

**From:** [Wells Wilkinson](#)  
**To:** [EBSA MHPAEA Request for Comments](#)  
**Subject:** Comments on Technical Release 2023-01P  
**Date:** Tuesday, October 17, 2023 4:45:37 PM  
**Attachments:** [image001.png](#)  
[image002.png](#)  
[image003.png](#)  
[CMHC 2023.10.17 comments on MHPAEA Technical Release \(Data\) FINAL.pdf](#)

---

**CAUTION: This email originated from outside of the Department of Labor. Do not click (select) links or open attachments unless you recognize the sender and know the content is safe. Report suspicious emails through the "Report Phishing" button on your email toolbar.**

Please find the attached comments on Technical Release 2023-01P, submitted on behalf of The Childrens Mental Health Campaign.

Regards,

Wells G. Wilkinson, JD

Senior Supervising Attorney | **HealthLawAdvocates**

Access to Care and Coverage Practice

**E:** [wwilkinson@hla-inc.org](mailto:wwilkinson@hla-inc.org) | **Direct Phone:** 617-275-2983

**A:** One Federal Street, 5th Floor, Boston, MA 02110

**W:** [www.healthlawadvocates.org](http://www.healthlawadvocates.org)

**Main:** 617-338-5241 | **Toll-free:** 855-218-2519

**Fax:** 617-338-5242

**Pronouns: He, Him, His**



NOTICE: This e-mail/letter communication, and any attachments (the "communication") are confidential and may be legally protected or privileged. If you are not a named addressee or if you received this communication in error, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited, and we request that you immediately delete all copies from your system and contact HLA at 617-338-5241.

Unsecure email messages sent to HLA should not contain highly sensitive, or confidential information. Please contact us to arrange access to our secure email server. Thank you.



October 17, 2023

**Electronic submission:**

[mhpaea.rfc.ebsa@dol.gov](mailto:mhpaea.rfc.ebsa@dol.gov)

The Honorable Xavier Becerra  
Secretary  
U.S. Department of Health and Human Services

The Honorable Lisa M. Gomez  
Assistant Secretary  
Employee Benefits Security Administration  
U.S. Department of Labor

The Honorable Douglas W. O'Donnell  
Deputy Commissioner for Services and Enforcement  
Internal Revenue Service  
U.S. Department of the Treasury

**Re: Comments on Technical Release 2023-01P**

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

The Children's Mental Health Campaign (CMHC) 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").

The Children's Mental Health Campaign (CMHC) is a large statewide network that advocates for policy, systems, and practice solutions to ensure all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way. The CMHC Executive Committee consists of six highly reputable partner organizations: Massachusetts Society for the

Prevention of Cruelty to Children (MSPCC), Boston Children's Hospital, Parent/Professional Advocacy League, Health Care For All, Health Law Advocates, and the Massachusetts Association for Mental Health.

The CMHC has worked to enact legislation to ensure the accuracy of provider directories in commercial health plans; and more recently to expand the scope of community-based crisis response behavioral health (BH) services, to empower consumer and provider use of state and federal parity law through complaints, and to ensure enforcement of parity through periodic but mandatory market conduct exams in public and private insurance systems, among other initiatives.

In summary, we strongly support the Departments' proposed NQTL data collection requirements with a special emphasis on network composition as part of the Departments' efforts to increase access to BH 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 BH treatment than to medical/surgical treatment. Combined with the currently proposed new regulations related to the Mental Health Parity and Addiction Equity Act (MHPAEA), these data collection requirements described in the Technical Release would be powerful steps in the right direction to increasing access to BH treatment.

We urge the Departments to require that the data points for mental health (MH) services and Substance Use Disorders (SUD) services be separately collected, analyzed and reported, consistent with MHPAEA statutory and regulatory requirements. Data should also be collected for medical/surgical services to facilitate MHPAEA comparisons. We also urge the Departments to require that all data be collected, analyzed, and reported by age group, including especially children and adolescents, who often face serious barriers to accessing age-appropriate care under limited networks in commercial insurance. We also support collecting and analyzing data by race, ethnicity, language, gender identity, and sexual orientation (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 health plans.

We appreciate the Departments' commitment to ensuring that the data health plans will be required to collect can be used to make a meaningful assessment of their plan member's access to BH treatment. Given that the Departments' guidance to plans will likely need to evolve over time to ensure such assessment is accurate, we urge the Departments not to create a "safe harbor" for health plans 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 health plans that impose discriminatory barriers that inhibit access to BH treatment.

Our full comments are as follows.

## Comment 1 re Out-of-Network Utilization

- ❖ **We support requiring health plans to gather, assess and report on the number, percentage and total expenditures on out-of-network utilization of services to treat BH and medical/surgical conditions as a metric of their provider network composition.**

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 2019 Milliman report documented significant disparities between how frequently BH care is obtained OON compared to medical/surgical care.<sup>1</sup> This demonstrates the importance of such data.

For example, many consumers and families report difficulty finding available in-network providers of outpatient BH services, ranging from BH counseling to medication management services. In February 2022, the Association for Behavioral Healthcare (the membership association of outpatient mental health and substance use community clinics in Massachusetts) released survey data on waitlists and provider shortages in Massachusetts. The average wait time for a child or adolescent to receive ongoing, outpatient therapy services was 15.3 weeks.<sup>2</sup> Unfortunately, what happens all too often is that when a young person with mild to moderate symptoms and their family must wait so long to initiate treatment, the young person's condition worsens. As their child is suffering, parents and caregivers begin searching for an out-of-network provider to be seen as soon as possible. This outcome creates inequities in health care access, as only families that can afford to pay for services out-of-pocket can obtain care out-of-network.

It's important to note that youth and families that need specialized BH treatment are also more likely than those needing traditional BH services to seek care out-of-network. For instance, our member group Health Law Advocates has documented that the largest commercial and public plans in the Massachusetts all fail to include a single in-network provider of electrolysis services, a treatment for the mental health condition of gender dysphoria, even though there are many providers of such services throughout the state who see clients on a self-pay basis.<sup>3</sup> Likewise, our member group the Massachusetts Association for Mental Health has supported families in finding

---

<sup>1</sup> Melek, S., Davenport, S., Gray, T.J., *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* (Milliman Report) (2019), Page 6, Avail. at [https://assets.milliman.com/ektron/Addiction\\_and\\_mental\\_health\\_vs\\_physical\\_health\\_Widening\\_disparities\\_in\\_network\\_use\\_and\\_provider\\_reimbursement.pdf](https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf).

<sup>2</sup> Association for Behavioral Healthcare, *Outpatient Mental Health Access and Workforce Crisis Issue Brief*. Feb. 2022. Avail at: [https://www.abhmass.org/images/resources/ABH\\_OutpatientMHAccessWorkforce/Outpatient\\_survey\\_issue\\_brief\\_FINAL.pdf](https://www.abhmass.org/images/resources/ABH_OutpatientMHAccessWorkforce/Outpatient_survey_issue_brief_FINAL.pdf).

<sup>3</sup> Only one plan – a Medicaid managed care plan – across all commercial and Medicaid plans has been found to have a single such electrolysis provider that is in-network, and this sole provider is located in the far southwest corner of the state, rendering this provider inaccessible to most residents in the state.

outpatient therapy for pediatric obsessive compulsive disorder (OCD). Evidence-based treatment for this condition includes Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), and ERP (Exposure Response Prevention). There are virtually no outpatient pediatric BH clinicians in Massachusetts trained to provide these three therapies as treatment of OCD and who accept any form of insurance. Again, this is an equity issue, as only parents and caregivers that can afford to pay out-of-pocket for out-of-network services can receive this care.

- ❖ **To help detect such issues particular to youth, the data that plans gather under this guidance and the proposed MHPAEA regulations should be disaggregated by age strata, 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<sup>4</sup> and our country has an ongoing youth mental health emergency declaration.<sup>5</sup> To further health equity, we also encourage data to be disaggregated by race/ethnicity, language, gender identity, and sexual identity.

- ❖ **We support the proposal to specify that the relevant data on out-of-network utilization should be disaggregated by types of service related to the levels of care proposed, such as inpatient care, hospital based care, inpatient non-hospital based care, outpatient facility-based services (such as PHP and IOP programs) and outpatient office visits.**

## **Comment 2 re Data regarding In-Network Providers Actively Submitting Claims**

- ❖ **We support the Departments' proposal to collect information about in-network BH providers submitting or not submitting claims.**

Research studies indicate that collecting data regarding in-network providers actively submitting claims is critically important to determining the adequacy of a health plan's network. Health plans frequently circulate inaccurate provider directories which list providers as in-network even if they aren't actively submitting claims.<sup>6</sup> For instance, the only recent health insurance market conduct examination in Massachusetts by our state regulator of health insurance carriers<sup>7</sup> found systemic industry-wide errors in provider

<sup>4</sup> National Alliance on Mental Illness, *Mental Health Conditions*, avail. at <https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions>

<sup>5</sup> AAP-AACAP-CHA *Declaration of a National Emergency in Child and Adolescent Mental Health* (Oct. 2021) Avail. at <https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/>

<sup>6</sup> Zhu, Charlesworth, Polsky, et. al., *Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access In Oregon Medicaid*, *Hlth Affrs* Vol 41, No. 7. Avail. at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00052>

<sup>7</sup> In response to CMS funded grants for ACA implementation initiatives by state regulators (CMS CCIO Fact Sheet, *Health Insurance Enforcement and Consumer Protections Cycle I Grant Awards*, 10/31/2016, Avail. at <https://www.cms.gov/newsroom/fact-sheets/health-insurance-enforcement-and-consumer-protections-cycle-i-grant-awards>), the Massachusetts Division of Insurance conducted a "secret shopper"

directories listing BH practitioners that were not submitting claims. The examination found that often the phone numbers listed in the directory were not answered, were disconnected, or were fax numbers. This examination concluded that the “behavioral health provider records” in provider directories of the 14 insurance carriers examined “contained completely accurate information” between “29% and 64%” of the time.<sup>8</sup> This general problem of inaccurate provider directories by health plans continues despite a Massachusetts state law enacted in 2019<sup>9</sup> that expressly requires health plans to update their provider directory information, to audit that information regularly, and to correct errors reported by consumers in a timely manner. Nearly four years after its enactment, this law is not implemented, as state regulators have not yet finalized the implementing regulations, despite extensive recommendations negotiated by health plan, provider and consumer stakeholders to assist that implementation process.<sup>10</sup>

- ❖ **We support the suggestion that health plans must gather and assess data on “both the percentage of in-network providers who submitted no in-network claims and the percentage of in-network providers who submitted claims for fewer than five unique participants, beneficiaries, and enrollees during a period.”<sup>11</sup>**

Including this secondary category of providers will help ensure that regulators identify what proportion of in-network providers furnish very few services or serve very few plan members, giving a more complete view into the adequacy of the provider network.

### **Comment 3 re Time and Distance Standards**

- ❖ **We support the Departments’ suggestion that health plans collect detailed data on the percentage of plan members who can access specified provider types in-network within a certain wait time and geographic distance.**

We strongly agree with the Departments’ view that this data would help with the assessment of a health plan’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

---

market conduct exam to survey primary care and BH providers listed in directories who had not submitted a claim in a recent prior year.

<sup>8</sup> Massachusetts Division of Insurance, *Market Conduct Exam Reviewing Health Insurance Carriers’ Provider Directory Information*, June 2018, at pages 6-12, available at [https://www.mass.gov/files/documents/2018/06/15/Provider%20Information%20Report\\_06122018.pdf](https://www.mass.gov/files/documents/2018/06/15/Provider%20Information%20Report_06122018.pdf).

<sup>9</sup> Chapter 124 of the Acts of 2019, enacted on Nov. 26, 2019, and codified at Mass. Gen. Laws ch. 176O section 28.

<sup>10</sup> Provider Directory Taskforce Report, April 2020, as required by Section 4 of Chapter 124 of the Acts of 2019, <https://malegislature.gov/Reports/10308/Report%20of%20the%20Provider%20Directory%20Task%20Force.pdf>.

<sup>11</sup> U.S. DOL, Technical Release 2023-01P, page 12.

Department of Health and Human Services has already put forward strong proposed standards for Medicaid managed care and the Children's Health Insurance Program<sup>12</sup> which establish maximum appointment wait time standards for routine outpatient mental health and substance use disorder services of 10 business days and require independent secret shopper surveys. These standards align with appointment wait time metrics that have been adopted for Qualified Health Plans.<sup>13</sup>

In collecting data, the Departments should collect data on routine and crisis BH appointments, including the timelines for initiation of follow-up and ongoing care. This information can be collected in the form of "wait times" for providers who represent that they are available to accept new patients. When only initial appointment wait times are measured, health plans can manipulate their practices to have initial "intake" appointments while having long delays in the delivery of ongoing services.<sup>14</sup>

❖ **Data should be disaggregated by age group to assess wait times and travel distance for children and adolescents.**

It is also important to establish a requirement that the provider directories for health plans would only be considered accurate to the extent that they contain accurate data about the locations where providers actually see patients. The Departments should define the criteria for health plans to follow when listing locations at which providers see patients, and thus where that provider is available to accept new patients.

Acknowledging that some providers may have the ability to see patients at various locations, but in actuality they may not utilize all of those locations, a multi-stakeholder Task Force on Provider Directory requirements in Massachusetts recommended that health plan directories should be more granular with respect to locations that providers see patients.<sup>15</sup> Similarly, we recommend that the Departments consider including such a requirement in their data collection standards, and in any other federal requirements based on their federal authority<sup>16</sup> to increase accuracy of provider directories, such that:

❖ **Provider directories be required to indicate the frequency each listed individual provider sees patients in each listed location**

---

<sup>12</sup> CMS, HHS proposed rule, *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*, May 3, 2023, 88 FR 28092, avail. at <https://www.federalregister.gov/documents/2023/05/03/2023-08961/medicaid-program-medicare-and-childrens-health-insurance-program-chip-managed-care-access-finance>

<sup>13</sup> See 45 C.F.R. § 156.230(a)(2)(B)(implementing future standards with respect to "appointment wait time..." as a component of network adequacy.)

<sup>14</sup> San Francisco Examiner, *Long Mental Health Wait Times at Kaiser May Violate State Law, Aays Sen. Wiener*, Aug. 14, 2022, Avail. at [https://www.sfoxaminer.com/news/long-mental-health-wait-times-at-kaiser-may-violate-state-law-says-sen-wiener/article\\_a86d2c34-19d1-11ed-9b2a-5798b7b30eae.html](https://www.sfoxaminer.com/news/long-mental-health-wait-times-at-kaiser-may-violate-state-law-says-sen-wiener/article_a86d2c34-19d1-11ed-9b2a-5798b7b30eae.html)

<sup>15</sup> Provider Directory Taskforce Report, as required by Section 4 of Chapter 124 of the Acts of 2019, <https://malegislature.gov/Reports/10308/Report%20of%20the%20Provider%20Directory%20Task%20Force.pdf>.

<sup>16</sup> E.g. 42 U.S.C. § 300gg-115 Protecting patients and improving the accuracy of provider directory information.

For example, a Massachusetts Task Force recommended that provider directories that list more than one address for a provider should also indicate the frequency that the provider practices at that location, i.e. (a) at least once per week, (b) at least once per month, or (c) as a cover/fill-in as needed.

In addition, telehealth is an important new development that has increased access to BH services for many. We support continued provision of access to BH services via telehealth, with the caveat that due to the importance of a patient's comfort with interpersonal communication methods used in BH treatment, plan members who wish to receive BH treatment in person should not be forced to rely upon telehealth modes of BH care.

With the already overburdened pediatric BH care system, limitations on in-network care often extends the wait times children and adolescents face to access the level of care they require. In Massachusetts, we see this most drastically in eating disorder patients, as many insurance networks do not enroll a sufficient number of inpatient or residential eating disorder treatment programs. When one of the very limited spots opens, patients may be prevented from securing a bed due to ongoing and elongated approval processes for out-of-network care. With eating disorder patients, this means they are often awaiting placement from a hospital bed at a medical hospital where they are not receiving the level of intervention required.

#### **Comment 4 re Network Availability and Distribution of Professions**

We applaud the Departments for focusing on whether providers are accepting new patients under proposed section 29 C.F.R. § 2590.712(c)(4)(iv)(2).

- ❖ **We support the Departments' suggestion to require health plans to gather data on network providers who are accepting new patients.**

This information is crucial, in light of the high demand for BH services, and the recurrent barriers plan members report about trying to find available providers. It is important to define the term "accepting new patients" in a clear and meaningful manner in accordance with related current or future regulatory obligations for provider directories under federal law.<sup>17</sup>

- ❖ **We recommend that the Departments consider adding an additional category of "providers with limited availability for new patients."**

One useful addition to this definition is to add a "limited availability" category that communicates that there is not an inexhaustible capacity for the BH provider to accept new patients. This suggestion is based on our understanding that few BH providers

---

<sup>17</sup> 42 U.S.C. § 300gg-115 Protecting patients and improving the accuracy of provider directory information.



have such broad availability, and it was also proposed by a multistakeholder Provider Directory Task Force convened in Massachusetts under state law.<sup>18</sup> A BH provider with just a few time slots available does not add significant capacity to health plans' networks.

- ❖ **We recommend that the term “accepting new patients” should be defined in a manner that precludes health plans from manipulating their provider directory data and comparative analysis data based on fictitious assumptions based upon the terms of their contracts with providers.**

Specifically, BH providers report being offered contracts by health plans that require the BH provider to agree to accept any new patients, even if the BH provider may actually lack the capacity to do so. Our organizations have proposed that forthcoming state regulations on accurate provider directories would be strengthened by including regulations that prevent health plans from including or trying to enforce any contractual provisions that interfere with the accuracy of the provider directory information, such as requiring the provider to agree to accept new patients when they cannot.<sup>19</sup>

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 often 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 BH and medical/surgical sides) on the percentage of the top 10 different professions that make up the network.**

---

<sup>18</sup> Provider Directory Taskforce Report, as required by Section 4 of Chapter 124 of the Acts of 2019. Pages 5, 13, 17. Avail. at <https://malegislature.gov/Reports/10308/Report%20of%20the%20Provider%20Directory%20Task%20Force.pdf>

<sup>19</sup> We have also heard reports from BH providers who significantly dislike the terms and conditions of work with a health plan, but feel compelled to stay with the plan in order to continue to see their current patients who may have that health plan. Such BH providers should be able to decide whether to agree to see new patients from this health plan or not, without any coercion by the terms of their contract. In this regard, a metric that revealed that a health plan had many providers who are actively submitting claims but not agreeing to see new patients points to a need for the plan to either expand its network to more providers, or if it unable to do so, to change the terms and conditions of network participation such that those providers are no longer reluctant to accept new patients from that health plan.

This range of data would reveal whether a health plan is recruiting and retaining all the different possible BH professionals needed to adequately address the full spectrum of BH care.

Our coalition member Boston Children's Hospital sees many patients present to the hospital in a BH crisis tied to their eating disorder. After medical stabilization, often requiring an inpatient level of care, patients are often "stuck" awaiting placement at an eating disorder specific program. Frequently, their insurance may not have any programs in-network that provide inpatient or residential treatment for eating disorders. Even if an insurance provider is willing to sign a single case agreement (SCA) for this level of care, many programs are unwilling to accept this form of agreement. If an SCA is executed, many patients have extended waits as the lengthy approval process often prevents them from securing an open bed in a timely manner.

In addition, as we noted in our accompanying comments<sup>20</sup> on the proposed MHPAEA rule changes (attached), inadequate BH provider networks are a serious barrier to treatment, and are likely a common parity violation.

### **Comment 5 re Network Admissions**

In assessing network composition and access to BH services, we urge the Departments to review the criteria and processes by which health plans determine which providers to admit into networks and/or how health plans define when a network is considered "full" or "closed." Reports from BH providers suggest that they have been denied participation in networks due to those networks being "closed" or "full," even though patients are unable to find appropriate providers in that network. Some BH providers who are eventually admitted into networks report having to wait as long as nine months to be added. Other BH providers report challenges related to very low offers of reimbursement rates.

Health plans 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, criteria, and rates at which plans have added new providers will help reveal the extent to which health plans bear responsibility for the lack of access to BH services. For example, health plans 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, etc.) how long after application they are approved, and how long after application they are able to start seeing patients.<sup>21</sup>

---

<sup>20</sup> For more information, see comments by the Children's Mental Health Campaign (CMHC) submitted to 0938-AU93, 1210-AC11, 1545-BQ29, Requirements Related to the Mental Health Parity and Addiction Equity Act.

<sup>21</sup> One driver of BH provider enrollment in a health plan network is the BH provider's desire to continue to see an existing patient when the patient's health coverage changes. BH providers genuinely care about their clients, they know that there are long wait lists for patients who change providers, and they know that

## Comment 6 re Reimbursement Rates

We applaud the Departments' suggested data collection relating to reimbursement rates, which are critical determinants of network adequacy. We also commend the Departments for requiring reimbursement rate data to be "compared to billed rates." These rates also profoundly affect the availability of BH providers longer term, as potential providers make decisions on whether to enter or remain in the field based in part on their perceptions and predictions of future opportunities for compensation.

For example, coalition member Health Law Advocates is seeing BH providers starting to seek legal support to file parity complaints about the particularly low reimbursement rates of some health plans, compared to other plans in the same area. Gathering this data is essential to fully understanding reports by health plans regarding "difficulty" in recruiting or retaining BH providers, and assessing if this is a direct result, if not an intended result, of the plans own low reimbursement rates.

- ❖ **As one means to measure the adequacy of reimbursement rates, we recommend the Departments evaluate the ratio of paid in-network amounts to OON billed market rates for BH and medical/surgical services.**

The billed rates of OON providers are the most accurate representation of the market rate.

- ❖ **We urge the Departments to reject health plan efforts to use of the Medicare Fee Schedule.**

This benchmark is discriminatory with respect to both mental health conditions and age. For example, given that Medicare is not subject to MHPAEA, using the Medicare Fee Schedule effectively bakes in discrimination. Furthermore, Medicare rates are not relevant for child and adolescent services since this population does not participate in the Medicare program.

## Comment 7 re Aggregate Data Collection

Health plans have responsibilities under MHPAEA to regularly gather data in order to comply with their QTL and financial requirement obligations. This includes gathering data needed to determine the predominance of QTLs under the plan, according to 29 C.F.R. § 2590.712(c)(3)(i). But MHPAEA also requires the plan to gather more detailed data with respect to different coverage units (such as self-only, family, and employee plus spouse) if the plan applies different QTLs to those forms of coverage under the

---

the therapeutic alliance between BH providers and their patients is the single best indicator of successful outcomes of BH care. Thus they can seek to join a new plan in order to prevent a client they care about from going through an interruption in treatment. However, significant delays in enrolling providers could easily be a tactic aimed to frustrate those provider concerns. As parity requirements become more meaningful under the 2023 Proposed Rule, and provider reimbursement rates are corrected, delays in joining new networks would be important to document and assess.

plan. See 29 C.F.R. § 2590.712(c)(3)(ii). The principle is that plans must use pools of data that correspond to the contours of the limitations/plan management strategies they use.

With respect to data needed for the comparative analysis required under MHPAEA, the most important consideration is ensuring that the data is gathered in a manner that prevents manipulation and misrepresentation of the information when it is sought by both regulators, and by plan members requesting parity documentation. In some cases, aggregate data that captures the performance, and limitations applied to the health plan's network may be appropriate. In other cases, such as a plan member requesting information, the scope of the data that is relevant may need to be limited to that concerning the plan member's discrete plan.

- ❖ **We support the Departments' consideration and clarification of when an entity like a TPA or insurance carrier must gather and assess data with respect to a single group health plan, or they must gather and assess data with respect to multiple plans that are using the same provider network under the same limitations.**

For instance, with respect to some NQTLs, such as provider admission to a network, those criteria may be broadly applicable to the entire network. Other NQTLs may be applied by a TPA in different ways to different plans, at the direction of the employer. To the extent the Departments feel the need to gather data in the aggregate, in order to more effectively enforce MHPAEA across all the health plans that a TPA manages, we support the Departments' interest in that approach.

### **Comment 8 re Service Utilization Data**

In assessing network composition and access to (and potential under-utilization of) BH services, we urge the Departments to require plans to report on utilization rates for specific BH services and level of care. These utilization rates should be compared to estimates of plan members who have related BH conditions, as well as to utilization rates for medical/surgical services.

Gathering and assessing data about predicted and actual utilization of BH services at all levels of care is essential to understanding whether the health plan's network of providers is adequate, and available to plan members' needs. A new Massachusetts law discussed below requires health plans to gather and report this information publicly, with subsequent review and publication by state regulators.<sup>22</sup>

- ❖ **We recommend that the Departments require health plans to gather and assess utilization data on the following types of BH services and levels of care:**

---

<sup>22</sup> See Mass. Gen. Laws. ch. 26, § 8M(d)(iv) for fully-insured commercial plans; ch. 118E, § 80(c)(vi) for Medicaid plans.

- **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 BH diagnoses;**
- **High-demand needs such as services for children and adolescents, eating disorder, 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 BHs.**

### **Comment 9 re Data on Appeals of Plan Denials**

Other NQTLs that could impact the provider network include the *administrative burden on providers*. This burden is associated with a range of health plan practices, including prior authorization and other utilization review processes, submission of and payment of claims, and rates of approvals and denials by the plan. The significant administrative burden that some plans put upon BH and other providers is often reported as one of the most discouraging aspects of taking health insurance, in addition to unreasonably low reimbursement rates.

Toward that end, the Departments could consider that, in addition to the numbers and percentages of approvals and denials, plans should also gather, assess, and explain to regulators data about the numbers and rates of provider and consumer appeals related to denials for services to treat both BH and medical/surgical conditions.

A recently enacted Massachusetts statute requires fully insured health plans and Medicaid plans to annually gather and submit:

- (iv) a breakdown of treatment authorization data for each carrier for mental health treatment services, substance use disorder treatment services and medical and surgical treatment services for the immediately preceding calendar year indicating for each treatment service:
  - (A) the number of inpatient days, outpatient services and total services requested;

(B) the number and percent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lower amount of inpatient days authorized than requested and the reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved, inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external appeal was filed and upheld and inpatient day requests where an external appeal was filed and overturned; and

(C) the number and percent of outpatient service requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the denial, outpatient service requests where an internal appeal was filed and approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external appeal was filed and upheld and outpatient service requests where an external appeal was filed and overturned;<sup>23</sup>

This information could be an important indicator of whether and how often health plans are imposing barriers in the form of denials for BH services that are commonly or frequently overturned. It could also indicate whether health plans are denying expensive forms of BH care, such as inpatient or residential treatment, but approving care at these treatment levels when they are requested by providers treating medical/surgical conditions.

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 medical/surgical pediatric subspecialists to the lists (e.g., pediatric cardiologists, pediatric neurologists, etc.) for purposes of assessing parity compliance.

### **Comment 10 re Safe Harbor**

The Technical Release also requested feedback on the potential of a "safe harbor" for NQTLs related to network composition. Under this proposed safe harbor, if the health plan gathered data to show that it had met not-yet-established metrics, then the plan would be relieved from further analysis of their NQTLs related to network adequacy of BH providers, such as their comparative analyses obligations, including the assessment

---

<sup>23</sup> Mass. Gen. Laws. ch. 26, § 8M(d)(iv) for fully-insured commercial plans; ch. 118E, § 80(c)(vi) for Medicaid plans.

of the possible impact of an NQTL upon access to BH services under 29 C.F.R. § 2590.712(c)(4)(iv)(A), § 2590.712(c)(4)(iv)(A)(B), and 29 C.F.R. § 2590.712-1.

- ❖ **We urge the Department not to proceed with a safe harbor at this time. Network adequacy has always been difficult to define and easy to mismeasure. And networks of BH providers are currently strained due to under payment for years, combined with the added pressures brought on during the COVID pandemic, including increased need for services by children and adults and increased acuity.**

Establishing a safe harbor from further scrutiny of network adequacy and composition requirements under MHPAEA has the potential to undermine MHPAEA implementation and enforcement if the data collection requirements are not capturing a full and complete picture of plan members' access to BH services. Given the significant work that the Departments need to do – and likely refinements that are necessary over time – to ensure that the data to be collected by health plans is complete, accurate, and meaningful, a safe harbor should not be considered in the near future. A safe harbor should only be considered when the Departments and key consumer stakeholders are confident that (1) appropriate standards or metrics related to consumer access can be established in a universal manner that could apply to health plans in all geographic areas and with respect to all demographic and ethnic groups in such localities, and (2) the data to be collected by plans accurately captures actual access to BH services. If a safe harbor is put in place prior to this occurring, it could cause enormous damage by giving non-compliant health plans a “safe harbor” against accountability.

- ❖ **We further oppose the creation of the safe harbor due to concerns that it will introduce complexity and thus undermine other MHPAEA enforcement of NQTLs unrelated to the safe harbor by state regulators**

If a health plan was determined to have met the future criteria for a ‘safe harbor’ under subsequent federal guidance, due to the complexity of MHPAEA analysis, the health plan would be less likely to receive appropriate scrutiny from state regulators in areas that may be potential violations of MHPAEA but are unrelated to the proposed Safe Harbor. The Massachusetts Division of Insurance, which regulates commercial insurance health plans in Massachusetts, has conducted no publicly announced parity investigations or market conduct examinations. This agency initially refused to enforce MHPAEA, claiming that they had no authority to do so until the state Legislature enacted a law explicitly permitting the agency to do so in 2012,<sup>24</sup> which was followed by a subsequent state law ten years later that requires the agency to do so.<sup>25</sup> Given the complexity of MHPAEA, the lack of sophistication many state regulators likely have in understanding or enforcing MHPAEA, and their possible concerns about taking state action in potential contradiction of a federal standard and possible federal preemption, a Safe Harbor created under federal law would likely cause far more harm than good.

---

<sup>24</sup> Mass. Senate Bill 2400, Section 23, 187th Legislature, Avail. at <https://malegislature.gov/Bills/187/S2400>

<sup>25</sup> See Mass. Gen. Laws ch. 26, § 8K.

## Comment 10 re Meaningful Data & Preventing Data Manipulation

- ❖ **To ensure 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.**

Without clear definitions, we are concerned that plans may define categories and collect data in a manner that is not comparable across plans, or that in some cases, plans may seek to gather data using definitions that make their utilization rates appear more positive than they are in reality. For example, the Departments should make clear – using definitions for “claim denial,” “partial claim denial,” and “claim approval” – that failure to pay a claim in full (with the exception of applicable cost-sharing) may constitute a partial denial.

- ❖ **We recommend that the Departments not only collect data on the number and percentage of claims denials, but should also require health plans to gather, assess, and, when necessary, report information about both claims denials and service denials (i.e., prior authorization denials, etc) to capture the complete picture of health plan denials.**

Corresponding with our recommendation above, the Departments should also define “service denial,” “partial service denial,” and “service approval” to accurately record the plan’s decisions on pre-claim services requests (i.e., prior authorization requests). To the extent possible, these definitions should also ensure that health plan practices to deny services verbally through peer-to-peer reviews, or other similar practices, are still documented as denials. For example, a recent Massachusetts law attempting to address this problem – i.e. verbal health plan decisions to reject a requested treatment not being treated as an actual denial – by requiring Medicaid plans “to maintain documentation of all requests for benefits or services, whether the request is submitted by, or on behalf of, the intended recipient of those benefits or services. Any request that is not fulfilled in full shall be considered a denial and shall result in the prompt written notification to the intended recipient through electronic means, if possible.”<sup>26</sup>

In Massachusetts, we are growing increasingly concerned about health plans’ consistent and intentional failures to issue written denials about post-service claims, as is required by ERISA and the PHSA.<sup>27</sup> We see that several health plans rely upon issuing written notice of claim denials using only an Explanation of Benefits (EOB) notices, which often do not comply with the many notice requirements under state and federal laws. In addition, some major commercial health plans in Massachusetts have ceased sending even these insufficient EOB notices to plan members, and instead, the health plans post an even more deficient claims summary on the consumer’s patient

---

<sup>26</sup> Mass. Gen. Laws ch. 118E § 47.

<sup>27</sup> See 29 C.F.R. § 2560.503–1(g), 45 C.F.R. § 147.136(b)(2), (3).



portal, leaving the plan member effectively no notice that the health plan has issued a denial. These consumer-portal based electronic notices lack both the basic information explaining the rationale for the claim and the mandated disclosures to inform the plan member of their appeal rights, among other deficiencies.<sup>28</sup>

The Massachusetts Legislature enacted statutes in August 2022 that require health plans to annually report on detailed information about their approval and denial practices, including information detailing, carrier by carrier, their rates and total numbers of denials for both BH and medical/surgical services, etc.<sup>29</sup> Because these annual reporting requirements under state law have not been fully implemented yet, the Departments' creation and inclusion of definitions for these terms under these proposed MHPAEA regulations would increase clarity about the definitions of the types of denial data to be gathered. These definitions would likely help our Massachusetts state regulators move forward implementing the new state law protections, and ensure alignment with federal regulations.

### **Comment 11 re Disaggregating MH and SUD Data**

- ❖ **We encourage the Departments to clarify 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.

For instance, a Massachusetts statute enacted in 2014<sup>30</sup> requires fully-insured plans to defer to the treating provider with respect to the medical necessity of services to treat SUD in 24-hour care settings, such as residential or inpatient care. Thus the approval rate for SUD treatments has been markedly increased due to this statute. However, this law has likely had little to no impact upon the approval rates for mental health services. Other states have enacted other requirements for health plans to address the widespread opioid addiction crisis. These examples illustrate how disaggregating MH and SUD data by health plans is necessary to be sure that regulators, policy makers and others would not be misled.

### **Conclusion**

We support these proposed efforts by the Departments to ensure that robust, appropriate and meaningful data about BH provider network composition is gathered and reviewed by health plans as part of their comparative analysis of MHPAEA

---

<sup>28</sup> See 29 C.F.R. § 2560.503–1(g)(i),(iv), et seq.; 45 C.F.R. §§ 147.136(b)(2)(ii) et seq., 147.136(b)(3)(ii) et seq.

<sup>29</sup> See Mass. Gen. Laws. ch. 26, § 8M(d)(iv) for fully-insured commercial plans; ch.118E, § 80(c)(vi) for Medicaid plans.

<sup>30</sup> See Ch. 258 of the Acts of 2014, codified at Mass. Gen. L. ch. 176G, § 4AA, etc.

compliance. We ask the Departments to also include our recommendations above to further strengthen this Technical Release to improve network adequacy and access to BH services.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Wells Wilkinson at Health Law Advocates at [wwilkinson@hla-inc.org](mailto:wwilkinson@hla-inc.org) or 617-275-2983.

Respectfully,

Wells Wilkinson  
Senior Supervising Attorney  
Health Law Advocates

On behalf of the Children's Mental Health Campaign