From:	Lerner, Bradley
To:	EBSA MHPAEA Request for Comments
Cc:	Macenka, Loretta T.
Subject:	Elevance Health"s MHPAEA Technical Release comments: Technical Release 2023–01P
Date:	Tuesday, October 17, 2023 6:37:40 PM
Attachments:	image001.png image004.png Elevance Health Comments_RFI MHPAEA Technical Guidance(2023-10-17).pdf

Please find attached Elevance Health's MHPAEA Technical Release comments. Best, Brad Lerner

Elevance Health

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October 17, 2023

The Honorable Julie Su
Secretary of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Request for Comment on Proposed Relevant Data Requirements for Nonquantitative Treatment Limitations 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

Dear Secretaries Su, Becerra, and Yellen,

Below please find our comments on the U.S. Department of Labor (DOL), U.S. Department to Health and Human Services (HHS), and U.S. Department of Treasury's (collectively, the Tri-Agencies) 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 (the Technical Release).

Elevance Health is a lifetime, trusted health partner fueled by its purpose to improve the health of humanity. We support consumers, families, and communities across the entire care journey—connecting them to the care, support, and resources they need to lead healthier lives. Elevance Health's companies serve approximately 118 million people through a diverse portfolio of industry-leading medical, digital, pharmacy, behavioral, clinical, and complex care solutions. Elevance Health has taken significant steps in furtherance of MHPAEA implementation. These efforts preceded MHPAEA final regulations, which were released in 2013, and continue today through working with employers, health plans, state Medicaid agencies, regulators, legislators, providers, behavioral health interest groups and advocates, and others to further parity compliance. At the same time, Elevance Health ensures the right

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level of care for consumers in an affordable manner, a goal compatible with parity compliance and consistent with broader clinical practice.

In addition, Carelon Behavioral Health, an Elevance Health company, is a leading behavioral health services company serving one out of six people across all 50 states. We work with employers, health plans and government agencies to support mental health and emotional wellbeing, crisis and foster care, substance use disorder recovery, and employee health programs that improve the health and wellness of people every day. Our multimodal insights-driven approach allows us to integrate social, behavioral, and physical health solutions to drive improved outcomes for everyone we serve. By collaborating with a network of providers in communities around the country, we help individuals live their lives to the fullest potential.

Background

Elevance Health appreciates the opportunity to submit comments to the proposed measures related to the network composition NQTLs. Creating a network of providers that is adequate to serve members' mental health/substance use disorder (MH/SUD) needs is critical. As Elevance Health notes in its response to the concurrent Proposed Rule, we have undertaken a wide variety of initiatives that have expanded access to mental health resources through expanded telehealth options, building community capacity, staffing crisis hotlines, and aiding clinics that seek to integrate mental and physical health services.

Workforce Shortages

Addressing access primarily through the network composition outcomes is flawed given the well-documented MH/SUD provider shortages. Government Accountability Office's (GAO's) October 2022 report on the MH/SUD workforce in the U.S. included the following conclusions:

- Approximately half of counties in the U.S. did not have an active psychiatrist or addiction medicine specialist;
- More than 150 million people live in federally designated MH professional shortage areas; and,
- In the near future, the U.S. will be short between 14,280 and 31,109 MH/SUD providers.[1]

[1] Government Accountability Office: Behavioral Health: Available Workforce Information and Federal Actions to Help Recruit and Retain Providers (October 2022): https://www.gao.gov/products/gao-23-105250.

A recent report from the American Psychological Association reinforces the fact that demand for services exceeds the supply of MH professionals. Nearly half of 2,300 psychologists surveyed said they were unable to meet demand for treatment, while 60% have no more openings for new patients, and 42% have waitlists of at least 10 patients.[2] Given these shortages, there is a misconception that there is a broad universe of providers who are interested in joining health plan networks but are being prevented from doing so due to administrative barriers and reimbursement rates. Moreover, plans cannot force providers to join networks nor can plans control a providers' willingness to accept new patients.

Healthcare Quality and Affordability

Strict application of network adequacy standards can lead an issuer to enter into agreements with providers that otherwise would not meet the issuer's standards with respect to affordability and/or quality of care simply to meet the numerical standard. This can result in higher reimbursement rates and increased premiums. We believe that an effective network adequacy review process should not be solely outcome specific, but consider the factors that go into a plan or issuer's development of a network for a particular marketplace, such as care management, contracted rates, and provider quality.

Consideration of Telehealth

Given the tremendous increases in MH/SUD telehealth availability for consumers, as discussed in our Proposed Rule comment letter, we recommend that the Tri-Agencies explore creating a telehealth parity credit for payers that have implemented robust national MH/SUD telehealth networks. The growth of telebehavioral services allows consumers to receive near immediate access for a variety of mild to moderate conditions. Virtual companies like LiveHealth Online and American Well that partner with payers and employers should be recognized in any measurement of parity compliance since these offerings far surpass any such telehealth initiatives in the medical/surgical (M/S) space.

[2] American Psychological Association: Psychologists Struggle to Meet Demand Amid Mental Health Crisis (November 2022): https://apa.org/pubs/reports/practitioner/2022-covid-psychologist-workload.pdf.

Network Adequacy Is Best Addressed by States and In Other Regulatory Proceedings

Considering the measures being proposed in this Technical Release, many network adequacy measures are already collected as part of other accreditation or compliance requirements. State Departments of Insurance are best positioned to assess demographics, provider mix, and utilization trends in order to appropriately define network adequacy measures suited to their state.

MHPAEA is not the best vehicle to address network adequacy; several other regulatory vehicles exist that are concurrently developing infrastructure and processes for improving network adequacy. For example, CMS is addressing appointment wait times in three other regulations: the Notice of Benefit and Payment Parameters; the Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; and the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality rules. As we commented previously, no current system exists for health plans to collect information such as appointment wait time data. The Fast Healthcare Interoperability Resource (FHIR) is the industry interoperability standard that allows health data, including clinical and administrative data, to be quickly and efficiently exchanged between entities. Currently, appointment scheduling information cannot be included in the FHIR record. Any attempt to implement new network access standards without a reporting system that is workable for both health plans and providers, including modifications to the FHIR standard would lead to significant provider abrasion and discourage rather than encourage provider participation in plan networks.

The Tri-Agencies should not add another potentially conflicting network adequacy regulatory rubric in MHPAEA and instead should continue to rely on the existing proceedings to fine-tune requirements.

Provider Directory Improvements

The provider directory publication requirements already help to ensure network adequacy without the need to expand MHPAEA. While we still need providers to provide us with updated and accurate information in a timely manner, Elevance Health has undertaken significant work to develop an internal provider directory accuracy program with the goal of identifying and correcting data accuracy errors. On average, this program has improved our

internal directory accuracy score significantly in each market that we serve. The methodology uses analytics comparing our data to internal business rules, third party, and other payer data sources to meet CMS standards. This program involves a proactive monitoring approach by comparing Elevance Health data with several external sources which generates recommendations for correction while also applying automatic updates. These improvements help consumers better understand provider participation. Indeed, members play an active role in deciding both their plan benefits and selecting providers. Therefore, if plans provide accurate provider directories, network composition should not be viewed as a limit on the scope or duration of benefits.

Specific Feedback

Below we provide responses to some of the questions raised by the Tri-Agencies in the Technical Release. We also direct the Tri-Agencies to consider the comments submitted by the Association for Behavioral Health and Wellness (ABHW), AHIP, and Blue Cross Blue Shield Association (BCSBSA) for their specific comments on areas of the regulation that we did not address below.

We have general concerns about creating a safe harbor for the provider network composition NQTL type(s) only and not for any other NQTL type. We would like to better understand why the Tri-Agencies believe that network composition NQTLs are unique, and additionally, how meeting the standards of the safe harbor would affect the NQTL comparative analysis. We would support such a safe harbor if reaching reasonable measure performance could alleviate the need for the NQTL comparative analysis.

The Tri-Agencies outline four specific types of data that they are considering requiring plans and issuers to collect and evaluate as part of their comparative analyses for NQTLs related to network composition. The four types of data are: out-of-network utilization; percentage of in-network providers actively submitting claims; time and distance standards; and reimbursement rates. The Tri-Agencies request detailed feedback on all aspects of these types of data to inform future guidance.

Out-of-Network (OON) Utilization

***Issue*:** The Tri-Agencies are considering requiring plans and issuers to collect and evaluate data on the OON utilization for M/S, MH, and SUD benefits.

Recommendation: Elevance Health recommends that the Tri-Agencies not require plans and issuers to collect and evaluate data on OON utilization for M/S, MH, and SUD benefits.

Rationale: Elevance Health does not believe out-of-network utilization is a proper measure for network adequacy. Out-of-network service utilization is driven by a wide variety of factors, including convenience of location, perceived quality (potentially unrelated to actual quality scores), provider referrals or recommendations, recommendations by family or friends, provider advertisements (including by for-profit providers of residential MH/SUD care), and continuity of care (after changing health plan or insurer). Individuals seeking MH/SUD care may be particularly incentivized to seek out-of-network care due to a number of factors, including perceived or real stigma regarding their condition. Therefore, while out of network utilization rates may be helpful for a plan or issuer to investigate, it should not form the basis of a parity compliance standard.

As we have noted in our comments to the Proposed Rule, outcomes measures are only meaningful to the extent they are truly comparing similar services and providers. If the Tri-Agencies did want to compare out-of-network utilization, we would suggest doing so for M/S services that may show similar utilization patterns and preferences.

With regard to the question of how to account for situations where there is no claim for out-of-network services, Elevance Health has no means to collect information related to such care or determine whether such self-pay services were medically necessary (*e.g.*, in dermatology self-pay may include non-covered cosmetic services). For this reason, we do not believe services with no claims should be included in any out-of-network service counts.

Percentage of in-Network Providers Actively Submitting Claims

Issue: The Tri-Agencies are considering requiring plans and issuers to collect and evaluate data regarding the number of claims submitted by in-network providers to determine providers that are listed as in-network but not accepting patients.

Recommendation: Elevance Health recommends that the Tri-Agencies not require plans and issuers to collect and evaluate data on in-network providers actively submitting claims.

Rationale: Elevance Health does not believe that this metric, as proposed, is an appropriate relevant data metric for assessing MHPAEA compliance. In particular, the metric as contemplated in the Technical Release has never, to our knowledge, been used or tested in

any way. The version of the metric in the Model Data Request Form (MDRF) tool referenced in Appendix 1, does not include any comparison to rates for M/S services. As such, the MDRF version is an arbitrary measure pointing only to MH/SUD providers without any reference to comparability, the keystone of any MHPAEA analysis. Moreover, the MDRF measure fails to examine or account for the wide range of reasons that may contribute to a provider submitting few or no claims within a given time period. Such reasons may include random fluctuations in demand for the provider's services (especially in rural and frontier areas), random fluctuations in the distribution of a provider's patient mix across contracted payers, excess capacity in the plan's provider network, and personal preferences. Without testing for measure validity and reliability to determine whether meaningful conclusions can be drawn from these data, Elevance Health recommends that this measure not be used to determine MHPAEA compliance.

Notably, providers generally do not give information to health plans on how they determine whether to accept a new patient and plans do not have access to this data unless a provider communicates it. We have also found significant inconsistencies between provider availability self-reported to health plans and availability for actual patients; and no standards exist for this data, further complicating monitoring access and availability. As such, any health plan reported data on this metric is a limited representation of access.

Lastly, we recommend that the collection and evaluation of data about providers accepting new patients not include the following proposed MH/SUD provider types: inpatient care; mobile crisis unit; opioid treatment providers; geriatric providers; eating disorder providers; and autism spectrum disorder providers. Many of these disciplines are not discrete provider types, but rather specializations.

Time and Distance Standards

Issue: The Tri-Agencies are considering requiring plans and issuers to collect and evaluate data on the percentage of participants, beneficiaries and enrollees who can access, within a specified time and distance by county-type designation, one (or more) in-network providers within MH/SUD provider categories.

Recommendation: Elevance Health recommends that the Tri-Agencies not require plans and issuers to collect and evaluate data on time and distance standards for MH and SUD providers to compare against M/S providers as a part of MHPAEA compliance.

Rationale: Provider to enrollee ratios are a well-tested and commonly used metric for network adequacy criteria. However, they have not previously been used in the context of parity—only as a minimum requirement. To this end, if finalized, the Tri-Agencies should provide a safe harbor for plans meeting a certain provider ratio.

Furthermore, there is no standard to account for the role of telehealth in providing access to patients. Telehealth has been valuable tool across health care, but specifically has been an invaluable tool to expanding access to MH/SUD services in underserved areas. Behavioral health is particularly well suited to telehealth for many conditions and many patients now rely on this technology for their care. However, these providers are not accounted for in the calculations underlying time and distance standards. This is a disservice to the critical function these providers serve in bridging gaps in underserved communities and for patients looking for a provider that is not easily accessible in their community for various reasons (*e.g.*, specific race, ethnicity, gender identity, other demographic information). However, it also means that the calculations are skewed towards the provision of brick and mortar-based services and, particularly given the provider shortages, establishing impossible comparisons to M/S providers who are more evenly distributed across the country. Elevance Health recommends that plans and issuers be permitted to credit the availability of telehealth providers toward all time and distance standards, to the extent that telehealth is clinically appropriate for the provider's services, as though the telehealth provider were located within the relevant geographic location.

Lastly, we recommend that the categories of MH/SUD and M/S providers analyzed generally align with the data definitions used for network adequacy requirements for other markets that are served by the plan's network (*e.g.*, the Qualified Health Plan standards). Other Regulatory Agencies and State Departments of Insurance have invested substantial effort to develop standards that can account for a variety of factors and have mechanisms to account for provider shortages, and also contemplate potential approaches to account for telehealth. As we noted earlier, creating a duplicative standard that would potentially contradict those already doing this work would be wasteful and confusing.

Reimbursement Rates

Issue: The Tri-Agencies are seeking feedback on the use of reimbursement rates to evaluate network NQTL.

Recommendation: Elevance Health recommends that Tri-Agencies focus on measures that allow the apples-to-apples comparison of base fee schedule amounts as a percentage of an

external benchmark (such as Medicare rates) and not include comparing provider reimbursement rates to billed charges, but instead compare payments by specialty under private plans to Medicare reimbursement rates.

Rationale: As a threshold matter, Elevance Health opposes comparison of reimbursement rates to billed charges, as the Agencies note they are considering. Our opposition stems from the fact that billed charges are arbitrary values set solely by providers. Requiring plans and issuers to meet a certain threshold of billed charges creates a perverse incentive for providers to increase billed charges in a bid to force higher reimbursement rates with no constraints on price increases.

Next, reimbursement rates are based on a variety of factors. Compared to M/S providers, MH/SUD providers who choose self-pay and do not participate in networks at greater rates regardless of reimbursement rates. Payment rates are influenced by a variety of factors including work force availability, provider choice whether to join a network, and level of licensure.

Elevance Health also opposes requiring plans to use individual provider reimbursement rates for evaluation and recommend the Tri-Agencies consider the use of base rates or set fee schedules instead. The base rate or fee schedule is the starting point for every negotiation between a plan and a provider and should therefore be the data evaluated for comparison. Individually negotiated rates reflect the results of a provider's negotiating skills and preferences,[3] while a base rate or fee schedule reflects that plan's policies, rate-determination process, and adherence to MHPAEA's requirements. Elevance Health believes that looking at base reimbursement rates, as a percent of Medicare between CPT codes used both for MH/SUD and M/S services is worthwhile for the Tri-Agencies to explore. This would need to be adjusted for provider-type to ensure that providers with similar education and training for M/S and MH/SUD benefits are compared with each other.

We recommend that the Tri-Agencies publish analogous provider types for the sake of comparing reimbursement rates that are standardized and specific enough to be truly comparable. These provider comparison standards should be made available for public

[3] This is especially true for any consideration of inpatient rates. Inpatient facilities, both M/S and MH/SUD, have varying preferences on reimbursement methodology impacting the manner and amounts they are reimbursed. Plans and issuers generally adhere to these preferences (*e.g.*, DRG, per diem) when negotiating rate reimbursements. The result is a general lack of comparability between the actual rates paid due to these provider preferences, and is further reason why inpatient rates should not be subject to review as an NQTL.

comment, and should include (1) provider type, (2) common CPT codes, (3) geographic region, and (4) a materiality standard.

By developing and publishing a detailed list of standards to conduct provider comparisons, health plans will be better equipped to accurately measure parity in reimbursement rates. We also recommend that the Tri-Agencies adopt a materiality standard, so that issuers are not reviewing provider type and/or CPT code combinations for which there are very low claims experience as such analyses are likely to be skewed, highly variable based on the reporting period, or otherwise problematic, making these analyses of limited credibility and value.

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Conclusion

Elevance Health thanks the Tri-Agencies for this opportunity to provide our initial feedback on the Technical Release. As we noted in our Proposed Rule comments, Elevance Health will continue to implement innovative programs that improve access to quality, affordable, and evidence-based behavioral health care. We will also continue to work with policymakers in removing barriers to further innovations and improvements for those individuals with MH/SUD conditions. Should you have any questions or wish to discuss our comments further, please contact Brad Lerner at (757) 406-0191 or brad.lerner@elevancehealth.com.

Sincerely,

Elizabeth P. Hall
Vice President, Public Policy and Issues Management, Elevance Health