year period, plan/issuer compliance with outcome data submission and analysis, the value of the proposed metrics measures, and the relationship to improved access to network services.

In response to the Departments' inquiry on the appropriate timeline for plans/issuers to meet the network composition data requirements, **we urge the Departments to adopt the same timeline as the applicable date of the proposed Parity Act regulations**: the first day of the plan year beginning on or after January 1, 2025 for group health plans and, for individual policies, the first day of the plan year beginning on or after January 1, 2026. While plans/issuers have failed to report outcome data on network composition to date, these are not new requirements. Many plans/issuers that offer state-regulated insurance products are currently required to submit access plans that report data on their network composition, and plan administrators use sophisticated data analytics to build and assess networks. Research also documents the feasibility of collecting and evaluating this data. **We urge the Departments to issue guidance on the outcome metrics promptly and set a short timeline for plan/issuer implementation.**

I. Out-of-Network Utilization

As the Departments have observed, the disproportionately high use of out-of-network (OON) providers for MH and SUD treatment[4] strongly suggests that plan/issuer reimbursement, administrative and other contracting practices often exclude, preclude or deter many MH and SUD providers from joining networks. An analysis of out-of-network utilization of MH, SUD and medical/surgical (med/surg) benefits is essential to identify NQTLs that are not comparable to or are more stringently applied to MH and SUD services.

We support the proposed analysis of the items and services outlined in the Technical Release. Specifically, we agree that:

[4] In addition to the studies identified in the Proposed Rule and Technical Release, the Bowman Family Foundation recently issued a report on a NORC patient-experience survey of access to network MH and SUD services, which identified similarly disparate access to network MH and SUD services than physical health services, even though the reasons for seeing a non-network provider were the same across all health benefits. Equitable Access to Mental Health and Substance Use Care: An Urgent Need, App. A at 16-17 (July 2023), https://www.mhtari.org/Survey_Conducted_by_NORC.pdf.

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- inpatient services as well as non-hospital residential services must be assessed for MH, SUD and medical/surgical benefits and that the proposal identifies the correct settings of non-hospital care for each of the three benefits.
- the designated "intensive" outpatient services for med/surg care are good comparative services for intensive outpatient and partial hospitalization services for MH and SUD benefits.
- outpatient office visits and other outpatient items and services should be separately analyzed.
- Requiring an analysis of the two most recent years of claims data is the correct look-back period.

We urge the Departments to add "opioid treatment programs" (OTP) to the outpatient facility-based services that must be assessed for OON utilization and, in final guidance, specifically identify "drug testing" as included in "other outpatient items/services." Just as plans/issuers have excluded coverage for residential MH and SUD services, the Departments continue to identify plans that exclude coverage of OTPs,[5] which forces plan members to obtain such services through an OON provider and pay high out-of-pocket costs. For example, the Legal Action Center is currently assisting a consumer in New York with employer-sponsored insurance who is forced to pay $115 out-of-pocket every week for OON OTP services because his plan fails to maintain an adequate network of OTPs. Devastatingly, he has considered leaving his job so that he would qualify for Medicaid and be able to afford his medication. The availability of network OTPs may not be fully captured with other outcomes measures (e.g. billing by OTP practitioners is likely done via the OTP's NPI and not captured by the proposed claims billed data point). Similarly, disparate standards for drug testing impose financial burdens on patient and providers and should be a specific area of examination.[6]

In response to the Departments' inquiry on the claims data that should be collected, we note that Maryland's recently updated network adequacy regulations, COMAR § 31.10.44, require substantial reporting of OON utilization (and other) data by carriers in their access plans (as well as some public facing documents) (*see* § 31.10.44.04(c) and (e)) and offer useful guidance on many questions posed in the Technical Release. We have relied on these standards for many of the following recommendations.

First, we recommend that plans/issuers report the total number and percentage of claims that were submitted for OON providers and the total number and percentage of claims that were paid in full, paid in part, and denied (separately reporting the number of claims by outcome). A claim should be disaggregated into its component parts (i.e. all codes) for payment data in order to understand reimbursement patterns for payment of the full claim or only partial payment, which may differ between MH, SUD and med/surg providers. In other words, a plan/issuer may violate the Parity Act by not only having an insufficient number of MH and/or SUD providers in the network but also by establishing reimbursement practices that result in fewer discrete OON services being paid for MH and SUD care compared to med/surg services. Finally, the plan/issuer should report on payments made on OON claims based on the dollar figure for claims paid in full and paid in part and the dollar figure for claims that have been denied in whole and in part. Reporting on the "total dollar amount of all claims" alone could distort the outcome based on the potential high cost of specific med/surg services.

[5] MHPAEA Comparative Analysis Report at 35 (exclusion of MH and SUD residential services) and 40 (exclusion of OTPs).
[6] MHPAEA Comparative Analysis Report at 40.

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Second, we agree that reporting should be broken out by geographical region to help assess the extent to which provider shortages in various geographical regions may contribute to OON utilization. It is appropriate to use the geographical regions that the Departments adopt for the travel time and distance metric reporting for this purpose, although the proposed geographical regions may not provide sufficiently granular information for some states. For example, Maryland adopted a different set of geographical regions (urban, suburban and rural) for its travel distance metric (§ 31.10.44.05A(1)(c)) after initially considering the Medicare Advantage geographical regions, concluding that those regions would not provide meaningful data. (*See* discussion *infra* point III.).

For plans/issuers that have closed panel networks, including health maintenance organizations (HMO) and exclusive provider organizations (EPOs), we recommend the collection of data on the number of member requests for single case agreements (SCAs) to see a non-participating provider and the number and percentage of such requests that are approved and paid (separately reported). HMOs are required to deliver all covered services through a network provider and, in some states, must cover the cost of a non-participating provider if the network is not sufficient to meet the member's needs within a reasonable time and distance.[7] Such entities should, therefore, track services that are delivered by non-participating providers through SCAs. As of July 2022, eighteen (18) states have laws that protect plan members from balance billing requirements when a plan/issuer's network did not include providers that can deliver covered services.[8] In such circumstances, the plan/issuer would be required to enter into a SCA with a non-participating provider to deliver the service.

We agree that the Departments must carefully define each term that is used in the required analyses to ensure uniformity and validity of the plan/issuer's OON analysis and avoid data manipulation that could distort the plan/issuer's actual practices.[9] Among the terms that must be defined are:

- the setting(s) of care that must be included for each of the service delivery classifications (inpatient hospital, inpatient non-hospital, outpatient facility, outpatient office and other office services);
- the method for counting "claims" when multiple billed services or codes are requested in single claim;
- the terms "paid in full," "paid in part," denied" and "denied in part;" and
- the method for identifying the numerator and the denominator for all percentage calculations.

Finally, in response to the Departments' general request for information on a definition of "in-network" and "out-of-network" in the context of these data requirements, we note that the Department of Health and Human Services (HHS) glossary provides a good starting point. We offer the following recommendation that build on several definitions.

- In-network providers are the providers and facilities that a plan/issuer has contracted with to provide services and include both preferred and participating providers that contract with a plan that offers multiple tiers of in-network providers.

[7] Maryland's network adequacy regulations require reporting of single case agreement data in issuer access plans. COMAR § 31.10.44.04.C(3)(e).
[8] Legal Action Center, Survey of State Balance Billing Standards (Aug.2022) (on file at Legal Action Center).
[9] The Mental Health Treatment and Research Institute's (MHTARI) Model Data Request Form (2023) provides definitions for some of these terms. *See* https://mhtari.org/Plan_Sponsor_Recommendations.pdf.

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- Out-of-network providers are providers and facilities that do not have a contract with a plan/issuer and deliver services to members, beneficiaries or participants. Services may be delivered through a single case agreement for plans that are legally obligated to cover services as an in-network benefit even if a network provider is not available.

II. In-Network Providers Actively Submitting Claims

We fully support the Departments' proposal to require plans/issuers to collect and analyze data on the frequency at which designated providers submit claims for unique participants, beneficiaries, and enrollees. Numerous studies have documented the high level of inaccurate, incomplete, and inflated provider listings in directories,[10] which significantly burdens access to care for consumers and undermines efforts by providers to join networks. Individuals seeking SUD and MH care are often in the midst of a health care crisis and do not have the time, resources or capacity to contact providers who are not available or accessible to deliver care. Any delay in accessing SUD and MH care can result in the individual's death, yet many people delay or forgo care because of directory deficiencies. For providers who seek to join a network, an inflated directory can deter some from pursuing credentialing and may be used to justify a plan/issuer's refusal to contract with additional providers or negotiate favorable contract terms for a provider, further disincentivizing MH and SUD providers from joining networks.

A. NQTLs Implicated in Active Billing by Network Providers

We view active billing data as relevant to several network composition NQTLs, including network adequacy, provider directory accuracy (i.e. plan/issuer processes and strategies to monitor and update provider participation), provider admission and continued participation, and, relatedly, opening and closing networks for new providers. First, a network that has a disparately lower rate of active billing by listed SUD and MH providers compared to med/surg providers means that covered and affordable MH and SUD services are less accessible and available to members than med/surg services. More individuals are then forced to seek out-of-network care, but most individuals cannot afford to go to a non-participating provider. Even if a portion of listed med/surg providers does not actively bill, a disparate rate of active billing for SUD and MH providers may demonstrate that the adequacy of plan/issuer's network is not comparable.

Second, the provider directory is the information source to which plans/issuers direct members to identify network providers. The inclusion of "ghost" practitioners delays access to MH and SUD care as members, including those with an out-of-network benefit, rely on and exhaust those lists to find affordable care. We also often hear that plans require members to exhaust their search of the provider directory before seeking care from a non-participating provider in HMO plans or in other plans that operate under state laws that authorize access to non-participating providers when networks are inadequate. To the extent the rate of inaccuracy for SUD and/or MH providers is greater than that for med/surg providers, members endure greater delays and administrative burdens in seeking and accessing MH and SUD care (including additional time and effort required to identify and secure payment for a non-participating provider under a SCA if applicable).

[10] *See* Zhu, Jane M., et al., "Phantom Networks: Discrepancies Between Reported and Realized Mental Health Care Access in Oregon Medicaid," 41 HEALTH AFF. 1013 (July 2022), doi: 10.1377/hlthaff.2022.00052 (setting out research for commercial, Medicare Advantage, and Medicaid plans).

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Third, to the extent the plan/issuer relies on the number of providers listed in the directory to determine whether to contract with new providers and/or open and close networks (without regard to the extent of the provider's active billing and patient census),[11] greater disparities for MH and SUD active billers means that the plan/issuer will not add SUD and MH providers to the network with the same frequency as med/surg providers, and MH and SUD services will remain far less available than med/surg services. A health plans/issuer can easily perpetuate network inadequacy by failing to assess or account for the "real time" availability of varying MH and SUD providers.

Finally, apart from network outcome metrics, a disparate rate of active network providers is directly relevant to compliance with the scope of services NQTL. The lack of available network providers means that specific levels of SUD or MH care, while covered by the plan, may not be available and accessible. Indeed, a plan/issuer's failure to ensure that sufficient active providers are available to deliver services at each level of the MH and SUD continuum should also result in a finding of parity non-compliance for scope of services.

B. Data Collection and Analysis

In structuring the data gathering, reporting and analysis to assess active MH, SUD and med/surg providers, we offer the following observations and recommendations to ensure meaningful data:

- List of Providers
    - MH Providers that Bill: The proposed list of MH providers captures the key providers who bill for services and, appropriately, calls for separate reporting for child and adult psychiatrists and psychologists. **We urge the Department to also include Applied Behavioral Analyst, to assess coverage of autism spectrum disorder services.**
    - SUD Providers that Bill: The proposed list of SUD providers does not provide the same level of granularity as the list of MH practitioners and could result in an undercounting of SUD practitioners who are authorized to bill under state law. **We recommend that "addiction psychiatrists," "licensed professional counselors," "master's level licensed or certified addiction counselors," and "master's level licensed or certified alcohol and drug counselors" be explicitly identified.** [12]
    - MH and SUD Providers that Do Not Bill: We note that the proposed list also includes non-master's level MH counselors who may not bill the plan, but instead deliver services under the supervision of a licensed practitioner who bills for their

[11] In Maryland, we often hear from issuers that they rely on providers to correct information in plan directories, and we hear from providers that efforts to correct information is often futile.

[12] Among the licensed SUD counselors who can bill (depending on the state's education requirements) are: Licensed Addiction Counselors, Licensed Advanced Alcohol & Drug Counselors, Licensed Masters Addiction Counselor, Licensed Clinical Alcohol & Drug Counselors, Master Licensed Alcohol & Drug Counselor, Licensed Clinical Addiction Specialist, Advanced Alcohol and Drug Counselor. *See* U.S. Dept. of Health and Human Services, Asst. Sec. for Planning and Evaluation, CREDENTIALING, LICENSING, AND REIMBURSEMENT OF THE SUD WORKFORCE: A REVIEW OF POLICIES AND PRACTICES ACROSS THE NATION, App. A. (Nov. 2019), https://aspe.hhs.gov/sites/default/files/private/pdf/263006/CLRSUDWorkforce.pdf.

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services. In contrast, comparable SUD practitioners, including non-master's level addiction counselors and/or non-master's level alcohol and drug counselors have not been included. **The Departments should determine whether an accurate assessment of network coverage requires the inclusion of MH and SUD practitioners whose services are billed by a licensed practitioner and adjust the list accordingly to capture comparable data for MH and SUD providers.**

- Office-Based v. Facility Setting Billing: We also note that a substantial number of SUD and MH providers deliver services in a community-based treatment program or other facility setting and may bill under a treatment facility's NPI and, thus, must be captured to accurately reflect network coverage. Indeed, some SUD services – opioid treatment programs – must be delivered in a DEA-registered facility. Similarly, a count of network med/surg providers may also capture practitioners who deliver services in facility settings, such as federally qualified health centers, rural health centers, and other clinic settings, and similarly bill under the facility. **We recommend that active billing data include service delivery in both office-based and facility-based settings and, as noted below, separately report the site of service delivery for outpatient and inpatient services for the comparative analysis**.

- Definition of Terms: The proposed list of med/surg providers will similarly require clarification of several terms to ensure uniform data gathering across plans/issuers and avoid selective data reporting that may distort plan/issuer's network adequacy. For example, the Departments should identify the practitioner types that are covered as "non-physician primary care providers" and "non-physician specialty providers" and also determine the number and identity of specialists for whom data must be reported. We note that key specialty practitioners, including dermatologists, oncologists, obstetrician/gynecologists, gastroenterologists and others, have not been identified. The selective inclusion of med/surg specialty providers could distort the comparison.

- Measuring Provider Participation

  - Look-back period. We agree that the **appropriate look-back period for claims filing is six calendar months** ending 90 days prior to the month in which the report is filed.

  - Active Billing Benchmarks. In determining the appropriate benchmarks, **we agree that plans/issuers should report two benchmarks** – one of which should be "no claims" filed. In identifying the second benchmark, we recommend that the Departments rely on a metric that has been identified in the research literature as an indicator of network billing to determine whether a slightly higher number of unique patients would be a more appropriate indicator of inactive participation.[13] We also urge the Department, in defining terms, to ensure that the claims for unique patients

[13] *See*, e.g., Zhu, *supra* note 10, Phantom Networks at 1014 (testing various unique patient cut-offs as the basis for determining network participation in Medicaid managed care organizations).

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are submitted by providers with a network contract as opposed to claims filed by providers who have entered a SCA with the plan/issuer to deliver services.

- Data Points: **We recommend that plans/issuers should report both the total number and percentage of active and inactive providers**. The number of providers is important to understand the relative volume of SUD and MH providers in the network, which can be compared to the number of licensed MH and SUD practitioners in a state who would be eligible for network inclusion. Plans/issuers often assert that workforce shortages are the cause of inadequate networks. An assessment of the number of eligible licensed practitioners – information generally available from state licensure bodies – compared to the network participants would help test that assertion.

- Accepting New Patients: We agree that **providers should be required to identify whether they are accepting new patients.** With the overwhelming need for SUD and MH services and the high likelihood that active providers participate in multiple plan/issuer networks, it is important to measure disparities that exist across MH, SUD and med/surg providers when a new patient seeks care.

- Telemedicine Providers: We agree that plans/issuers should be permitted to count providers who bill services via telemedicine to the extent the plan/issuer demonstrates that (1) telehealth services are clinically appropriate, (2) telehealth delivery is available and accessible to members, (3) the provider offers comparable in-person services, and (4) the member has the right to select the mode of service delivery. While consumers continue to use telemedicine services more frequently for MH care than other medical services (and SUD care to a lesser degree than MH) post-COVID pandemic,[14] research demonstrates that the majority of patients received **in-person care** for MH and SUD even at the height of the pandemic.[15] Telemedicine utilization varies based on age, geographical location, access to broadband, comfort level with technology and digital literacy,[16] highlighting the need to honor patient preference and needs in determining whether telemedicine services are, in fact, clinically appropriate, available and accessible to a plan member.[17] Research has demonstrated that patients value the choice in how to

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[14] See FAIR Health Telehealth Tracker, https://www.fairhealth.org/fh-trackers/telehealth (last visited Aug. 30, 2023) As of May 2023, mental health diagnoses rank first among the top five diagnoses in all four regions across the United States with substance use disorder diagnoses ranking among the top five in two of four regions (and at no greater rate than the three other identified medical conditions).

[15] KFF and Epic Research found that, for the period March-August 2021, **over one-half of MH or SUD services were delivered in-person regardless of the specific condition.** Telehealth service delivery accounted for 29% of visits for both opioid and alcohol-related disorders and 33% - 43% of services for a range of MH conditions. Justin Lo, et al., *Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic* (Mar. 15, 2022), https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/#.

[16] *Id.*

[17] Research by NCQA concluded that "equitable and innovative care delivery should always place the patient at the center, thus, the design of technology and digital tools that facilitate care delivery must prioritize patient preference and needs." NCQA, The Future of Telehealth Roundtable: The Potential Impact of Emerging Technologies on Health Equity (2022) at p. 10. Individual patient factors and considerations, such as digital

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receive MH and SUD care, and experience a greater therapeutic relationship when they have that choice.[18] To allow plans/issuers to count telehealth service delivery without considering a patient's preference and need for in-person care on a periodic or regular basis over the course of care would not accurately reflect the adequacy of the network and would exacerbate existing inequities in care access.

We are also aware that some national carriers offer very large, nation-wide all-telemedicine networks for MH and SUD care and structure plan costs to incentivize members to join such plans. These plan networks do not meet a member's need for in-person care, as health conditions change, and would result in high out-of-pocket costs for any in-person service. Anecdotally, nationwide telehealth networks may reduce the availability of practitioners who are willing to join networks of in-person service providers.[19] These trends are important to monitor and consider in the development of the parity-focused network adequacy outcome metrics; MH and SUD services will invariably be affected to a greater extent than med/surg services based on the disproportionate use of telemedicine across MH, SUD and med/surg services.

To allow for a full assessment of trends, we recommend that the Departments require separate reporting of active billing by providers delivering in-person services and those delivering telehealth services. The Centers for Medicare & Medicaid Services (CMS) has emphasized in its recently proposed Medicaid managed care regulation the need to "balance the use of telehealth with the availability of providers that can provide in-person care and enrollee's preferences for receiving care to ensure that they establish network adequacy standards…that accurately reflect the partial use of both types of care in their State."[20] To ensure that States reflect this, CMS has proposed that telehealth appointments be counted toward the satisfaction of appointment wait time metrics only if the provider also offers in person services. CMS would require a secret shopper survey to assess network strength and require the separate reporting of in person and telehealth appointments.[21]

- Geographical areas: Data should be evaluated by geographical regions, based on the definition of geographical regions that are used for the other metrics. As noted above, the MA geographical regions may not generate useful data in some states,

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literacy, English proficiency, visual, cognitive, intellectual, mobility and functional needs, comfort level with sharing video, and socio-economic status, all contribute to a patient's care decision. *Id*. at pp. 10-113323.

[18] Jessica Sousa et al., *Choosing or Losing in Behavioral Health: A Study of Patients' Experiences Selecting Telehealth Versus In-Person Care*, Health Affairs (Sept. 2023), https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00487.

[19] *See* National Academy for State Health Policy, "Health Insurance Market Officials Raise Questions at They Look Toward the Future of Telehealth, Jan. 31, 2022), https://nashp.org/health-insurance-market-officials-raise-questions-as-they-look-toward-the-future-of-telehealth/ (increasing access to a greater number of remote providers could result in the availability of in-person services; Sousa, *supra* note 18, "Choosing or Losing In Behavioral Health," (noting one-third of surveyed patients receiving MH therapy did not see clinicians offering both in-person and telehealth visits).

[20] Centers for Medicare & Medicaid Services, Medicaid Program; Medicaid and Children's Health Insurance Program Managed Care Access, Finance and Quality, 88 Fed. Reg, 28092, 28099 (May 3, 2023)

[21] Centers for Medicare & Medicaid Services, *supra* note 20, 88 Fed. Reg. 28102.

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suggesting that urban, suburban and rural regions could be preferable. Standardized definitions should be adopted.

C. Conducting the Comparative Analysis of Active Billers

We recommend that the Departments require plans/issuers to report the discrete rate of active billing by the proposed list of provider types for MH providers, SUD providers and med/surg providers (with the adjustments proposed above). To the extent the total number of network providers in any of the provider type categories is too small to allow for a meaningful calculation, we recommend that the provider types be categorized as "physician" and "non-physician practitioners." We envision that psychologists, social workers and the full range of master's level licensed or certified MH or SUD counselors would be identified as a "non-physician practitioner" as would non-physician specialty medical providers. Additionally, active billing by practitioners who specialize in child and adolescent MH, SUD and med/surg care should be evaluated separately from adult care to better assess availability and access to care for that population and identify parity violations that exist among sub-groups of MH or SUD practitioners.

For the comparative analysis, we urge the Departments to consult with health economists and other statistical experts on a valid comparative analysis for active billers in the outpatient and inpatient classifications. One option is to compare active billers by "physicians" and "non-physician practitioners," for both the outpatient and inpatient classifications, comparing data for:

- MH physicians v. med/surg physicians
- SUD physicians v. med/surg physicians
- MH non-physician practitioners v. med/surg non-physician practitioners
- SUD non-physician practitioners v. med/surg non-physician practitioners

A separate analysis should be conducted for facility setting billing for both outpatient and inpatient facilities, separately comparing MH facility billing v. med/surg facilities and SUD facility billing v. med/surg facilities.

D. Definition of Terms

In addition to defining the terms identified above and the practitioners who fall into each practitioner billing type, guidance should define "unique patients" and all components of the analysis. To the extent providers of telehealth services are counted, guidance must also establish the telehealth services that constitute a "billable" service and that the telehealth provider meets the criteria for inclusion (as identified above).

III. Travel Time and Distance Standards

We agree with the Departments' proposal to require plans/issuers to submit data on network access based on travel time and distance standards. As noted in the Technical Release, this metric is used by CMS for Medicare Advantage plans and qualified health plans (QHPs) on federally-facilitated exchanges (FFE) and is, therefore, a metric with which many entities that offer health coverage in both the private and public markets are familiar and currently evaluate. Additionally, states that have adopted quantitative metrics for network adequacy in state-regulated individual and group plans generally include a travel distance metric (distance, time

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or both). Based on a 50-state survey of state network adequacy standards conducted by the Legal Action Center and Partnership to End Addiction, as of March 2020, twenty-six (26) states have geographic travel distance and/or travel time metrics, twelve (12) of which have specific metrics for MH and SUD services.[22]

A. Travel Time and Distances Metrics

In structuring the collection and reporting of travel time and distance, we recommend the following:

- Provider Types and Quantitative Values

We support the Departments' proposal to assess a range of SUD, MH and med/surg practitioner types and facility types and agree that the list of MH and SUD providers should include, at a minimum, those identified in the Technical Release. **We note that neither the QHP nor MA list of MH and SUD provider and facility types[23] is sufficiently granular to fully evaluate access to such treatment for Parity Act purposes, and both lists combine providers of MH and SUD care, which must be disaggregated to conduct a parity compliance review.** Accordingly, in addition to the proposed provider list, which appropriately captures a fuller cohort of SUD and MH practitioners, **we urge the Departments to separately assess providers of MH and SUD services and identify (if not separately track) several additional provider types,** as in the Maryland network adequacy regulation (COMAR § 31.10.44.05.A(5)): Addiction Medicine, Licensed Clinical Social Worker, Licensed Professional Counselor,[24] Psychiatrists separately reported for youth/adolescent and adults, Psychologists, Outpatient Mental Health Clinic, Outpatient Substance Use Disorder Facility, Residential Crisis Services, and Substance Use Disorder Residential Treatment Facility (reported separately from MH inpatient/residential services). It is critically important to capture SUD and MH facilities as they deliver a substantial portion of services, particularly to lower-income individuals who may transition from Medicaid to exchange or employer plans. Additionally, practitioners at MH and SUD facilities generally bill through the facility's NPI and some would not be captured if facility settings were not counted discretely.[25]

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[22] Legal Action Center and Partnership to End Addiction, "Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services: Federal and State Regulation and Enforcement of the Parity Act," Exh. A (May 2020), https://www.lac.org/resource/spotlight-on-network-adequacy-standards-for-substance-use-disorder-and-mental-health-services

[23] CCIIO 2023 Final Letter to Issuers in the Federally-facilitated Exchanges (April 28, 2022) at p. 12-13, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf; Medicare Advantage and Section 1876 Cost Plan and Network Adequacy Guidance (last updated March 4, 2022) at 13-14, https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Medicare%20Advantage%20and%20Section%201876%20Cost%20Plan%20Network%20Adequacy%20Guidance_03_04_2022.pdf (Medicare does not cover community-based SUD programs as a covered provider thereby excluding a significant source of SUD care and does not track access to opioid treatment programs.)

[24] We note that the QHP list of providers appears to combine the full range of MH and SUD counselor types in one provider type (Outpatient Clinical Behavioral Health – licensed, accredited, or certified professionals). A similar approach can be taken for psychologists, LCSWs, LPCs and other practitioners who are eligible to bill directly, as long as providers of MH and SUD services are separately reported, and the Departments articulate the full range of providers for the "counselor" type.

[25] The Technical Release requests guidance on counting providers who bill under a group NPI or for groups that have multiple providers on staff. Apart from capturing SUD and MH facility billing, we urge the Departments to clearly articulate standardized rules for common billing protocols to prevent data manipulation and ensure accurate comparative data.

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In establishing travel time and distance values for the above SUD and MH provider types (non-facility), we urge the Departments to apply the same values as the current QHP standard for Outpatient Clinical Behavioral Health professionals. As the QHP standards tacitly recognize, these professionals are often the "primary care" providers of SUD services, given the limited integration of SUD care in primary care settings, and should be as readily accessible as pediatric and adult primary care practitioners.

For outpatient SUD and MH facilities (OTPs, mobile crisis units, SUD facilities and MH facilities), we urge the Departments to apply the same travel distance and time values as currently applied for urgent care, skilled nursing facility, outpatient surgical care, diagnostic radiology and infusion centers. These providers also serve as the front-line and, often, only source of care in a community. This will establish a baseline metric that is comparable for MH, SUD and med/surg outpatient facilities, as required under the Parity Act.

For residential MH and SUD facility-based services, we note that **the existing QHP FFE travel distance and time values for Inpatient or Residential Behavioral Health Facility Services are substantially greater than the values for Skilled Nursing Facilities (SNFs) and Acute Inpatient Hospitals**. As the Departments have long recognized, benefit standards for intermediate levels of care for MH and SUD must be comparable to those for SNFs,[26] and inpatient SUD and MH facilities are essential to meet care needs and address limited availability of hospital inpatient services. In establishing a comparable metric for MH, SUD and med/surg services, **we urge the Departments to align the values for MH and SUD residential services with SNFs and inpatient hospital care in both the QHP FFE standards and proposed Parity Act outcome data metrics.**

- Geographical Regions:

As noted above, the existing CMS Medicare Advantage (MA) geographical region standards offer a framework with which many national and state-based carriers are familiar based on their participation in the MA market and QHP FFE market. The specific travel time and distance values for covered providers also offer a standardized benchmark across plans and states. That said, our review of state quantitative metrics for travel time/distance found that 11 of 26 states do not identify any geographic regions and, of the 15 states that do, only 2 have adopted the MA/QHP geographical regions. The remaining 13 states have adopted a variation of urban and rural, urban, suburban and rural, or metropolitan statistical area (MSA) and non-MSA. We defer to the Departments on the appropriate geographical regions and recognize that uniformity across financing systems is important, to the extent possible.

- Measuring Travel Distance

We recommend that the standard for measuring travel distance be based on the distance between the member's residence and the provider's location and calculated based on road travel distance. Travel time should take into consideration both automobile travel and public transportation[27] to account for the use of public transportation, which may be used more frequently by individuals with lower-incomes, communities of color and underserved

[26] *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Red. 68240, 68246-47 (Nov. 13, 2013).

[27] Spotlight on Network Adequacy, *supra* note 22 (New Jersey and New York's standards address the use of public transportation).

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populations, and will add substantial time to accessing services in many geographical regions.

- Telehealth Services

As noted above, specific conditions must be satisfied for telehealth services to be counted for satisfaction of travel distance/time or any other metric, including, as proposed below, appointment wait time. The telehealth service must be (1) clinically appropriate, (2) available and accessible to the plan member/participant, and (3) elected by the plan member. Additionally, comparable in-person services must be available at the member's request. This ensures that plans/issuers offer telehealth services to supplement, not replace, in-person services.

We are aware that Medicare Advantage permits plans to claim a telehealth credit to satisfy travel time/distance standards under limited circumstances, consistent with the above conditions. 42 C.F.R. §§ 422.116(d)(5) and 422.135.[28] MA plans are permitted to count the additional telehealth benefits as basic benefits covered under traditional Medicare (which MA plans are obligated to cover) only if they "[f]urnish in person access to the specified Part B services(s) at the election of the enrollee…[and] advise each enrollee that the enrollee may receive the specified Part B service(s) through an in-person visit or through electronic exchange…." 42 C.F.R. § 422.135.

If telehealth services are to be taken into consideration, we oppose the adoption of a credit, which serves as an arbitrary enhancement of network availability. Plans/issuers should be able to add billing codes to designate a telehealth service and thereby directly count the delivery of a telehealth service just like an in-person service. The Department of Health and Human Services has rejected the adoption of a telehealth credit for QHPs finding that "more research is needed" and asserting that "telehealth services should be made available in addition to, rather than instead of, in-person care."[29]

B. Additional Metrics

We recommend that the Departments require plans/issuers to report on appointment wait times, as is required of QHPs on the FFEs beginning in the 2025 plan year.[30] The wait time to obtain a MH and SUD appointment is the most critical metric to assess access to care, as limited

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[28] Centers for Medicare & Medicaid Services, Medicare Program: Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, 85 Fed. Reg. 33796, 33856 (June 2, 2020) (noting that the credit is designed to be "a supplement to an existing in-person contracted network [giving] enrollees more choices in how they receive health care").

[29] Dept. of Health and Human Services, Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27208, 27333 (Final Rule May 6, 2022). CMS similarly rejected the adoption of a telehealth credit for Medicaid managed care plans in its proposed rule earlier this year, highlighting the consistency with the requirement for QHPs. CMS Medicaid Managed Care Rule, *supra* note 20, 88 Fed. Reg. at 28103.

[30] Dept. of Health and Human Services, Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27208, 27322 (Final Rule May 6, 2022). CCIIO, 2024 Final Letter to Issuers in the Federally-facilitated Exchanges at 12 (May 1, 2023), file:///C:/Users/eweber/Downloads/2024-Final-Letter-Issuers-508.pdf. CMS has similarly proposed appointment wait time standards for outpatient MH and SUD services (pediatric and adult), primary care (pediatric and adult), obstetrics and gynecology and one state-selected provider type in the Medicaid managed care and Children's Health Insurance Program, aligning the wait time metrics with those for QHPs. Centers for Medicare & Medicaid Services, Medicaid Program; Medicaid and Children's Health Insurance Program Managed Care Access, Finance and Quality, 88 Fed. Reg, 28092, 28097 (May 3, 2023).

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network providers result in excessive delays in initiating treatment and often result in patients abandoning efforts to get necessary care. The wait time metric is essential to gain a true assessment of the breadth of the plan/issuer's network and, importantly, will account for providers who are taking new patients (which may be more difficult to ascertain through a travel distance/time metric, which is generally ascertained through geo-mapping rather than direct contact with providers). In our tracking of network adequacy in Maryland, issuers have routinely satisfied travel distance metrics for MH, SUD and medical services but fail to meet appointment wait time metrics for MH and SUD benefits. For these individuals, it makes little difference that a provider is accessible within a reasonable travel distance if a timely appointment is not available.

To assess compliance with wait time metrics, we recommend that the Departments, at a minimum, adopt the QHP wait time standards of 10 calendar days for MH and SUD treatment (both initial and follow-up appointments that would be deemed "non-urgent" or "routine" visits), 15 calendar days for primary care (routine) and 30 calendar days for specialty care (non-urgent).[31] Aligning outcome data with the wait time standards that currently apply to QHP issuers on FFEs will ease administrative burden on plans/issuers. We also recommend that additional metrics be established for "urgent care" SUD, MH and med/surg services, as required under Maryland's network adequacy standards. COMAR § 31.10.44.06.A(2).

To ensure uniformity across plans/issuers and the collection of meaningful data (without data manipulation), the Departments must articulate the full range of MH, SUD and med/surg provider and facility services that are to be counted and define the term "routine" service (and "urgent" service, if adopted). The Departments must also establish a standardized methodology for calculating the first available appointment using a random sample of network providers and facilities (including the designated sample size) and the designated timeline and/or frequency for collecting such data. We note that Maryland's network adequacy regulations set out a standardized methodology and allow for the department of insurance to conduct a separate, centralized survey to measure wait time. COMAR §31.10.44.06.A.(3)-(5). An excellent method for ascertaining appointment wait times has been proposed by CMS in its recently proposed regulations for Medicaid managed care and CHIP plans; those rules, if finalized, would require managed care plans to use an independent entity to conduct annual secret shopper surveys to determine compliance with proposed appointment wait time metrics.[32] CMS has observed that:

> [T]he best [appointment wait time] results are obtained when the survey is done by a secret shopper….Results from these surveys should be unbiased, credible, and reflect what is truly like to be an enrollee trying to schedule an appointment, which is a perspective not usually provided by, for example, time and distance measures or provider-to-enrollee ratios.[33]

One other commonly used network adequacy metric – provider-to-patient ratios – has not

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[31] CMS has proposed the same metrics for routine outpatient MH and SUD care and routine primary care in its proposed Medicaid managed care and CHIP rule. *See*, CMS Medicaid Managed Care Rule, *supra* note 20, 88 Fed. Reg. at 28098. The proposed rule would permit telehealth service appointments confirmed via the secret shopper survey to be counted for satisfaction of the wait time metric **only if** the provider also offers in-person appointments. See § 438.68(f)(2)(ii). States that have adopted quantitative appointment wait time metrics also impose appointment wait time requirements for MH and SUD benefits that are either equal to or shorter than primary care provider metrics. *See* Spotlight on Network Adequacy, *supra* note 22. Exh. B.

[32] CMS Medicaid Managed Care Rule, *supra* note 20, 88 Fed. Reg. at 28101.

[33] *Id.*

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provided useful data to assess the breadth of an issuer's MH and SUD network in comparison to med/surg services, based on Maryland's experience. The most commonly identified value (e.g. 1:2000) sets a very low bar that does not meet the significant need for care nationwide. We, therefore, do not recommend the inclusion of this metric in outcome data reporting.

C. Structuring the Comparative Analysis

In structuring the comparative analysis for travel distance/time, we recommend that the Departments require plans/issuers to calculate the percentage of plan members/participation who can access one (or more) in-person provider for each of the provider types and facilities within the designated travel distance/travel time. While MA and QHP standards establish a satisfaction threshold of 90% of plan members, in our experience in Maryland, most plans achieve that threshold for virtually all MH, SUD and med/surg benefits. We, therefore, urge the Departments to set a higher threshold of 95% and evaluate the plan/issuer's performance across each provider type and facility type to assess, as a preliminary cut, the general strength of the network, identifying the degree to which members have access to various MH and SUD providers/facilities compared to access across the various med/surg provider types. Consistent patterns of non-satisfaction for MH and/or SUD providers/facilities compared to med/surg providers/facilities would strongly suggest an inadequate network.

A comparative analysis of a subset of SUD, MH and med/surg provider types should also be conducted for provider types that require the same travel time/distance values and/or, alternatively, have comparable levels of credential; i.e. physician v. non-physician providers as well as facility types. We recommend consideration of the following potential comparisons:

- Addiction Physicians v. Primary Care Physicians
- Psychiatrists - Pediatrics v. Primary Care - Pediatrics
- Psychiatrists - Adult v. Primary Care – Adults
- MH Counselors (all types combined) v. Primary Care (based on the same travel distance/time values)
- SUD Counselors (all types combined) v. Primary Care (based on the same travel distance/time values)
- Non-physician MH counselors v. Non-physician Occupational Therapists/Speech Therapists/Physical Therapists
- Non-physician SUD counselors v. Non-physician Occupational Therapists/Speech Therapists/Physical Therapists
- Outpatient MH facilities v. Outpatient med/surg facilities (based on the same proposed travel distance/time values)
- Outpatient SUD facilities v. Outpatient med/surg facilities (based on the same proposed travel distance/time values)
- SUD residential facilities v. Skilled Nursing Facilities
- MH residential facilities v. Skilled Nursing Facilities
- Hospital Inpatient SUD v. Acute Inpatient Hospitals
- Hospital Inpatient MH v. Acute Inpatient Hospitals

The proposed appointment wait time metrics would allow for a straight-forward comparative analysis of MH and SUD services, respectively, compared to primary care and specialty care services, respectively.

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IV. Reimbursement Rates[34]

We strongly support the Departments' proposal to conduct two types of reimbursement rate analyses:

- In-network payments v. billed charges for MH, SUD and med/surg benefits in two classifications - inpatient and outpatient (separating office visits and all other charges); and
- Reimbursement for four commonly billed CPT codes 99213 (E&M low-level established patient visit, 20-29 minutes), and 99214 (E&M mid-level visit established patient) and 90834 (psychotherapy, 45 minutes with patient) and 90837 (psychotherapy, 60 minutes with patient).

As described below, the first analyses – payment to billed charges – will capture service delivery rates across the full range of SUD and MH services, many of which are not captured under the Medicare Fee Schedule, and will also allow for a better assessment of the gap in reimbursement for MH and SUD services compared to med/surg services.

The Medicare Fee Schedule has substantial limitations as a benchmark for most comparative analyses.

- Medicare does not cover the full complement of SUD service settings, including community-based outpatient clinic settings and residential treatment settings, and will only begin to cover licensed professional counselors (LPCs) and marriage and family therapists (MFTs), as of January 1, 2024.
- Medicare establishes a discriminatory reimbursement rate for licensed clinical social workers (LCSWs), LPCs and MFTs, setting reimbursement at 75% of the physician fee schedule compared to 85% of the physician fee schedule for other non-physician medical providers.
- Medicare rates (and the Medicare program generally) are not subject to the Parity Act and, thus, have never been evaluated for compliance with non-discrimination standards.
- Medicare rates do not include rates for discrete youth/adolescent services.

CMS has long recognized that the relative value unit (RVU) methodology for establishing Medicare rates results in a "systemic undervaluation of work estimates for behavioral health services"[35] and that "any potential systemic undervaluation could serve as an economic deterrent to furnishing these kinds of services and be a contributing factor to the workforce shortage."[36] According to CMS, primary therapy and counseling services for MH and SUDs are

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[34] We have consulted with Dr. Tami Mark, Distinguished Fellow, Behavioral Health, RTI International who provided guidance on the reimbursement rate analysis and recommended the out-of-pocket spending analysis described in point C.

[35] Centers for Medicare & Medicaid Services, Medicare and Medicaid Programs: CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 88 Fed. Reg. 52262, 52320, 52366 (Aug. 7, 2023); *see also*, Marua Calsyn and Madeline Twomey, "Rethinking the RUC: Reforming How Medicare Pays for Doctors' Services" (July 13, 2018), https://www.americanprogress.org/article/rethinking-the-ruc/ (identifying the undervaluing of cognitive services, such as those involved in MH and SUD counseling patients, compared to procedure-based services, and the underlying flaws in the process for establishing RVUs).

[36] *Id.* at 52367.

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among the services most affected by their methodology, which undervalues the practice expenses incurred in the administrative labor, office expenses and all other expenses incurred by practitioners who bill the psychotherapy codes (including CPT 90834 in the proposed analysis).[37] To the extent plans/issuers use Medicare as a benchmark, they perpetuate imbedded inequities that must be eliminated.

A. CPT Code Analysis

We agree that the proposed evaluation of the two E&M codes (99213 and 99214) will allow for a direct assessment of reimbursement disparities between psychiatrists and addiction physicians and med/surg physicians, all of whom bill the same E&M codes. We recommend that the Departments require plans/issuers to submit data for all physicians and physician specialists who bill these two E&M codes and report the mean, median and, additionally, the distribution of reimbursement rates. The distribution will provide evidence of plan/issuer's practice of paying higher rates to attract some provider types that are in high demand and short supply.[38] A separate comparison of the plan/issuer's average and median rates to the allowed Medicare rate for 99213 and 99214 will also reveal any percentage increase or reduction disparities in MH and SUD reimbursement compared to med/surg. Any disparate reimbursement rates should be proof of a Parity Act violation.

For the psychotherapy codes, the Departments should similarly require a comparison of the plan/issuer's average and median reimbursement for psychologists, LCSWs, LPCs and MFTs to the Medicare allowed amount to assess percentage increases/decreases, with separate calculations for MH and SUD services. The Departments could also require plans/issuers to compare reimbursement for MH and SUD non-physicians for psychotherapy to med/surg services by identifying comparable billing codes for occupational therapy, physical therapy and speech therapy and comparing the percentage increases/decreases against the Medicare benchmark.[39]

We also recommend that the Departments require plans/issuers to conduct one additional facility type comparison for opioid treatment programs (OTPs) based on Medicare reimbursement. In contrast to other Medicare rate-setting for MH and SUD services, CMS has carefully assessed the proper reimbursement rate for OTPs to account for the cost of care delivery and complexity of patient needs.[40] A comparison of the plan/issuer's rate for OTPs[41] compared to that for Medicare would provide direct evidence of disparate rates that violate the Parity Act.[42]

In conducting a comparison of reimbursement to the Medicare rates for all four CPT codes, we

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[37] *Id*. at 52367-68.

[38] We note that the total reimbursement to psychiatrists and addiction physicians will be less than that paid to physicians delivering other medical services based on procedure code billing that is not available for MH and SUD care.

[39] *See* DOL Self-Compliance Tool, App. II.

[40] Centers for Medicare and Medicaid Services, Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 87 Fed. Reg. 69404, 69768-74 (Nov. 18, 2022)

[41] The OTP billing codes are G2067-G2075. The methadone weekly bundled rate code, G2067, may be the most appropriate code for comparison purposes.

[42] We are familiar, for example, with OTPs in Maryland that have applied for plan credentialing but could not accept the non-negotiable plan rate, as it did not cover the cost of services that OTPs are required to provide under state and federal law.

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recommend using the relevant locality's rate rather than the national rate to account for geographical difference in reimbursement rates. We agree with the Departments' proposed look-back period of two-years, using the most recent and complete calendar years that ended 90 days prior to the start of the policy/plan year.

B. Billed v. Reimbursed Rates

The proposed analysis of billed versus reimbursed rates is a far more useful analysis to capture the full range of MH and SUD providers for inpatient and outpatient services. We caution, however, that plan reimbursement rates must consider the rates that individual practitioners are able to negotiate with plans/issuers as opposed to corporate entities, such as Headway, that negotiate reimbursement with plans and contract with individual practitioners to help build the plan/issuer's network. We are aware that such corporate entities are able to negotiate higher rates with some plans/issuers than the individual practitioner is able to negotiate on their own. The former rate will distort reimbursement practices, as some practitioners refuse to operate as a third-party contractor yet cannot negotiate a sufficiently high rate with the plan/issuer to participate in the network.

For outpatient provider office visits, we recommend that the Departments require plans/issuers to:

- collect and report both the billed and reimbursed rates for all MH, SUD and med/surg provider types that bill and compare the values for physician billers and non-physician billers;
- collect and report billed and reimbursed rates for outpatient facility settings that bill under the facility's NPI number. We note that facility billing may be particularly important for SUD treatment, for which services will more likely bill under the clinic's NPI than the practitioner's NPI.
- report the average and median billed and reimbursed rates as well as the distribution of reimbursement rates, which will reveal disparities in reimbursement for high demand SUD, MH and med/surg provider types that may have shortages of high demand practitioners.

For inpatient provider services, we recommend that the Departments require plans/issuers to:

- collect and report hospital inpatient billed and reimbursed MH, SUD and med/surg services and separately collect and report non-hospital residential MH, SUD and med/surg services.
- Report the average and median billed and reimbursed rates as well as the distribution of reimbursement rates.

C. Additional Reimbursement Analysis[43]

As an analogue to the out-of-network utilization data, we recommend that the Departments require plans/issuers to conduct a reimbursement rate analysis that directly examines the relationship between reimbursement rates and the cost burden on members who access out-of-

[43] Dr. Tami Mark, RTI International, who has studied coverage and reimbursement of SUD and MH services in all major financing systems has proposed this analysis.

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network services for MH and SUD benefits at a disproportionate rate.[44] The proposed analysis would examine the total out-of-pocket (OOP) payments by plan members for MH, SUD and med/surg services divided by the total reimbursement for MH, SUD and med/surg services, respectively, both in-network and out-of-network; i.e. a comparison of the portion of service costs that members pay for MH and SUD care (separately analyzed) versus med/surg care. That is, the plan would calculate the total amount that all plan members paid OOP over the course of the year for OON MH benefits, SUD benefits and med/surg benefits (calculated separately) and divide that number by the total amount that the plan/issuer paid for both in-network and OON for MH benefits, SUD benefits and med/surg benefits (respectively and separately calculated). Since the Parity Act has largely addressed disparities in financial requirements related to plan/policy deductibles and copayments/coinsurance, OOP spending for out-of-network services will reveal the additional disparate costs that members incur. We expect the data will confirm trends that have being described in the research literature: out-of-network care rates and cost-sharing payments are much higher when members seek care for MH and SUD care compared to other medical services.[45] Claims would provide relevant data on the billed and allowed amounts and the member's responsibility.

To conduct the analysis, the Departments would identify a subset of SUD, MH and med/surg services for outpatient and inpatient out-of-network care, such as:

- psychiatry, addiction medicine, and PCP, OB/GYN and other specialist office visits
- non-physician specialists, including psychologists, LCSWs, LPCs, MFT delivering MH services and non-physician specialists delivering med/surg services
- non-physician specialists, including psychologists, LCSWs, LPCs, MFT delivering SUD services and non-physician specialists delivering med/surg services
- Outpatient SUD facility services and OP med/surg facility services
- Outpatient MH facility services and OP med/surg facility services
- Residential SUD facility services and skilled nursing facilities
- Residential MH facility services and skilled nursing facilities.

Disparities in the proportion of OOP spending within each provider group, like out-of-network utilization rates, is evidence of a Parity Act violation, as increased cost burden limits equal access to SUD and MH care. A second level analysis of the plan/issuer's average and median reimbursement for practitioners at the top 75th and 95th percentile for in-network and out-of-network MH, SUD and med/surg practitioners would reveal pay disparities that account for or contribute to network participation. The same analysis could be conducted for facilities across all their procedures. Based on disparities in out-of-network costs and reimbursement rates, the plan/issuer would be required to fix the reimbursement rates to remove disparities and/or take other steps that may influence provider participation in the network (e.g. burdensome administrative requirements, including utilization management practices).

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[44] Xu, et. al, *supra* note 1, "Cost Sharing Disparities for Out-of-Network Care for Adults with Behavioral Health Conditions," (higher cost sharing and out-of-network (OON) rates for MH and SUD conditions relative to other chronic conditions; individuals with MH conditions had cost sharing for OON care $341 higher than those with diabetes, individuals with alcohol use disorders $1138 higher and drug use disorders $1242 higher than individuals with diabetes; Zirui Song, et al., Out-of-Network Spending Mostly Declined in Privately Insured Populations With A Few Notable Exceptions From 2008 to 2016, 39 HEALTH AFF. 1032 (June 2020), doi: 10.1377/hlthaff.2019.01776 (noting the sizable difference in out-of-network spending across various professional services, with psychiatric services having the highest level of approximately 30% and remaining at this level over the 8-year study period; out-of-network spending for medical services remained stable or declined over the study period with the exception of hospitalist services, pathologist services and laboratory tests).

[45] Xu, *supra* note 1.

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V. Aggregate Data Collection

We recognize the value in collecting and analyzing aggregate data for plans and policies that are administered by a third-party administrator or other service provider and use the same network of providers. We have no objection to this approach provided a finding of disparate outcomes (at the agreed upon level) is treated as a conclusive violation for all plans or policies that use the network and the use of aggregate data does not conceal disparities that may exist on a plan/policy-specific basis. Without testing the applicability of this approach for each of the four types of data, we cannot offer further input.

VI. Safe Harbor for NQTLs Related to Network Composition

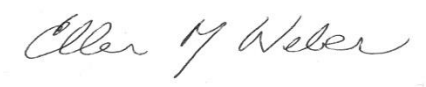
The Technical Release requests feedback on the adoption of an enforcement safe harbor for plans/issuers that meet or exceed specific data-based standards identified in future guidance. We believe it is premature to adopt an enforcement safe harbor and urge the Departments to fully review, over multiple years, plan/issuer data submissions and analysis of the four data points, identify whether the required analyses are accurate measures of network composition and disparities, and assess whether the plan/issuer has improved access to network MH and SUD services. Additionally, while a safe harbor would not affect enforcement actions on other NQTLs that affect provider participation in networks (e.g. utilization review standards, administrative practices, contracting requirements); we are concerned that applying a safe harbor based on network outcome data could make it more difficult to address non-compliance in other NQTLs, such as scope of services.

The Departments have recognized that plans/issuers have not, to date, submitted useful outcome data or complete NQLT analyses, notwithstanding long-standing requirements and clear direction. Based on this track record, we envision a period of uneven compliance with outcome data reporting and analysis, which must be resolved before offering an enforcement safe harbor. We also anticipate the need to refine and rework data collection specifications and analyses to capture meaningful data and to assess plan responses to the Departments' other proposed modifications of the Parity Act regulations. That process should be completed in advance of the adoption of a safe harbor to avoid immunizing plans from enforcement actions for a lengthy timeframe based on incomplete data and performance assessment.

The Departments are taking important steps to address the most glaring violations of the Parity Act that have dramatically limited access to SUD and MH care. We urge the Departments to give regulatory reforms, including outcome data requirements, a chance to work and to verify a plan's commitment to truly equitable access to care before tying the Departments' hands and that of private litigants.

Thank you for considering our views.

Sincerely,



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