From:	Marissa Y. Long
To:	EBSA MHPAEA Request for Comments
Cc:	Yoshi Pinnaduwa; Roslyn Windholz
Subject:	NYC DOHMH Comment RE: Technical Release 2023-01P, Proposed Relevant Data Requirements for NQTLs
Date:	Monday, October 2, 2023 4:18:07 PM
Attachments:	DOL RFI MHPAEA Network Composition Draft Response final (Signed Copy).pdf

Hello,

I am writing to submit a comment on behalf of the New York City Department of Health and Mental Hygiene (DOHMH) in response to Technical Release 2023-01P, Proposed Relevant Data Requirements for NQTLs Related to Network Composition. Please find a PDF attached.

We thank the Departments for allowing DOHMH the opportunity to comment.

Sincerely,
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NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
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September 13, 2023

RE: Technical Release 2023-01P (Request for Comment; Proposed Relevant Data Requirements for NQTLs)

The New York City Department of Health and Mental Hygiene (DOHMH) submits these comments in response to the Departments of the Treasury, Labor, and Health and Human Services' (collectively, the Departments) 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 (MHPAEA).

DOHMH appreciates DOL's attention to the ways in which insurance networks are constructed to prioritize their beneficiaries' physical health needs over their behavioral health needs of. We support the goal to increase health plans' accountability in terms of their networks' capacity to meet the mental health and substance use disorder service (MH/SUD) needs of their members.

A growing number of private plans with restrictive networks are being offered on insurance marketplaces compared to plans with networks that allow access to more types of services and providers. In 2016, 60% of plans offered on healthcare.gov were HMOs or EPOs, the two most restrictive plans. In 2020, 78% of plans offered on healthcare.gov were HMOs or EPOs.[1] Restrictive network plans are often attractive options for consumers due to lower upfront costs such as premiums and deductibles, but studies have shown that this "network narrowing" can have negative impacts on health outcomes.

Network narrowing forces consumers to switch plans to keep seeing providers with whom they have built relationships. Furthermore, insurance plan changes are associated with decreased rates of chronic disease control, increased reliance on subspecialists for primary care services, and greater use of emergency departments. These changes can also impact referral capabilities, as clinicians may need to refer patients to unfamiliar or non-preferred specialists and facilities. Lastly, network narrowing can impact communication within an individual's healthcare team, as providers may find themselves in small networks with others who don't share the same health IT or clinical guidelines.[2]

[1] Graves JA, Nshuti L, Everson J, et al. Breadth and Exclusivity of Hospital and Physician Networks in US Insurance Markets. *JAMA Netw Open*. 2020;3(12):e2029419. Published 2020 Dec 1. doi:10.1001/jamanetworkopen.2020.29419

DOHMH sees this opportunity to address potential new data collection requirements for plans subject to MHPAEA as critical to expanding provider networks as well as behavioral health care access for New Yorkers enrolled in both Medicaid Managed Care and commercial insurance plans. Please see below for our responses to select requests for comment.

Out-of-Network Utilization (p.9)

Solicitation:

1. Departments are considering specifying the relevant data that plans and issuers would be required to collect and evaluate for NQTLs related to network composition which would include data on the out-of-network utilization for M/S, MH, and SUD benefits for the following types of items and services. Should different categories of items and services be used instead of the categories described below?
    - Inpatient, hospital-based services;
    - Inpatient, non-hospital-based services, including inpatient rehabilitation facilities and skilled nursing facilities for M/S items and services, and non-hospital-based inpatient facilities and residential treatment facilities for MH/SUD items and services;
    - Outpatient facility-based items and services, including physical, occupational, speech, and cardiovascular therapy, surgeries, radiology, and pathology, services for M/S care provided in an outpatient facility setting; and intensive outpatient and partial hospitalization services for MH conditions or SUDs in an outpatient facility setting;
    - Outpatient office visits; and
    - Other outpatient items and services.
2. How should the Departments control for treatment received from MH/SUD providers where no claim for benefits was made (i.e., because the participant, beneficiary, or enrollee did not submit a claim for services furnished by an out-of-network provider)?

Recommendations:

DOHMH appreciates DOL's attention to high out-of-network utilization as a potential indicator of MHPAEA non-compliance. With respect to Question 1, In addition to the categories listed above, we suggest utilization data be collected for the following MH/SUD service categories that may not be covered by commercial insurance plans:

- Opioid treatment programs;
- Medication assisted treatment options;
- Recovery support services;
- Sub-acute care in a residential facility;
- Assertive community treatment services;
- Home & community-based care;
- Critical time intervention services; and
- Crisis intervention services

In response to Question 2, if the Departments were to seek data on the number of self-pay clients that providers serve, DOHMH encourages the Departments or states to provide technical assistance and/or financial incentives for providers to comply with additional reporting requirements necessary to collect this data in order to reduce administrative burden.

We would also like to note our concern that seeking out-of-network care is only an option for those who can afford the full cost or the small portion of insureds with plans that offer out-of-network benefits to help to defray some of the cost. According to a 2018 Robert Wood Johnson Foundation report, 64% of

small group plans and only 29% of individual plans offer out-of-network benefits. [2] Unfortunately, this leads a large number of beneficiaries to forgo needed care. A 2023 Kaiser Family Foundation survey further found that 43% of respondents who rated their own mental health as fair or poor were unable to get needed mental health care in the past year. Among those under 30, over half (55%) reported they did not get needed mental health care.

As a stopgap, we encourage the Departments to require that plans increase the availability of out-of-network benefits and enforce this coverage through provisions of the ACA that govern individual and small-group plans.

Time and Distance Standards (p.16)

Solicitation:

1. Should the Departments require plans and issuers to collect and evaluate the ratio of providers to participants, beneficiaries, and enrollees (also known as provider-to-enrollee ratios)? Are there models, either from Federal network adequacy or state network adequacy requirements, that could inform such a measure?
2. How can the Departments account for any difficulties that underserved and minority groups face that may not be accounted for in traditional time and distance measures?
3. Should the Departments require plans and issuers to collect and evaluate data separately for different county type designations, similar to existing CMS standards, or some other method of accounting for different geographic areas?

Recommendations:
With respect to Question 1, we recommend the Departments require plans and issuers to evaluate provider-to-enrollee ratios that take into account the incidence rates of mental illness and substance use disorders from the CDC's National Health Interview Survey and the needs of individuals with dual diagnoses. Such an assessment was enacted into law by Massachusetts in 2016 though H.4056.

Traditional time and distance measures are not calculated with public transportation in mind -- only two states, New York and New Jersey, incorporate public transportation into time and distance standards for state-regulated plans.[3] Therefore, with respect to Question 2, we suggest the Departments apply this requirement nationwide, and even in suburban or rural areas. We further suggest plans be required to consider barriers those without personal vehicles may face.

As for Question 3, we recommend plans be required evaluate data from large metropolitan areas, such as New York City, as one geographic designation rather than by county. It is extremely common for individuals to seek care outside of their home county or borough (especially for MH/SUD services, where stigma plays a role). Therefore, in large metropolitan areas, city-wide calculations will best reflect utilization trends.

Reimbursement Rates (p.18)

Solicitation:

1. The Departments are considering specifying the relevant data that plans and issuers would be required to collect and evaluate for NQTLs related to network composition which would include in-network payments and billed charges for inpatient MH/SUD and M/S benefits, outpatient office

[2] Marketplace Pulse: Unexpected Insurance Bills to Consumers (rwjf.org)
[3] Microsoft Word - Network Adeqaucy Spotlight final.docx (lac.org)

visit MH/SUD and M/S benefits, and all other outpatient MH/SUD and M/S benefits. Are there different or additional CPT codes than those outlined above (99213, 99214, 90834 and 90837) that would help plans and issuers evaluate their reimbursement rate structures?

2. How should the evaluation of reimbursement rate data requirements take geographic area into account? How should the Departments define geographic areas?

Recommendations:

With respect to Question 1, in addition to in-network payments and billed charges, we recommend the Departments consider collecting and evaluating beneficiary reimbursement rates, in addition to provider reimbursement rates, following out-of-network service utilization.

A common payment model for MH/SUD services, especially those furnished by solo practitioners or small facilities without administrative staff, is for beneficiaries to pay a provider in full and submit claims to their insurer afterward for reimbursement. We therefore invite the Departments to consider collecting data on reimbursements paid directly to beneficiaries, as they are often a small percentage of the service cost, leaving individuals financially burdened despite having out-of-network benefits.

As for billing codes, we suggest plans be required to evaluate reimbursement rate structures for the following crisis service codes in addition to the codes outlined above: CPT codes 90839 and 90840, and Medicaid billing codes S9484 and H2011. State mental health authorities have reported varying degrees of success in having behavioral crisis services reimbursed by commercial insurers, and reimbursement is often dependent on how state regulators enforce crisis coverage and whether individual insurers consider crisis services to be emergency medical services.

We also invite the Departments to consider requiring plans to demonstrate that the factors they used in contract negotiations with providers, such as coding rules and payment policies, are equivalent and equitable, especially as it relates to ensuring network adequacy, when there is no fee schedule, or where plans deviate from their set fee schedule to create particular incentives.

Similar to our suggestion in the previous section regarding time and distance standards, with respect to Question 2, we recommend that reimbursement rate data evaluations account for service provision in metropolitan areas. Relying on state-level calculations would nullify the significant variations in cost of living and average billed charges that exist between urban and rural areas.

Additional Comment Solicitation (p.24)

Solicitation:

1. What data currently collected by States (including, but not limited to, those in the Appendix) is particularly useful to demonstrate parity in how plans and issuers establish provider networks and show that NQTLs related to network composition applied to MH/SUD benefits are comparable to, and are applied no more stringently than, such NQTLs applied to M/S benefits, or demonstrate the comparability of plans' and issuers' MH/SUD networks as compared to their M/S networks?

Recommendations:

We suggest the Departments consider adapting the following state model: Connecticut collects information on MH/SUD utilization review requests and denials by level of care in their Consumer Report Card on Health Insurance Carriers in Connecticut (published yearly).[4] The levels of care include acute inpatient, residential, partial hospitalization, intensive outpatient, routine outpatient, and substance abuse detox, but we would encourage expanding these categories further to match the out-of-network utilization categories we suggested above (opioid treatment programs, medication assisted treatment options,

[4] https://portal.ct.gov/-/media/CID/1_Reports/2022-ConsumerReportCard.pdf

recovery support services, sub-acute care in a residential facility, assertive community treatment services, critical time intervention services, and mobile crisis intervention services). Stratification by level of care may help illuminate overly restrictive applications of medical necessity criteria or other NQTLs.

We thank the Departments for allowing DOHMH the opportunity to comment on proposed data requirements related to network composition, which we believe will significantly improve access to behavioral health care for New York City residents covered by health plans subject to MHPAEA.

Sincerely,

Deepa Avula, MPH
Executive Deputy Commissioner, Mental Hygiene
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