From:	Deanna Zois
To:	EBSA MHPAEA Request for Comments; Allison.Ivie@centerroadsolutions.com
Subject:	Walden Behavioral Care Technical Release Comments
Date:	Tuesday, October 17, 2023 2:46:57 PM
Attachments:	Outlook-A black ba.png MHPAEA Technical Release REDC Comments - TEMPLATE.pdf

Please see the attached comments provided by Walden Behavioral Care. Thank you for the opportunity comment.

Sincerely,
Deanna

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Monte Nido & Affiliates
Treating Eating Disorders

October 16, 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: Comments on Technical Release 2023-01P

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

The Walden Behavioral Care appreciates the opportunity to comment on the Department of Health and Human Services, Employee Benefits Security Administration, and the Internal Revenue Service's (the "Departments") Technical Release 2023-01P, 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 (hereinafter "Technical Release").

Monte Nido and Affiliates is a multistate eating disorder treatment organization with 50+ facilities in fifteen states. Our centers provide inpatient, residential, partial hospitalization and intensive outpatient levels of care for individuals with eating disorders and co-occurring mental health disorders including Posttraumatic Stress Disorder and Substance Use Disorders. Our organization's mission is: "Guided by empathy and unwavering support, we challenge harmful norms and work to eradicate eating disorders." We agree to treatment and operational standards including accreditation by the independent accrediting bodies of the Joint Commission and/or Commission on Accreditation of Rehabilitation Facilities (CARF), conduct collaborative research, and work together to address treatment access issues facing individuals with eating disorders and their families.

We strongly support the Departments' proposed NQTL data collection requirements relating to network composition as part of the Departments' efforts to increase access to mental health and substance use disorder (MH/SUD) treatment. Such data collection is critical to ensure that plans and issuers do not impose treatment limitations that place a greater burden on plan members' access to MH/SUD treatment than to medical/surgical (M/S) treatment. Combined with the accompanying proposed requirements related to the

Mental Health Parity and Addiction Equity Act (MHPAEA), the data collection requirements that are envisioned in the Technical Release would be powerful steps in the right direction to increasing access to MH/SUD treatment. We urge the Departments to require that the data points for MH services and SUD services be separately collected, analyzed, and reported, consistent with MHPAEA statutory and regulatory requirements. Data should also be collected for M/S services to facilitate MHPAEA comparisons. We also urge the Departments to require that all data be collected, analyzed, and reported by age group, including children and adolescents, and by race/ethnicity (where possible). The Departments should also develop uniform definitions and methodologies for the collection of all data points so that valid data are collected and can be compared across plans/issuers.

We appreciate the Departments' commitment to ensuring that the data plans/issuers will be required to collect are an accurate reflection of individuals' access to treatment. Given that the Departments' guidance to plans will likely need to evolve over time to ensure such accuracy, we urge the Departments not to proceed with a "safe harbor" for plans/issuers based on data collection that has yet to be validated as meaningful. As we describe below, we believe that a "safe harbor" should not be explored until data collection has been extensively validated. Otherwise, the Departments may give "safe harbor" to plans/issuers that impose discriminatory barriers that inhibit access to MH/SUD treatment.

Our full comments are as follows.

Out-of-Network Utilization

Studies indicate that the percentage of services received out-of-network (OON) is a key indicator of the availability of in-network services. Due to the higher cost-sharing of OON services, individuals rarely choose to obtain care OON if adequate in-network services are available on a timely basis. The landmark Milliman report demonstrates the importance of such data and how frequently MH/SUD care is obtained OON compared to M/S care. The data should be disaggregated by age groups, so that utilization by children and adolescents can be distinguished from adults. This is particularly important given that half of lifetime mental health conditions begin by age 14 and our country's ongoing youth mental health emergency.

We support the Departments' reference to quantitative templates in the Appendix that have already been validated and are in use by employer groups and state regulators. The Bowman Family Foundation Report, which is based on a patient and provider survey conducted by NORC, shows multiple analyses of OON use and access problems, as do other consumer and employer and provider surveys and studies. Recently published research also shows that MH/SUD patients go out of network because of MH/SUD network inadequacies – the same reasons that M/S patients go out of network.

- Insurance rarely covers nutrition counseling for individuals with an eating disorder diagnosis at the outpatient level of care. Coverage is better at higher levels of care as it is a bundled service. Although the ACA requires insurers to cover nutritional counseling for those with chronic conditions—diabetes, hyperlipidemia, obesity, etc., eating disorders is not deemed chronic and patients consistently either forgo treatment or pay out of pocket to see an OON provider.

Percentage of In-Network Providers Actively Submitting Claims

Research studies indicate that collecting this data is critically important to determining the adequacy of a network. Plans/issuers frequently pad their networks by having providers listed as in-network even if they aren't actively submitting claims. This metric can also be important in suggesting the existence of other

reasons why providers listed as in-network might not be available, including low reimbursement that incentivizes providers to fill appointments with patients with insurance that pays more and/or cash-pay patients. Again, this data should be disaggregated by children and adolescents. While we welcome the Departments' reference to child psychiatrists and psychologists, all types of pediatric providers should be included. Additionally, it is important to include data on M/S pediatric subspecialists to the lists (e.g., pediatric cardiologists, pediatric neurologists, etc.) for purposes of assessing parity. Examples of providers listed as in-network but not available for plan members are detailed below.

- "I am part of a multidisciplinary outpatient eating disorders team for adolescents and young adults in Virginia. We have a large patient base of patients with state funded insurance. Based on our experience, currently there do not appear to be few if any IOP, PHP or residential programs for eating disorders covered in-network for children with Medicaid in Virginia. Although Medicaid MCOs Optima and Virginia Premier list programs as providing care for eating disorders, those programs tend to provide only one week of inpatient psychiatric care, and that care is usually not specific to eating disorders. In one case, we have recommended an adolescent for a higher level of care for 10 months. The patient has been accepted into residential care, but then insurance has continued to deny coverage despite many appeals. This scenario happens repeatedly in our clinic for patients with Virginia Medicaid."

- "I am a Pediatric Nurse Practitioner at a major Children's Hospital where I work in Adolescent Medicine, specifically with eating disorder patients in both the inpatient and outpatient settings. Eating disorder resources are scarce and insurance continues to be a significant and troubling barrier and source of inequity for our patients, and the examples are endless.

  Recently, we had an adolescent admitted with a new diagnosis of Anorexia Nervosa - Restricting Subtype who required medical stabilization due to her malnutrition and bradycardia. She was medically stabilized, but due to her severity of illness, she remained dependent on an [nasogastric] (NG) tube for all her nutrition. She was ineligible for any residential program in the country based on the combination of her NG reliance and her insurance. The only residential program in the country that accepts Medicaid is The Emily Program, which is in Minnesota, and not possible for many of our families in Washington. To note, the Emily Program in Minnesota does not accept NG tubes, and often refer to their collaborative program, Veritas, who does not take Medicaid. These youth had zero options in the entire country for care.

  We started the application process for scholarships, but we were told that the awards (which may take several months) wouldn't cover the full cost of the programs (for example, 6 weeks at Eating Recovery Center in Denver was quoted at $58,000). Safe disposition planning and no accessible eating disorder treatment was the barrier to discharge. Through the incredible efforts and meal support coaching done by our team, this adolescent began to take her nutrition by mouth, and became eligible for one additional residential program in Oregon, that still required a single case agreement for her to be able to access it. Insurance barriers were the primary factor contributing to inequitable care in this case, and those of us who work in the field of eating disorder care experience this distressing fact daily."

Time and Distance Standards

We strongly support the Departments' suggestion that the Departments collect detailed data on the percentage of participants/beneficiaries/enrollees who can access specified provider types in-network

within a certain time and distance. We strongly agree with the Departments' view that this data would help with the assessment of a plan/issuer's operational compliance with respect to any NQTLs related to network composition. We also recommend that the Departments collect data on appointment wait times, which are an essential metric to measure network adequacy and the most critical for participants/beneficiaries seeking timely access to care. The Department of Health and Human Services has already put forward strong proposed standards for Medicaid managed care and the Children's Health Insurance Program (CMS-2439-P), which establish maximum appointment wait time standards for routine outpatient mental health and substance use disorder services of 10 business days and require such independent secret shopper surveys. These standards align with appointment wait time metrics that have been adopted for Qualified Health Plans.

In collecting data, the Departments should collect data on routine and crisis appointments, including for follow-up and ongoing care. When only initial appointment wait times are measured, plans/issuers can manipulate their practices to have initial "intake" appointments while having long delays in the delivery of ongoing services. Data should be disaggregated by age group to assess wait times and travel distance for children and adolescents.

We also urge the Departments to require any plan/issuer that uses a source or evidentiary standard for its network adequacy standards (whether a state/federal government or an independent entity such as NCQA) to identify and explain how the standards were designed, as written, to comply with MHPAEA. The Departments should require that, for any source, a plan/issuer must provide and define all the factors and evidentiary standards relied upon for each MH/SUD network standard (e.g., time and distance) and complete a comparative analysis for each factor to demonstrate that the standard is comparable and no more stringent, as designed, for MH/SUD than for M/S.

For example, MH/SUD outpatient providers often have different characteristics such as smaller size and/or smaller caseloads than M/S providers. It is essential that the Departments require plans/issuers to demonstrate that these different characteristics are considered and addressed in assessing the adequacy of each standard. As an illustration, many MH/SUD professionals can only treat 8 to 10 patients per day, while many Primary Care Physicians (PCPs) can see 30 to 40 patients per day. A network adequacy standard that has equivalent time and distance standards (10 miles / 30 minutes) for one full-time PCP and one full-time Psychologist is not comparable and is more stringent, due to the provider case load.

The Departments should require the same type of analysis for MH/SUD facilities. For example, how are MH/SUD acute and subacute inpatient facilities the same or different as compared to acute and subacute M/S facilities – and how is that considered and addressed by the plan in developing each standard? The plan should be required to describe the factors used to compare types of MH/SUD facilities (e.g., psychiatric versus substance use), as well as capacity (e.g., number of beds, availability of beds) of MH/SUD facilities versus M/S facilities.

We urge the Departments to also ensure that as-written NQTL analysis also address the factors of supply/demand for both MH/SUD and M/S outpatient professional and facility providers, including definitions for these factors, evidentiary standards and sources. Studies, reports or data measuring provider supply (including shortages) and market demand should be required to be provided.

- Hospitals across the nation are reporting the inability to keep up with demand as St. Louis Children's Hospital in Missouri is seeing 8-15 kids per day for behavioral health issues including suicide attempts, eating disorders, anxiety, and psychosis. At C.S. Mott Children's Hospital in Ann

Arbor, Michigan, administrators found medical admissions among adolescents with eating disorders during the first 12 months of the pandemic more than doubled the mean for the previous 3 years. At Arkansas Children's, the hospital has seen a 150% increase in mental health disorder emergency room admissions, including a rise in eating disorders. The state does not offer any residential treatment for adolescent eating disorders, which means kids must get sicker to reach an inpatient level of care or find care out of state.

- "My daughter suffers from anorexia. While living in San Francisco she placed herself in a 72 hour hold for suicidal ideation. On exit from the hold, she requested treatment from Kaiser. She was told the first available appointment was 30 days in the future. At that point I panicked, researched programs in the US. A parent will do anything for their child. I flew her to ERC Colorado, and they admitted her. When we asked Kaiser for coverage, they denied as a result of out of network, pre-authorization. I spent close to $200,000 of my retirement funds in treatment costs out of pocket. We used Kantor and Kantor law firm and sued Kaiser. They would not budge and continued to argue that her out of network treatment was unauthorized."

Network Availability and Distribution of Professions

We applaud the Departments for focusing on whether providers are accepting new patients (Section (c)(4)(iv)(A)(2) of the proposed rule), which is a crucial issue in light of the high demand for MH/SUD services. A MH/SUD provider with just a few time slots available does not add significant capacity to plans/issuers' networks. We believe that the Departments should require that any network adequacy standard should consider typical limits on MH/SUD providers, who typically have smaller caseloads, less capacity and limited availability for new patients as compared to most M/S professional providers. (For example, a standard that equates 1 full-time PCP to 1 full-time Psychologist is not comparable in light of the differences in caseloads and capacity).

It is also important to require metrics on the number of available providers who fill high-demand needs in the network, such as those seeing children & adolescents, those who specialize in eating disorders or LGBTQ patients, and those who meet the language needs of the population served by the network. While the Service Utilization metrics below in these same categories would address how much certain services are being utilized, it may be that while there is a reasonable level of, for example, eating disorder services provided by network providers, those providers may be completely full. Thus, it is also important to assess whether new patients with these specialized needs can find available providers.

A robust network has a full range of different professions and training levels to handle the varying needs and more complex problems of the patient population. Thus, we recommend gathering data (on both the MH/SUD and M/S sides) on the percentage of the top 10 different professions that make up the network. We also support that plans should measure the actual numbers of licensed MH/SUD professionals by geo zip code.

- The recurring theme we hear from patients is the dearth of health care professionals who specialize in eating disorders. This can be registered dietitians who specialize in weight management, which means they see patients who have obesity and seeking weight loss—not an appropriate provider for an individual seeking an RD for eating disorders nutrition counseling. We also have heard of psychologists that do not specialize in eating disorders. This results in patients 1) forgoing care, 2) attempting to access care in-network only to be negatively impacted by the experience or 3) pay out of pocket for an OON provider.

- "I was referred by my therapist to see a nutritionist who specializes in eating disorders. My insurance said they don't cover nutrition for "eating disorders" and after calling multiple in network providers, it was clear that no in network providers were trained or had experience with eating disorders. I tried to get coverage with a single case agreement, but insurance just took us around in circles and denied coverage. I still see this nutritionist for an ongoing eating disorder and have to pay out of pocket which means I can only see her once a month."

- "Our insurance provider didn't have any in-network dietitian providers with eating disorder experience/expertise/certification. They would not agree to cover any of the ED experts in our area. We paid out of pocket for many years. At the height of her illness, we were paying $900 a month. They had many dietitians on their in-network list that specialized in diabetes, obesity, etc.

  Earlier, when we had an HMO, we were given the choice of one dietitian. She had no experience with eating disorders and missed many signs of my daughter's relapse. We weren't willing to risk that again, so we paid out of pocket."

Network Admissions

In assessing network composition and access to MH/SUD services, we urge the Departments to review the criteria and processes by which plans/issuers determine which providers to admit into networks and/or how plans/issuers define when a network is considered "full" or "closed." Reports from MH/SUD providers suggest that they are often denied participation on networks due to the networks being "closed" or "full," even though patients are unable to find appropriate providers in that network. Other providers who are eventually admitted into networks report having to wait as long as nine months to be added.

Plans/issuers should not be allowed to claim a workforce shortage as a reason for access to care issues and simultaneously keep networks locked or slow to accept new providers. Collection of information about processes and criteria will reveal how much responsibility plans/issuers bear for the lack of access to MH/SUD services. For example, plans/issuers should provide metrics on how many providers applied to the network, what percentage were rejected and the reasons for the rejection (e.g., network full, provider not qualified, and the time it takes to bring providers into the network from when they first apply).

- An eating disorder treatment facility is awaiting a final contract with a payer after credentialing approval and agreement on reimbursement rates in October 2022. The contract was sent over and the facility signed the contract and never received a counter signed contract as the payer, "needs to rethink the reimbursement language and strategy for the type of service you offer. We will revisit your contract after the first of the year in early 2023 when we have more information."

  After several email follow-ups, the eating disorder treatment facility received the following in June 2023, "Thank you for continuing to follow up and I apologize for the delay in sending you a contract to add your group to our provider network. We have a hold on adding providers as we continue to finalize internal workflows. Our target is to follow up with you in September 2023 to start the contracting process." There has been no communication since.

  The state is in need of eating disorder treatment providers and the local university has reached out to this facility requesting their help as students are presenting with higher acuity than they're able to handle. This delay from the plan is unacceptable while individuals continue to get sicker.

Reimbursement Rates

We applaud the Departments' suggested data collection relating to reimbursement rates, which are critical determinants of network adequacy; many studies show the strong correlation between network access and reimbursement rates. We also commend the Departments for putting forward potential requirements that reimbursement rate data be "compared to billed rates." Reimbursement rates that are not reflective of current market reimbursement can profoundly affect the availability of MH/SUD providers, including current providers' decision to join a network and potential providers' decisions whether to enter the field. We strongly recommend the Departments evaluate the ratio of allowed in-network and OON amounts to OON billed market rates for MH/SUD and M/S. The billed rates of OON providers are the most accurate representation of the market rate. We also support developing additional reimbursement rate measures, such as percent of out-of-pocket (OOP) expenses for enrollees using out-of-network providers for MH/SUD versus M/S care.

With respect to the use of Medicare Fee Schedule and other external benchmarks such as Fair Health, we urge the Departments to utilize significant care to avoid perpetuating historic (and ongoing) disparities between MH/SUD and M/S reimbursement rates that are embedded in these benchmarks. We urge the Departments to recognize that Medicare and other claims databases and benchmarks rely on historical data that embeds legacy disparities in reimbursements between MH/SUD and M/S. Additionally, we strongly believe that caution is warranted with respect to Medicare because it:

- Is not subject to MHPAEA;
- Does not have allowed amounts for certain sub-types of MH/SUD providers (e.g., sub-acute inpatient care and the full range of MH/SUD professional providers);
- Does not cover some MH/SUD services for children and adolescents given that this population does not participate in the program;
- Only recognizes IOP and PHP levels of care in limited settings; and
- Has a structure that undervalues the work of MH/SUD professionals, which CMS recently acknowledged in its recent Physician Fee Schedule proposed rules.

Nonetheless, we recognize that the Departments, multiple state regulators, and research organizations (such as Milliman) have documented significant disparities between Medicare allowed amounts and plans/issuers' allowed amounts for MH/SUD providers versus M/S providers. As described below, the ultimate determiner of parity for any reimbursement comparison is the access to services (i.e., adequacy) within MH/SUD networks in comparison with M/S networks. Indeed, reimbursement rate comparisons could actually show that MH/SUD providers are reimbursed at the same level as M/S providers, yet if MH/SUD network inadequacies persist, plans/issuers should be required to increase rates further for MH/SUD providers to address network inadequacies, as plans/issuers do for M/S.

While taking into account that the Medicare fee schedule and other external benchmarks may have legacy disparities embedded for MH/SUD services compared to M/S services, we have seen that they can be used as tools to demonstrate parity non-compliant reimbursement rates. This was the case in the U.S. Department of Labor and New York Attorney General's 2021 lawsuit against United Healthcare and United Behavioral Health (UBH) and resulting settlement agreement, which were based, in part, on UBH's disparate reductions from baseline rates derived from Medicare.

The Departments have made it clear that when faced with M/S provider shortages, if plans increase reimbursement rates for M/S providers to ensure adequate M/S networks, they must increase rates to address MH/SUD providers shortages as well to ensure adequate behavioral networks. The Bowman Family Foundation publication, "Federal Parity Law (MHPAEA): NQTL of In-Network Reimbursement Rates: Non-Comparable Use of Factors of Provider Leverage a/k/a Bargaining Power and Workforce Shortages" references federal data that shows there are more zip codes in the U.S. with Primary Care Physician (PCP) shortages than Psychiatrist shortages. Yet, there is relatively low out-of-network use for PCPs, and PCPs are routinely paid more than Psychiatrists for the same evaluation and management billing codes. Key quotes include:

- "Nationally, the average in-network reimbursement for MH/SUD professional office visits from commercial insurers was approximately 2.5% below Medicare reimbursement, and OON use of such visits was approximately 17%, i.e., 5.4 times higher than for primary care providers."

- "Nationally, the average in-network reimbursement for primary care professional office visits from commercial insurers was approximately 20% above Medicare reimbursement, and OON use of such visits was approximately 3%."

- "HRSA identifies "Health Provider Shortage Area" (HPSA) designations, which indicate that demand far exceeds supply. As reported by Kaiser Family Foundation, this national data as of Sept. 30, 2021 shows more shortages for PCPs than for mental health providers (7447 vs. 5930 shortage areas)."

The Departments guidance in the 2020 Self Compliance Tool is also clear:

"NOTE – Plans and issuers may attempt to address shortages in medical/surgical specialist providers and ensure reasonable patient wait times for appointments by adjusting provider admission standards, **through increasing reimbursement rates, and by developing a process for accelerating enrollment in their networks to improve network adequacy.** To comply with MHPAEA, plans and issuers must take **measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers,** even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan's network…" (Emphasis added).

As with all quantitative data metrics, multiple measures are important to accurately assess the compliance of any NQTL. Consistent with the current regulations and enforcement, as well as the Proposed Rules, reimbursement rates for MH/SUD providers are a key aspect of in-network access to care. We have seen that plans/issuers use reimbursement rate increases to establish and maintain adequate M/S networks, especially in addressing shortages of M/S providers. MHPAEA requires plans to take the same measures for MH/SUD providers to ensure adequate networks. Below are a few examples of how reimbursement rates impact providers and patients alike:

- A plan issued a 20% reimbursement rate reduction for nutrition counseling services for conditions the plan deemed "not chronic." Eating disorder diagnoses were part of the "not chronic" carveout along with conditions commonly seen with eating disorders, including irritable bowel syndrome (IBS) and polycystic ovary syndrome (PCOS). This same plan had also provided dietitians in their network the same rate for over 12 years forcing many dietitians to leave the network entirely.

Aggregate Data Collection

We strongly support the Departments, when reviewing self-funded employer group plans, to require relevant data to be collected and evaluated for both employer group enrollees as well as enrollees of the employer's third-party administrator (TPA) or other service provider in the aggregate. We agree with the Department that individual employer group plans may lack sufficient data.

Service Utilization Data

In assessing network composition and access to MH/SUD services, we urge the Departments to require plans to report on utilization rates for specific MH/SUD services and level of care. These utilization rates should be compared to estimates of participants/beneficiaries with these conditions, as well as utilization rates for M/S services. Examples of services providers, settings, and levels of care on which we urge the Departments to collect utilization data include:

- Child and adult psychiatrists, child and adult psychologists, master's level social workers and mental health counselors, psychiatric ARNPs, psychiatric PAs, all acute and sub-acute inpatient sub-types, and sub-types of outpatient facility programs, such as IOP, PHP, ABA, MAT, eating disorders, etc.;
- Each of the levels (and sub-levels) of care described in The American Society of Addiction Medicine (ASAM) Criteria and the age-specific Level of Care Utilization System (LOCUS) family of criteria developed by the American Association of Community Psychiatrists and the Academy of Child and Adolescent Psychiatry, as well as the average length of stay / treatment units and denial rates by each of these levels of care;
- Service utilization by MH/SUD diagnoses;
- High-demand needs such as services for children and adolescents, eating disorders, and services by providers who meet the language needs of the population served by the network;
- Cognitive behavioral therapy;
- Dialectical behavioral therapy;
- Coordinated Specialty Care;
- Medications for opioid use disorder (MOUD);
- Medications for alcohol use disorder (MAUD); and
- Medications for bipolar disorder, schizophrenia, major depressive disorder, and other MH/SUDs.

- As stated above, nutrition counseling/medical nutrition therapy services for individuals with eating disorders are underutilized because there is no coverage, limited to non-existent networks of dietitian specializing in eating disorders, or individuals having to navigate a plan ping ponging between M/S and MH/SUD seeking coverage for this service.

Safe Harbor

The Technical Release also requested feedback on the potential of a "safe harbor" for NQTLs related to network composition. We urge the Department not to proceed with a safe harbor at this time. We understand the desire to effectively target the Departments' enforcement resources. However, network adequacy has always been difficult to define and easy to mismeasure. Thus, a safe harbor has the potential to be harmful if the data collection requirements do not capture a complete picture of participants/beneficiaries' access to MH/SUD services. Given the significant work that the Departments need to do – and likely refinements that are necessary over time – to ensure collected data is complete, accurate, and meaningful, a safe harbor should not be considered in the near future. Such a safe harbor should only be considered when the

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Departments and key consumer stakeholders are confident that the data collected accurately captures actual access to MH/SUD services. If a safe harbor is put in place prior to this occurring, it could cause enormous damage by giving noncompliant plans/issuers a "safe harbor" against accountability. Furthermore, an issuer residing within such a "safe harbor" would almost certainly escape meaningful oversight from any applicable State authority.

Meaningful Data & Preventing Data Manipulation

To ensure that the proposed requirements relating to outcomes data and actions to address material differences in access are meaningful, we urge the Departments to issue standardized definitions on all data points and on methods for gathering and reporting data. For example, the Departments propose collecting data on the number and percentage of claims denials. Yet, there are many ways that plans can collect, and potentially manipulate, such "claims denials" data. For example, the Departments should make clear that failure to pay a claim in part or in full constitutes a denial and must find ways to capture common practices of undocumented denials that occur verbally through peer-to-peer reviews. Additionally, plans can manipulate denial data by approving each visit or day of treatment (thereby increasing the denominator) while telling the provider verbally that further visits/days will not be approved, which is another common occurrence. Such practices can result in meaningless data that bears little resemblance to what individual patients experience. The Appendix to the Technical Release lists templates already in use, including the Bowman Family Foundation's Model Data Request Form, which includes a section on Denial Rates. We support the continued use of templates that address the issues set forth above.

Disaggregating MH and SUD Data

We also encourage the Departments to make clear that MH and SUD data must be collected and analyzed separately. When MH and SUD data is simply aggregated, it can hide important discriminatory impacts.

Conclusion

We direct the Departments to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. All the stories provided have been sent previously to DOL for review. If the Departments are not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Molly Perlman, MD, MPH, CEDS, Chief Medical Officer of Monte Nido and Affiliates at mperlman@montenidoaffiliates.com.

Sincerely,

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Inpatient Clinician and Expressive Therapist
Walden Behavioral Care