From:	Leish, Emily
To:	EBSA MHPAEA Request for Comments
Cc:	Leish, Emily
Subject:	Technical Release 2023-01P Comments
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Attachments:	GNYHA Comments re Technical Release 2023-01P.pdf

Please see GNYHA's attached comments on Technical Release 2023-01P.

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Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service

Lisa M. Gomez
Assistant Secretary, Employee Benefits Security Administration
Department of Labor

Xavier Becerra
Secretary
Department of Health and Human Services

Re: Technical Release 2023-01P

Dear Mr. O'Donnell, Ms. Gomez, and Mr. Becerra:

On behalf of the 170+ voluntary and public hospitals that make up the acute care membership of the Greater New York Hospital Association (GNYHA), we appreciate this opportunity to respond to 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 (Technical Release), that accompanies the notice of proposed rulemaking (Proposed Rules) released by the Departments of Treasury, Labor, and Health and Human Services (the Departments).

In addition to submitting detailed comments on the Proposed Rules, GNYHA is also responding to this Technical Release to underscore our strong support of the Departments' emphasis on NQTLs related to network composition and their inherent impact on health plan enrollees' access to mental health and substance use disorder (MH/SUD) benefits.

Despite the 2008 enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA), the 2013 release of MHPAEA regulations, and copious guidance, GNYHA members report ongoing frustration with the realities of ensuring access to MH/SUD care for their patients. Inadequate reimbursement rates, insufficient health plan provider networks, prohibitive patient cost-sharing for out-of-network (OON) care, and disruptive health plan medical management practices all contribute to barriers for patients in accessing MH/SUD services.

In our comments on the Proposed Rules, we describe these member-reported challenges. We also address hurdles to constructing meaningful MHPAEA comparative analysis of these issues. Please refer to our

comments on the Proposed Rules for a more complete overview and discussion of GNYHA members' experiences delivering MH/SUD care. This response focuses on select issues raised in the Technical Release.

Relevant Data for Comparative Analysis for NQTLs Related to Network Composition: With the Technical Release, the Departments seek input on the application of the Proposed Rules' data collection and evaluation requirements to NQTLs related to network composition. We appreciate the Departments' thoughtful consideration of which data elements are likely to demonstrate that network composition NQTLs do not place greater restrictions on access to MH/SUD benefits than medical/surgical (M/S) benefits. Further, the Departments' detailed questions throughout the Technical Release indicate an understanding of the complexities in identifying, collecting, and comparing such data.

GNYHA believes the data elements proposed by the Departments for comparative analysis for NQTLs related to network composition (OON utilization, percentage of in-network providers actively submitting claims, time and distance standards, and reimbursement rates) are the relevant factors that, if accurately captured and meaningfully compared, would help reveal potential parity failures. We strongly encourage the Department to continue seeking stakeholder feedback to develop informed, workable strategies for this complex data analysis.

- **One key area for further development is how to control for underreported claims and utilization data endemic to MH/SUD services.** In-network (INN) utilization of MH/SUD services does not reflect the true scope of utilization, as many individuals seek treatment from OON providers. Claims for OON MH/SUD services are not submitted for a variety of reasons including stigma and plan design (i.e., no OON benefits). This leads to incomplete INN and OON data. The Departments note that disproportionately high use of OON MH/SUD providers is evidence that MH/SUD providers may be available but not inclined to join provider networks. However, relying on OON utilization data to draw the opposite conclusion (i.e., the provider network is sufficient) would be problematic given current data validity concerns.

- **We further support the Departments' consideration of collecting data on the frequency with which INN providers submit claims for unique enrollees.** GNYHA members strongly support requiring plans to compare the number of claims actually submitted by each provider and for how many unique patients. The Departments propose collecting and evaluating the percentage of providers submitting no claims and the percentage of providers submitting claims for fewer than five unique enrollees. This is another area where stakeholder feedback should be useful.

- **Regarding reimbursement rates, we note that inadequate reimbursement for MH/SUD services is a near-universal challenge for GNYHA members**. We also note that the nature of MH/SUD services is distinct. Any reimbursement parity comparison must be within a context that understands and accounts for the nature of MH/SUD services.

  MH/SUD services are *time intensive*. Intake visits, for example, can average 1.5 hours, and there is no comparable M/S evaluation and management (E&M) code conveying similar time and resources. Additionally, unlike their M/S physician counterparts, psychiatric and some addiction services *do not have physician extenders* (e.g., physician assistants, nurse practitioners, and registered nurses) to whom pieces of treatment can be delegated. Moreover, a time-based payment

system inherently creates disparity where M/S practices can see up to four patients per hour billing 15-minute intervals, while the nature of MH/SUD treatment makes it impossible to do so.

Further, *many of the hours that providers spend on patient cases are uncaptured* and unreimbursed. Treating a patient often involves communicating with family members, especially when the patient is a child or adolescent. (Often MH/SUD providers must also coordinate with collateral organizations such as the education or family court systems.) When MH/SUD services are provided to inpatients in an M/S setting, as frequently happens in acute inpatient settings and emergency departments (EDs), the inpatient stay or ED service is billed and reimbursed as an M/S service and the psychiatric services are only captured as a professional consult, with woefully inadequate reimbursement. Children and adolescents needing a psychiatric admission and awaiting placement are often "boarded" in the ED or given a pediatric M/S bed to avoid ED boarding, and with often only the psychiatric consult reimbursed.

Finally, *health plan medical management practices and payment policies further erode reimbursement.*

The current rates and rate structure simply do not cover costs of time and resources, and inadequate reimbursement is a key factor in MH/SUD network inadequacy.

- **Another critical issue needing further exploration is the appropriate benefit classifications for comparing MH/SUD and M/S benefits.** Parity analysis is based on comparisons within benefit classifications, yet many MH/SUD services do not fit neatly within the MHPAEA benefit classification structure, which is based primarily on M/S constructs. There are MH/SUD services currently considered within the outpatient category that are inherently different from most M/S outpatient services. Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs (PHPs), for example, are specialty services providing an intensive intervention for a potentially resolvable problem over recurring visits. It is not appropriate to compare them to the majority of M/S outpatient services. At minimum, individual MH/SUD services should be mapped to specific M/S services rather than treated as part of an overall benefit classification benchmark.

  For example, GNYHA members recommend *chemotherapy* as the M/S service with similar recurrent visit structures that is *most appropriate for comparison to IOP and PHP*. *Opioid Treatment Programs (OTPs) should be compared to dialysis*, as both OTPs and dialysis are generally used for extended periods of time. MH/SUD *crisis services are more appropriately considered emergency services* than outpatient services, given the reason for using these services. To truly understand disparity in access resulting from NQTLs, it is imperative that MH/SUD services be compared to the appropriate M/S classification, and subclassifications within a benefit category (where appropriate). *We urge the Departments to continue to explore appropriate classification with stakeholders and issue subclassification guidance.*

Aggregate Data Collection: The Departments request comments on a proposal to require third-party administrators or other service providers to collect and evaluate data in the aggregate for all plans using the same provider network or reimbursement rate. The Departments are concerned that plan or product-level data may not reflect sufficient claims experience. We recognize the economies of scale argument, and the

data challenges, but remain concerned that aggregate data has the potential to mask individual plan disparities. A lack of sufficient claims experience can be meaningful in and of itself, and plans should be required to evaluate and consider the causes. Additionally, given frustrations with MH/SUD carve-out vendors, data should be reported separately for payer-administered and carve-out benefits.

Future Potential Safe Harbor*:* Finally, the Departments are contemplating an enforcement safe harbor with respect to NQTLs related to network composition for plans and issuers that meet or exceed specific data-based standards identified in future guidance. Given the acknowledged potential harm of network composition NQTLs and the many challenges to conducting a meaningful comparative analysis, we respectfully question the purpose of such a safe harbor. We caution that it has the potential to undermine the goals of the Proposed Rules and accompanying future guidance: to cause providers to meaningfully and robustly review the impact of network composition NQTLs on access to MH/SUD benefits.

Thank you for the opportunity to provide feedback on the Proposed Rules. We urge the Departments to finalize the NQTL framework and continue engaging stakeholders in important dialogue on understanding MH/SUD services. We look forward to working with you to improve access to MH/SUD benefits.

Please contact me at eleish@gnyha.org with any questions about our comments.

Sincerely,

Emily Leish
Senior Vice President, Health Finance and Managed Care