From:	Greg Williams
To:	EBSA MHPAEA Request for Comments
Subject:	Third Horizon Strategies - Comments on the DOL/HHS/Treasury "Technical Release" Relating to Plans' Required MH/SUD Data Collection
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Re: Comments on Technical Release 2023-01P

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

Third Horizon Strategies is a mission-driven advisory firm providing direct support to governments, providers, and payers on the novel transparency in coverage data set now available through machine-readable files. Our firm 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 Nonquantitive 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").

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.

Out-of-Network Utilization

Our analysis of the machine-readable files indicates a limited number of in-network MH/SUD providers compared to medical/surgical providers in similar geographic markets. 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.

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 wherever possible. 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. We encourage the Departments to require actual participation data on all sub-types of MH/SUD professional providers for both adults and children, as well as inpatient and outpatient facilities.

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. We recommend that any network adequacy standards, such as time/distance, wait times, etc., issued by state or federal governments identify key sub-types of MH/SUD professional providers, such as child and adult psychiatrists, child and adult psychologists, master's level social workers and mental health counselors, psychiatric ARNPs, psychiatric PAs. In addition, all acute and sub-acute inpatient sub-types should have specific network adequacy standards, as well as sub-types of outpatient facility programs, such as IOP, PHP, ABA, MAT, eating disorder, etc.

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.

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.

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. Measuring and monitoring access to care for all sub-types of MH/SUD providers 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).

Reimbursement Rates

We applaud the Departments' suggested data collection relating to reimbursement rates, which are critical determinants of network adequacy; many studies show a strong correlation between network access and reimbursement rates. We believe the new transparency in the coverage data set found in the machine-readable files can support the development of comparison rate metrics. 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 , 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. We believe the machine-readable files from transparency in coverage are a far better

source to develop comparisons and benchmarks from by comparing commercial plans to commercial plans between medical/surgical and MH/SUD.

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.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Greg Williams, President of Third Horizon Strategies, greg@thirdhorizonstrategies.com.

Sincerely,

Greg Williams
President, Third Horizon Strategies
Manager, The Alliance for Addiction Payment Reform
Email: Greg@ThirdHorizonStrategies.com
www.IncentivizeRecovery.org
www.ThirdHorizonStrategies.org