From:	Silver, Dana
To:	EBSA MHPAEA Request for Comments
Cc:	Jones, Jennifer
Subject:	submission of BCBSA comments on MHPAEA Technical Release 2023-01P
Date:	Tuesday, October 17, 2023 2:16:42 PM
Attachments:	BCBSA MHPAEA Technical Release Comments_10.17.23.pdf

To whom it may concern:

Attached are the Blue Cross Blue Shield Association's (BCBSA) comments on the "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).

We look forward to continuing to work with the Departments on this issue as well as additional ways to ensure all Americans have affordable access to high-quality MH/SUD services. If you have questions, please contact Jennifer Jones at 202.942.1269 or Jennifer.Jones@bcbsa.com.

Best regards,

Dana Silver

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October 17, 2023

The Honorable Julie Su
Secretary of Labor
200 Constitution Avenue, N.W.
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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

Submitted via email to mhpaea.rfc.ebsa@dol.gov

RE: 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

Dear Secretaries Su, Becerra and Yellen,

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the Proposed Rule on "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).

BCBSA is a national federation of 34 independent, community-based and locally operated BCBS companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own.

We are committed to robust mental health and substance use disorder (MH/SUD) access. BCBS Plans have made considerable progress toward and continue to execute multifaceted strategies to build robust MH/SUD benefits. However, we have concerns that the proposed network composition NQTL is attempting to solve for variables that are not wholly within health

plans' control and, as a result, will either yield persistent industry-wide results that the Departments may view as indicators of noncompliance or force changes to be compliant that are not in the best interests of patients.

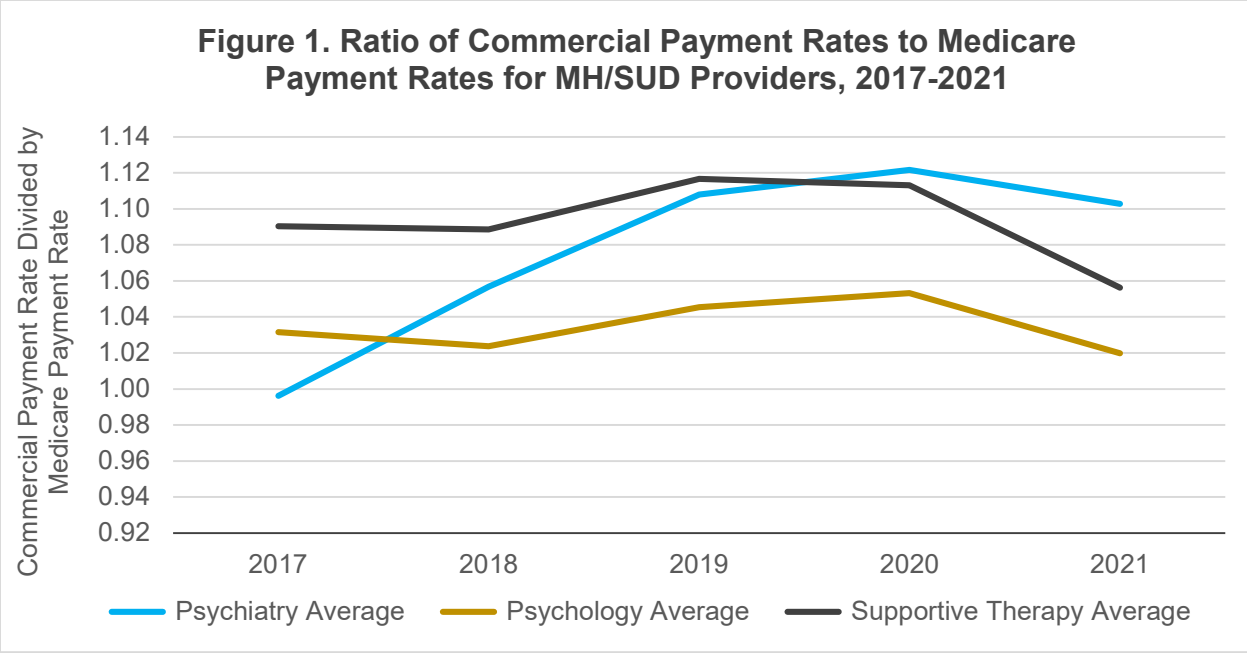
Addressing access primarily through the network composition outcomes proposed in the "Requirements Related to the Mental Health Parity and Addiction Equity Act Proposed Rule" assumes the primary driver of the access challenges is health plans not contracting with MH/SUD providers. This does not account for a number of factors, but two in particular. First, primary care is a consistent, and growing, source of care for MH/SUD needs which is not captured by a comparison of medical/surgical (M/S) to MH/SUD services. Second, the dearth of available MH/SUD providers is well documented. The Health Resources and Services Administration reports that there are 6,767 Mental Health Professional Shortage Areas containing 166 million people.[1] This shortage of workers is not evenly distributed as 55 percent of U.S. counties, all rural, have no practicing psychiatrists, psychologists or social workers. Another study found that 77 percent of counties had a severe shortage of mental health workers, both prescribers and non-prescribers, and 96 percent of counties had some unmet need for mental health prescribers.[2] In addition, the workforce was heavily impacted by the COVID-19 pandemic along with many other medical specialties. As a result, 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.

As BCBSA notes in its response to the Proposed Rule, health plans have done significant work to bolster reimbursement rates and to reduce administrative burdens. Yet, qualified MH/SUD providers still have unique incentives not to participate. The best example is the difference in average provider practice size between M/S and MH/SUD. Many M/S practices are large groups of providers and are increasingly becoming more consolidated, whereas MH/SUD providers tend to comprise more single-proprietor practices where the infrastructure costs required to contract with, bill and receive payment from third-party payers may be difficult to justify. In addition, many of these providers are accustomed to billing their patients directly and are not working towards learning different mechanisms for reimbursement, particularly as their practices are full regardless of whether they accept insurance. These factors and others discourage network participation for the limited number of non-contracted providers in the country today.

We are concerned that the Departments are relying on outdated information as justification for the proposals in the Technical Release. In particular, the Departments cite a 2019 Milliman analysis that purported to find widening disparities in network use and provider reimbursement for MH/SUD and M/S to justify the proposed outcomes-based comparisons. The Milliman report was published in 2019 and the most recent data it cites is from 2017. More recent data tells a different story. From 2017 to 2021, commercial health insurance payment rates for MH/SUD providers are higher than Medicare payment rates and generally growing more rapidly (see Figure 1).

[1] https://data.hrsa.gov/topics/health-workforce/shortage-areas

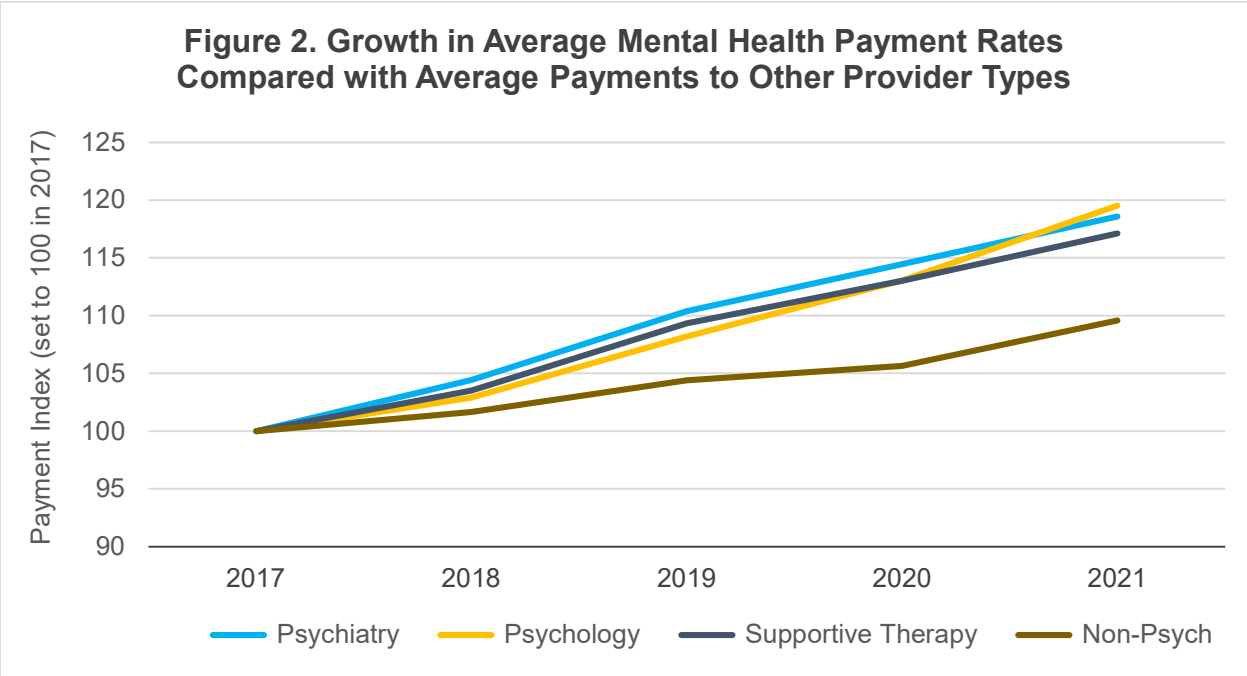
[2] Substance Abuse and Mental Health Services Administration, *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues,* January 24, 2013.



Source: unpublished estimates using Markets can claims data by the Employee Benefit Research Institute, 2023.

The ratios fall in 2021 but that was due to a one-time adjustment in Medicare payment rates that went into effect in 2021 during the height of the COVID-19 pandemic. (Ratios for non-MH/SUD providers also fell in 2021.) We expect payment data in future years to show continued improvement in commercial payment rates relative to Medicare.

Moreover, commercial payment rates for MH/SUD providers increased at a higher rate than payment rates for non-MH/SUD providers over the 2017-2021 time period (see Figure 2).



Source: unpublished estimates using Marketscan claims data by the Employee Benefit Research Institute, 2023.

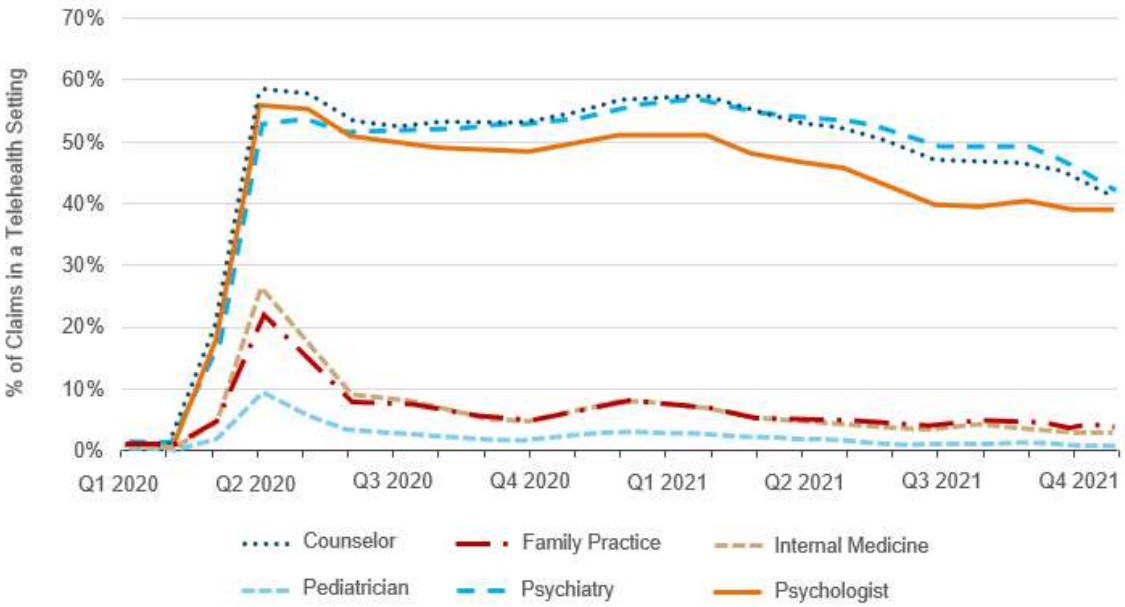
Looking at more recent data also indicates that the share of commercial premiums going towards outpatient mental health treatment has increased. That share has increased because of increased utilization as well as growth in payment rates. According to an analysis by the Employee Benefit Research Institute, year-over-year increases in MH/SUD provider reimbursement rates are outpacing medical/surgical (M/S).[3] Comparing common clinic visit payment rates over the 2017-2021 period, MH/SUD payment rates increased by an average of about 18.5%, nearly double the payment increases for non-mental health providers of 9.5%. Given that utilization was increasing, insurers responded by increasing payment rates to attract more providers. While overall mental health spending was relatively flat, this was because the average price of mental health drugs fell over the period as more generics came to market. This reduction in drug spending is important to consider in making apples-to-apples comparisons of changes in spending for MH/SUD services.

In addition, the network composition NQTL outcomes, as proposed, imply that a patient would only select an out-of-network (OON) provider if they had no option for an in-network provider and that patients will always select the provider that is geographically closest to their home or work. While not always the case, these assumptions are somewhat reasonable for M/S services, but less so for MH/SUD services. Consumers' preference for staying close to home or traveling out of area varies widely by type of service, which biases comparisons of OON use for M/S and MH/SUD services. For example, patients needing skilled nursing facility (SNF)-level care generally prefer to be close to home. But due to the perceived or real stigma associated with substance use, patients needing SUD treatment often prefer to go out of area for treatment, particularly if their plan covers OON services. In addition, patients are much more likely to try to find a provider who aligns with their personal demographics (e.g., race, gender identity, ethnicity) than for M/S services, particularly if the individual comes from a historically marginalized population. Unfortunately, the current MH/SUD provider workforce is less diverse than other M/S specialties and MH/SUD providers with diverse backgrounds are not evenly dispersed across the country. As a result, patients make the choice to travel farther to access their preferred providers where they are available. Also, the use of telehealth for the provision of MH/SUD services is increasingly common and, while not reflective of the patient's true "commute," may increase the impression that patients are more commonly accessing providers who are a greater distance away than seen for M/S services. While we are supportive of the increased use of telehealth for behavioral health services, we do have concerns with the proliferation of internet-based behavioral health companies that market directly to consumers and often refuse to partner with health plans. These companies can appeal to consumers who are not sure how to access care but steer them away from in-network services. Figure 3 shows the dramatic increase in the provision of MH/SUD services via telehealth from January 2020 through November 2021.[4] That trend appears to have generally continued to the present day.

[3] Paul Fronstin and M. Christopher Roebuck, "Use of Health Care Services for Mental Health Disorders and Spending Trends", EBRI Issue Brief, no. 569, Employee Benefit Research Institute, September 2022

[4] Norah Mulvaney-Day, David Dean, Jr., Kay Miller, and Jessica Camacho-Cook, "Trends in Use of Telehealth for Behavioral Health Care During the COVID-19 Pandemic: Considerations for Payers and Employers," *American Journal of Health Promotion*, 2022 Sep; 36(7): 1237–1241. doi: 10.1177/08901171221112488e.

Figure 3. Claims for Services Provided by Telehealth, January 2020 - November 2021



We suspect that the mental health provider community will strongly support the comparisons proposed in the Technical Release. We note that the proposed comparisons included in the Technical Release are largely based on the comparisons[5] advanced by a number of mental health advocacy organizations as part of the Path Forward. While some employer groups have been interested in evaluating such measures as part of voluntary efforts to evaluate mental health coverage, we have significant concerns with using these measures as an indicator of non-compliance because the reasons for differences in outcomes are multifactorial and cannot be controlled by health plans. Whether raising reimbursement rates will lead to increases in the supply of MH/SUD providers willing to accept insurance depends on their own price elasticity of supply (more specifically on the extensive margin—their network participation decision). There is little empirical evidence on this subject, but health plan experience suggests relatively inelastic supply, as discussed in our comments on the Proposed Rule. This raises the potential that increasing reimbursement may have a muted effect on some of the measures that the Departments are considering in the Technical Release.

Based on the numerous factors that lead to differences in provider network participation for MH/SUD and M/S benefits, differences for some of the comparisons that the Departments are considering, such as OON utilization, are unlikely to improve substantially until there is an adequate supply of MH/SUD providers such that the providers need volume from contracting with health plans to support their practices. Rebalancing supply and demand for MH/SUD services will require years and a concerted effort in terms of government and institutional investment to improve the pipeline of providers.

[5] See the Model Data Request Form (https://mhtari.org/Model_Data_Request_Form.pdf) produced by the Bowman Foundation and promoted as a resource by the Path Forward (https://pathforwardcoalition.org/resources/).

Another factor that should be considered when attempting to compare MH/SUD and M/S reimbursement are differences in practice costs. Practice expenses vary widely among different types of health care providers. Although somewhat dated, the American Medical Association (AMA) published practice expenditures for professional services in 2006 which found that expenditures for clinical social workers, clinical psychologists and psychiatrists were among the lowest of all clinical specialties.[6] As illustrated in Table 1 below, practice costs were substantially higher for the most common types of M/S providers of primary and specialty care noted in the Milliman report.

Table 1: Hourly Practice Expense by Specialty

Specialty	Total Expense per Hour
Clinical Social Workers	$18.33
Clinical Psychology	$21.52
Psychiatry	$32.10
Internal Medicine	$110.62
Pediatrics	$111.31
Family Medicine	$119.19
Obstetrics/Gynecology	$149.02
Orthopedic Surgery	$162.94
Dermatology	$264.88

In establishing the Medicare Physician Fee Schedule (PFS), the Centers for Medicare & Medicaid Services (CMS) incorporates practice costs and other factors to establish appropriate payment rates for different types of providers in Medicare. These payment rates vary among MH/SUD providers and M/S providers. As noted in our comments on the section of the Technical Release concerning reimbursement rates, we recommend that the Departments develop similar adjustments to enable appropriate comparisons between provider types.

Similar differences in the costs for inpatient services would also be evident. The costs of running an acute care hospital are substantially different than an inpatient mental health facility in terms of the physical space, equipment and staffing. There is significantly more equipment and machinery for the provision of inpatient M/S services than for MH/SUD treatment, all of which require resources to rent or purchase, space to store and use, and medical staff to operate.

To better reflect the elements of network composition, and utilization as a proxy, that health plans have an ability to influence, we recommend the Departments:

- **Not finalize outcomes reporting on OON utilization** as there are many drivers of OON utilization other than network adequacy and health plans have incomplete

[6] https://www.ama-assn.org/system/files/practice-expense-component.pdf

information on OON usage. Use of this standard would create an unlevel playing field across types of health plans that have access to varying levels of OON claims data and entail significant burdens on the industry. Based on the numerous factors that lead to differences in OON utilization for MH/SUD and M/S benefits and the long-term efforts needed to address imbalances in the market for MH/SUD services, we ask that the Departments not move forward with this measure at this time.

- **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 equivalency across these types of services is not reflective of the availability of providers in many of the communities Plans serve. This proposal and other components of the network composition NQTL proposed standards could force health plans to sacrifice provider quality and performance standards in order to ensure compliance.
- **Recognize the role of telehealth in increasing access to MH/SUD care.** There is no standard to account for the role of telehealth in providing access to patients when calculating underlying time and distance standards. This is a disservice to the critical function telehealth providers serve in bridging gaps in care. It also means that the calculations are skewed towards the provision of brick and mortar-based services and, particularly given the provider shortages, establishes impossible comparisons to M/S providers who are more evenly distributed across the country and less likely to provide care via telemedicine.
- **Develop reasonable comparators for reimbursement rates** for MH/SUD providers that can be fairly equated to M/S providers. In addition, reimbursement rates are not monolithic – they vary by reimbursement methodology, negotiations, acuity of patient load, training of the provider and a number of other factors can drive variation across and within specialties. These comparators should be adjusted for differences in practice cost across provider type.
- **Provide symmetry in compliance** whereby if there are not material differences in network composition outcomes data, the plan or issuer is compliant with the NQTL requirements. If a plan or issuer is deemed noncompliant based solely on outcomes data then the same should be true of being deemed compliant.
- **Provide adequate time for public comment on the methodology for any comparisons or outcomes the Departments move forward.** The Departments ask dozens of important and complicated questions in the Technical Release that many plans and issuers will not have adequate time to comment on appropriately or generate meaningful descriptive data on to inform their recommendations. Given the highly technical nature of these questions and the potential for comparisons to be used as indications of noncompliance, we recommend that the Departments issue their proposed approach for any comparisons through a white paper process that details their proposed methodology prior to proposing standards in rulemaking. This process has been used successfully by the Departments in recent years and would allow the public to more meaningfully comment on these proposals.

- **Create a safe harbor for plans and issuers reimbursing MH/SUD providers at or above Medicare reimbursement rates.** The rates CMS pays these providers under the Medicare program are rigorously evaluated, subject to substantial oversight, and objectively incorporate differences in cost of overhead. While we are not supportive of a mandate for health plans to pay Medicare rates, we suggest this safe harbor as a reasonable way to compare commercial payment rates to a defined and publicly available benchmark.

We look forward to continuing to work with the Departments on this issue as well as additional ways to ensure all Americans have affordable access to high-quality MH/SUD services. If you have questions, please contact Jennifer Jones at 202.942.1269 or Jennifer.Jones@bcbsa.com.

Sincerely,

Kris Haltmeyer

Vice President, Legislative and Regulatory Policy

RELEVANT DATA TO BE COLLECTED AND EVALUATED WITH COMPARATIVE ANALYSES FOR NQTLS RELATED TO NETWORK COMPOSITION

Issue: Out-of-Network Utilization Data

The Departments are considering requiring plans and issuers to collect and evaluate data on the OON utilization for M/S, MH, and SUD benefits for the following types of items and services: (1) Inpatient, hospital-based services; (2) Inpatient, non-hospital-based services, including inpatient rehabilitation facilities and skilled nursing facilities for M/S items and services, and non-hospital-based inpatient facilities and residential treatment facilities for MH/SUD items and services; (3) Outpatient facility-based items and services, including physical, occupational, speech, and cardiovascular therapy, surgeries, radiology, and pathology, services for M/S care provided in an outpatient facility setting; and intensive outpatient and partial hospitalization services for MH conditions or SUDs in an outpatient facility setting; (4) Outpatient office visits; and (5) Other outpatient items and services.

Recommendation:

BCBSA recommends that the Departments not require plans and issuers to collect and evaluate data on OON utilization for M/S, MH, and SUD benefits.

Rationale:

Plans and issuers cannot accurately report OON utilization, particularly for group health plans that do not offer OON coverage. In addition, BCBSA does not agree that high OON utilization of MH/SUD services necessarily signifies a network access deficiency, especially as many exceptions are granted to treat OON usage as in-network services. Rather, it can reflect a contracting preference on the part of behavioral health providers, as described earlier, and/or a greater preference on the part of enrollees to see their choice of MH/SUD provider even if the provider is OON, compared to choosing a M/S provider OON.

Patients may want to ensure that their M/S providers, spouses and other family members are not privy to their MH/SUD treatment. As mentioned in BCBSA's Proposed Rule response and earlier in our Technical Response, patients needing SNF-level care generally prefer to be close to home. But due to the perceived or real stigma associated with substance use, patients needing SUD treatment often prefer to go out of area for treatment, particularly if their plan covers OON services or if they live in small or geographically isolated communities.[7] While some may discount the role of patient preference in OON usage, we know that the relationship between patient and provider is especially critical in behavioral health and, unfortunately, there is a significant shortage in the behavioral health workforce for providers from minority communities or with otherwise diverse backgrounds. Coupled with shortages and contracting preferences among MH/SUD providers, this can in fact promote greater OON usage.

[7] We use this comparison as access to SUD treatment commonly surfaces in network adequacy discussions and, while this example highlights differences between M/S and MH/SUD utilization preferences, it also highlights that comparisons in provider types are not always "one-to-one" or as simple as it can seem on the surface – a SNF is in many ways not comparable to a SUD treatment center, but it is the best comparison to a SUD treatment center.

As a result, any comparison between OON utilization between M/S and MH/SUD is likely a false equivalency. In addition, as the Departments acknowledge, health plans only have visibility into the OON claims that are submitted to the plan by the provider or patient. OON utilization data is likely highly skewed based on the cost of the service provided (or any number of variables) which could further complicate any comparison to in-network utilization or between M/S and MH/SUD.

The question the Departments raise on how to measure OON claims for HMOs, EPOs, and closed network plans points to the limitations of using this comparison as an indicator of compliance. Such plans are unlikely to cover claims for non-participating providers. In addition, individuals with higher deductible plans with health savings accounts will be less likely to file claims for outpatient services and drugs than PPO plans with lower deductibles. As such, this standard will provide an unlevel playing field across plan types with regard to compliance that the Departments should avoid.

Recommendation:

While we ask the Departments not to finalize this measure, if the Departments do move forward we recommend guidance clarifying the following questions related to how to calculate OON utilization:

- Confirm that zero-dollar claims and Medicare cross-over payment should be excluded from the reporting.
- Confirm that calculations should be based on claims with a MH/SUD diagnosis, rather than a service provided by a MH provider (i.e., claims from M/S providers administering MH/SUD services be included). This is critical given that health plans are investing in integration of medical and behavioral health services with primary care providers.
- Confirm that the data should not be reported by place of service or geographic location. More granular reporting would impose an unnecessary burden on plans and issuers.
- Clarify OON utilization should be provided in terms of percentage of claims, not number of claims or dollar amounts. In addition, health plans should be permitted to make good faith efforts to determine which claims or line items are for MH/SUD or M/S services.
- Confirm that plans are permitted to review all services for fraud, waste and abuse without impacting data or parity outcomes.
- Provide adequate time for the run-out of MH/SUD claims. Submission of claims for OON MH/SUD are often submitted in paper form by members given that OON mental health professionals often refuse to assist consumers with filing claims. These claims submissions typically lag behind claims submitted directly by providers.
- Align reporting to prior to the last calendar year and allow health plans to account for OON claims submitted after the end of the applicable year for relevant dates of service.
- With regard to the issue the Departments raise about the fact that this comparison could not be equally applied to certain plans (e.g., closed panel HMOs), consider whether other metrics finalized by the Departments would be reasonable alternatives that would not disadvantage PPOs or other popular products that provide out-of-network coverage.

- Given the many differences that could lead to higher OON claims for MH/SUD, consider appropriate adjustments or thresholds if this comparison is used as an indicator of non-compliance.

Rationale:

Guidance on these technical questions is necessary to provide health plans with critical information on how to appropriately implement the outcomes reporting proposed by the Departments. Otherwise, there will likely be significant inconsistencies in how plans and issuers are interpreting the requirements. This would create uncertainty and additional burden on all parties to understand and comply with the Departments' expectations. Furthermore, it would meaningfully limit any interpretation of the data as it would be difficult, if not impossible, to fully understand what was being represented and compared.

Please also note that Plans did not have adequate time to answer the questions related to the relevant data that plans and issuers would be required to collect and evaluate for NQTLs related to network composition (e.g., data on the OON utilization for M/S, MH, and SUD benefits for the indicated types of items and services). Data analysis would be required to determine whether these items and services provide for a reasonable comparison. Please see our recommendation later in this response regarding a white paper process to solicit additional feedback in advance of finalizing any requirements.

Issue: Percentage of In-Network Providers Actively Submitting Claims

For this data element, the Departments contemplate requiring plans and issuers to collect and evaluate data for different types of providers (and make comparisons between a type of MH/SUD provider and an analogous type of M/S provider).

The potential types of providers that the Departments are considering include: (1) MH/SUD providers including child psychiatrists and psychologists; other psychiatrists and psychologists; psychiatric nurse practitioners; master's level MH counselors, marriage and family therapists, independent clinical social workers, and advanced social workers; non-master's level MH counselors; board certified SUD addiction medicine physicians; and other non-physician SUD professionals; (2) M/S providers including cardiologists; neurologists; orthopedists; pediatricians; other specialty physicians; physician primary care providers (other than pediatricians); non-physician primary care providers; and non-physician specialty providers.

Recommendation #1:

BCBSA recommends that any definition of "relevant data" for network composition standards not include data on providers accepting new patients.

Rationale:

Providers' willingness to accept new patients can fluctuate according to a provider's own considerations, including capacity to offer a specific level of care or triaging based on what they know about the patient (e.g., type of condition, acuteness of need) and how they were sourced (e.g., referred by another provider, cold calling the office). Given these variables, providers generally do not provide information to health plans on how they determine whether to accept a new patient and issuers do not have access to this data unless a provider communicates it. As

such, any health plan reported data on this metric is a limited representation of access. This is likely one of the reasons existing state network adequacy requirements generally do not include a metric of this kind, but rather health plans work to provide high level information on this variable in health plan provider directories.

Recommendation #2:

If the Departments move forward in finalizing this proposal, BCBSA recommends that the Departments maintain plans' and issuers' ability to determine the most appropriate provider types for this reporting.

Rationale:

There is significant variation in how providers and states define provider types and licensure/certification. Health plans maintain data, such as who is accepting new patients, based on these localized definitions. Developing a federal standard for these definitions, rather than deferring to existing local definitions, would force the retrofitting of data which would likely skew some of the analyses. To ensure the most accurate data which reflects the market under review, a plan should be allowed to defer to how a state or provider defines their own provider type/license/certification/etc.

Recommendation #3:

If the Departments do finalize a specific list of provider types for reporting on this data, BCBSA recommends that the list of providers for which health plans report on the proportion of providers accepting new patients be clarified to conform with how health plans maintain data on providers. To do so, we encourage the Departments to consult with industry experts to ensure the taxonomy is workable.

Rationale:

A number of the proposed providers, specifically those identified in the exclusions list in this recommendation, are not defined by current provider type or provider taxonomy, i.e., specialty codes, and therefore are not independently identifiable in health plan databases. Specifically, the "provider types" proposed are either not feasible for reporting (or performing comparisons on) or require clarification for the following reasons:

For MH/SUD providers:

- **"Other" psychiatrists and psychologists:** Psychiatrists and psychologists have provider type and specialty codes which all credentialed psychiatrists and psychologists are aligned to, respectively. Plans do not maintain a list of "other psychiatrists" or "other psychologists" that can be reported on.
- **Master's level MH counselors:** Education level (i.e., "master's level") is a data attribute that is not part of the taxonomy code set. States typically require certain education levels for licensure, but educational level is not relevant for assigning most taxonomy codes. As such, all MH counselors are coded using the same taxonomy codes and cannot be separated based on educational level.
- **Independent clinical social workers:** There is a taxonomy code for Clinical Social

Workers, but not for “independent” clinical social workers. Whether they are independent or part of a provider group is not a factor considered in the taxonomy code for these providers.

- **Advanced social workers:** BCBSA is unsure what the Departments mean by “advanced.” However, there are applicable taxonomy codes for licensed clinical social workers.
- **Non-master’s level MH counselors:** As mentioned above, educational level (i.e., “non-master’s level”) is outside of the taxonomy code set. States typically require certain educational levels for licensure, but educational level is not relevant for assigning most taxonomy codes.
- **Board certified SUD addiction medicine physicians:** Physicians are board certified in Addiction Medicine, but there is not an American Board of Medical Specialties (“ABMS”) board certification for “SUD Addiction Medicine.” Whether the physician is board certified in their contracted specialty is a separate data element and not one used to identify provider specialty.
- **Other non-physician SUD professionals:** There are taxonomy codes with SUD for non-physicians, but it is not clear which professionals are of interest to the Departments.

For M/S providers:

- **Non-physician primary care providers:** Most health plans only capture Primary Care versus Specialists for Managed Care products, and mainly for physicians and some limited nursing or physician assistant practitioners (i.e., HMO or POS product type).
- **Non-physician specialty providers:** Most health plans only capture Primary Care versus Specialist for Managed Care products (i.e., HMO or POS product type).

To reflect these nuances, we recommend the Departments clarify these provider types to conform with how health plans maintain data on providers. To do so, we encourage the Departments to consult with industry experts to ensure the taxonomy is workable.

Issue: Time and Distance Standards

The Departments 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 (including psychiatry, inpatient care, residential treatment, mobile crisis units, opioid treatment providers, child and adolescent providers, geriatric providers, eating disorder providers and autism spectrum disorder providers) and one (or more) in-network providers within certain M/S provider categories.

Recommendation #1:

BCBSA recommends that the Departments 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.

Rationale:

Setting an expectation that health plans meet the same time and distances outcomes as seen for M/S providers is not reflective of the limited number of MH/SUD providers in many communities. As the Departments note in the Proposed Rule, there is a severe shortage of mental health providers, particularly in rural areas and communities of color. More than one third of Americans live in areas with far fewer mental health[8] specialists than the minimum needed to meet the need.[9]

Furthermore, there is no standard to account for the role of telehealth in providing access to patients. Telehealth has been a 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. In fact, of the Plans that reported, 50% or more of all their behavioral health outpatient services are provided via telehealth. This statistic is reinforced by Oliver Wyman who cites that 30-50% of MH/SUD services are provided via telemedicine today. This is a significant, and growing, source of these services. 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). 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 and less likely to administer via telemedicine.[10]

As discussed in BCBSA's Proposed Rule response, we are concerned that this outcome and other components of the network composition NQTL proposed standard will lead to an impossible choice for health plans – ensure compliance with the standards by accepting lower quality providers into networks or retain existing quality standards and run counter to federal and state regulators. The reality that health plans are facing is that the quality providers that Plans encourage to come in network do not express interest in doing so and those that do join bring limited additional capacity for patients. Given that the pool of available providers is woefully insufficient to meet the needs of patients, health plans will be forced to consider the providers that were excluded from contracting based on quality and performance concerns. This outcome runs counter to the goals of the Departments to support access to drive better health for Americans.

Recommendation #2:

If the proposal is finalized, BCBSA recommends that the time and distance standards not include the following proposed MH/SUD provider types, or, at a minimum, that the

[8] Mental health disorders "involve changes in thinking, mood, and/or behavior." https://www.samhsa.gov/find-help/disorders

[9] https://data.hrsa.gov/topics/health-workforce/shortage-area

[10] Per Oliver Wyman, Individuals seeking MH/SUD treatment are significantly more likely to utilize telehealth than those seeking other M/S services (e.g., 30-50% of MH/SUD through telehealth vs. 5-10% of M/S).

Departments clarify these provider types: inpatient care; mobile crisis unit; opioid treatment providers; geriatric providers; eating disorder providers; and autism spectrum disorder providers.

Rationale:

The specified proposed provider types are not provider types BCBS Plans typically define and do not have associated taxonomy codes. Below, we explain why certain "provider types" are not appropriate to report on (or perform comparisons on), or require clarification from the Departments:

- **Inpatient care:** This is not a provider type, but rather a site of care. Many provider types with valid taxonomy codes provide inpatient care. Rather than defining providers based on their sites of care, we recommend the Departments only include traditional provider types as part of the required analyses.
- **Mobile crisis unit:** Generally, payers do not enroll providers as a mobile crisis unit. Instead, the providers who staff these units are enrolled according to their traditional provider type designation (e.g., psychiatrist, licensed clinical social worker).
- **Opioid treatment providers:** This is not a discrete provider type, but rather a specialization across providers.
- **Geriatric providers:** BCBSA recommends specifying the provider type as Geriatric Medicine Providers, which has an existing taxonomy code in place.
- **Eating disorder providers:** This is not a discrete provider type, but rather a specialization across providers.
- **Autism spectrum disorder providers:** BCBSA notes that not all Behavior Analysts are autism spectrum disorder providers. Behavior Analysis is provided for patients with autism spectrum disorders, but also patients without autism spectrum disorders.

Recommendation:

If finalized, we urge the Departments to consider including a pathway for health plans to explain why time and distance standards were not comparable across MH/SUD and M/S providers.

Rationale:

A pathway for a health plan to explain why, in certain geographic regions, it is unable to meet the outcomes standard for time and distance across MH/SUD and M/S could mitigate the unintended consequences of lowering network participation standards in order to be compliant. For example, this pathway could include a written explanation, supported by data analyses, of why there are insufficient MH/SUD providers to meet the standard even if all contracted with the health plan based on the level of participation for M/S providers. Alternatively, it could be an explanation, supported by data, of how a significant portion of outpatient MH/SUD services are being provided virtually and those providers are not captured by time and distance standards.

Recommendation:

If finalized, we recommend the Departments align the calculations for time and distance with the network adequacy standards outlined for Qualified Health Plans (QHPs).

Rationale:

This approach would create a national standard for calculating the outcomes data rather than relying on different state-based standards and, therefore, requiring significant additional complexity for health plans when conducting the analyses. Furthermore, as this is an existing and current standard, it would not require the regulators to identify new metrics or standards, reducing the burden on all parties and supporting consistency in development and interpretation of the analyses across health plans and markets.

Issue: Reimbursement Rates

The Departments are considering specifying the relevant data that plans and issuers would be required to collect and evaluate which would include the following data: (1) In-network payments and billed charges for inpatient MH/SUD and M/S benefits, outpatient office visit MH/SUD and M/S benefits, and all other outpatient MH/SUD and M/S benefits; (2) Allowed amounts for CPT codes 99213 and 99214 as well as CPT codes 90834 and 90837 for specific types of MH/SUD and M/S providers.

Recommendation #1:

BCBSA recommends that any definition of "relevant data" for network composition standards not include comparing provider reimbursement rates to billed charges, but instead compare payments by specialty under private plans to Medicare reimbursement rates.

Rationale:

Billed charges are arbitrary amounts unilaterally determined by the provider and not necessarily tied to any independent benchmark. In addition, billed charges are often not consistent with or reflective of the cost of the service and relying on billed charges gives MH/SUD an incentive to hike rates artificially. This reality has been consistently recognized in the work done by policymakers to address surprise billing. Appreciating the lack of foundation of these often heavily inflated charges, lawmakers explicitly excluded any reference to billed charges in the independent dispute resolution process to prevent biases in decision-making by the arbiters.

We believe the Medicare Physician Fee Schedule (PFS) is the most appropriate benchmark for comparing the adequacy of reimbursement for private plans. CMS establishes and updates the PFS for the Medicare program. The PFS incorporates practice costs and other factors and, unlike billed charges, is an unbiased, evidence-based payment mechanism that is beyond the control of both providers and issuers, and as such, is probably the most accurate and reliable information source that could be used by the Departments for assessing the reasonableness of commercial insurer payments to MH/SUD providers.

Recommendation #2:

BCBSA recommends that comparisons between MH/SUD and M/S provider payments be adjusted to reflect differences in both the requirements necessary to qualify as a licensed

professional in a particular specialty and the expenses that would be incurred to operate a practice.

Rationale:

Some types of medical professionals are subject to more extensive requirements in order to qualify to practice medicine in that field. For example, an orthopedic surgeon must complete a five-year residency in orthopedic surgery following graduation from medical school, and often then take an additional year or two to complete a fellowship in an orthopedic sub-specialty, while a psychiatrist is required to complete a four-year residency. Psychologists and licensed clinical social workers have less demanding licensing requirements than medical doctors who may provide a subset of the same services. With regard to the latter, mental health therapy generally does not require any specialized equipment, supplies or furnishings, whereas most other M/S professionals must make significant investments in specialized equipment and devote a considerable amount of resources to maintaining their clinical facilities and stocking them with appropriate supplies necessary for providing care.

As noted above, data from the AMA indicates that there are substantial differences in practice costs between MH/SUD and M/S specialties. This information is an input into the methodology used by Medicare to set the payment rates in the PFS. The mean practice expenses for the three MH/SUD provider types are the three lowest amounts, which demonstrates the extent to which MH/SUD care differs from the care from other specialties.

While we understand that publishing a list of comparative specialties with appropriate adjustment factors may be more complex for the Departments, there is a significant risk that comparing costs for the broad categories of services that the Departments outline in the Technical Release will have an inflationary impact on rates, and ultimately on costs for businesses, workers and their families. It is important to note that the average premium for an employer-provided family health insurance policy reached $22,221 in 2021 (one-third of the median household income), nearly triple what it was in 2001.[11] And the average employee contribution now accounts for 9% of the median household income. Rising prices are the primary drivers of rising health care costs. In the market for medical services, acquisition of physician practices by hospitals and private equity firms is driving up prices. The share of physician practices owned by hospitals more than doubled from 2012 to 2018. In a study for Physician Advocacy Institute, Avalere examined the impact of the COVID-19 pandemic on physician practice acquisition in 2019 and 2020 and found that 48,400 additional physicians left independent practice during the two-year study, and, by the beginning of 2021, only 30% of physicians in the U.S. were practicing medicine independently.[12]

According to a recent study on tax filings by physicians, the average physician in the US earned $350,000 in 2017.[13] This study also found a significant difference in earnings across specialties.

[11] Statistics are calculated from Sarah Flood et al., Integrated Public Use Microdata Series, Current Population Survey: Version 9.0. Minneapolis, MN: IPUMS, 2021, https://doi.org/10.18128/D030.V9.0, and Annual Employer Health Benefits Survey, Kaiser Family Foundation, for years 2001 and 2021, https://www.kff.org/wp-content/uploads/2013/04/6458.pdf and https://www.kff.org/report-section/ehbs-2021-summary-of-findings/.
[12] "2020 Health Care Cost and Utilization Report," Health Care Cost Institute, May 2022, https://healthcostinstitute.org/images//pdfs/HCCI_2020_ Health_Care_Cost_and_Utilization_Report.pdf, and BCBSA calculations based on data from Congressional Budget Office, Consumer Price Index, Historical Data and Economic Projections, May 2022, https://www.cbo.gov/data/budget-economic-data#4.
[13] https://www.washingtonpost.com/business/2023/08/04/doctor-pay-shortage/

It would be hard to rationalize benchmarking the reimbursement for MH/SUD professionals to the broad category of M/S physicians, which would include neurosurgeons that made $920,500, orthopedic surgeons that made $788,600, or dermatologists that made $655,200 a year during their peak earning years in 2017, according to this study.

We are concerned that the proposed comparison of reimbursement outcomes would extend the factors leading to unsustainable prices in medical and surgical services sector to mental health professionals. Thus, if the Departments proceed, the Departments should develop appropriate comparisons with adjustments for reasonable provider reimbursement or benchmark to some reasonable measure of adequate provider reimbursement, such as what is paid by Medicare.

Recommendation #3:

CMS should establish a limited list of comparative specialties for MH/SUD and M/S services for health plans to use to compare their average reimbursement rates, based on the recommendations outlined at a high level in Table 2.

Rationale:

If the Departments finalize the proposed categories of "relevant data" for the network composition standards, BCBSA recommends the Departments publish analogous provider types for the sake of comparing reimbursement that are standardized and specific enough to be truly comparable, as recommended in Table 2. These provider comparison standards should be made available for public comment, and should include (1) provider type, (2) common CPT codes, (3) geographic region, and (4) a materiality standard.

We specify the relevant provider types and example CPT codes we would recommend for this comparison below:

Table 2: Recommended Comparisons of MH/SUD to M/S Provider Types by CPT Code

M/S Specialty	MH/SUD Specialty	CPT Code Examples
• Internist • Endocrinologist • Neurologist • Pediatrician	• Psychiatrist	90792 99203 99204 99213
• Nurse Practitioner (M/S)	• Nurse Practitioner (BH)	90792 99203 99204 99213
• Chiropractor • Podiatrist	• Psychologist	90832 90791
• Occupational Therapist • Physical Therapist	• Licensed Clinical Social Worker	97161 - 97168

By developing and publishing a granular list of standards to conduct provider comparisons, health plans will be better equipped to accurately measure parity in reimbursement rates.

Recommendation #4:

BCBSA recommends that the Departments adopt a materiality standard for comparing reimbursement rates as proposed in Table 2.

Rationale:

Application of a materiality standard will ensure plans and 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.

Issue: Determination of Noncompliance based on Outcomes Data

If the relevant data evaluated reveals "material differences" in access to MH/SUD benefits as compared to M/S benefits, the differences would establish that the plan or issuer is not in compliance.

Recommendation #2:

BCBSA recommends that the Departments adopt a symmetrical rule whereby if there are not material differences in outcomes data, the plan or issuer is deemed compliant with the NQTL requirements for network composition.

Rationale:

As noted by the Departments, the goal of the statute and regulations is to ensure access to MH/SUD care.[14] Where objective outcomes data demonstrates that NQTLs in no way impede access to MH/SUD benefits relative to M/S benefits, the parity goal is met. In these situations, it is reasonable that plans and issuers should be presumed to be in compliance with the regulatory requirements and additional investigations would not be needed. This approach would reduce administrative burden on both sides but, more importantly, would allow the Departments and state regulators to focus their available resources on investigations that could have material impacts for patients' access.

Issue: Recommended Safe Harbor for Plans Paying Medicare Rates for MH/SUD Providers

The technical appendix seeks comment on two safe harbors but does not include a safe harbor that relates to the adequacy of payments to a publicly available benchmark that could be easily compared across health plans.

Recommendation:

We recommend that the Departments create a safe harbor for plans and issuers reimbursing MH/SUD providers at or above what CMS pays these providers under the Medicare program. This comparison would be to the ratio of reimbursement levels for the plan or issuer compared to Medicare for the MH/SUD specialists and CPT codes outlined above. Under this safe harbor, failure to meet any other reimbursement comparison finalized by the Departments would not be

[14] See, e.g., Prop. Treas. Reg. § 54.9812–1(a)(1), Prop. DOL Reg. § 2590.712(a)(1), Prop. HHS Reg. § 146.136(a)(1).

considered a strong indicator that the plan or issuer is not in compliance if plans paid at or above Medicare rates during the relevant period.

Rationale:

Comparing payment rates to Medicare is appropriate because Medicare's payments objectively incorporate differences in costs relating to overhead, such as training and licensing requirements, equipment, supplies, and furnishings used to provide care, and other miscellaneous office expenses. In addition to consideration of the costs of delivering MH/SUD care, Medicare's MH/SUD payment rates are updated by CMS on an annual basis and subject to rigorous public comment and Congressional oversight. Moreover, the payments under the Medicare program are evaluated annually by MedPAC, a non-partisan Congressional agency.[15]

Direct comparison to private and Medicare reimbursement rates for a defined subset of MH/SUD services would avoid many of the problems identified in our comment letter. In the Technical Release, the Departments seem most concerned about disparities in payment levels for outpatient mental health services and have cited research indicating that some plans and issuers are paying less than Medicare. It would make sense to focus on outpatient services for this safe harbor given the complexity of comparing payments for inpatient services.

While we are not supportive of a mandate for health plans to pay Medicare rates, we suggest this safe harbor as a reasonable way to compare commercial payment rates to a defined and publicly available benchmark. However, we would note that in some cases, health plans have multi-year contracts with providers, whereas Medicare's payment rates are updated annually. Thus, we would recommend the Departments provide reasonable tolerances for year-to-year fluctuations based on the update factors to Medicare fee schedules.

Issue: Aggregate Data Collection

For all four specific types of relevant data, the Departments are considering requiring relevant data to be collected and evaluated by a third-party administrator (TPA) or other service provider in the aggregate for all plans or policies, as applicable, that use the same network of providers or reimbursement rates because, in many instances, plan-level or product-level data may not reflect sufficient claims experience to provide enough data for plans and issuers to evaluate and consider the impact of an NQTL related to network composition on access to MH/SUD benefits as compared to M/S benefits.

Recommendation #1:

BCBSA supports the proposal that data would be in the aggregate.

Rationale:

BCBSA is concerned that it is not feasible for issuers to collect and evaluate outcomes data on a plan-level or plan-by-plan basis as issuers administer thousands of plans. Collection and evaluation of data at the plan level would add a significant burden on carriers in terms of time and resources. In addition, claims experience can fluctuate significantly for large group plans,

[15] Medicare Payment Advisory Commission, *March 2023 Report to the Congress: Medicare Payment Policy,* 15 March 2023, Washington DC. https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/.

and BCBSA does not believe that at the individual plan level the claims data would be credible.

Issue:

The Departments' proposed approach in the Technical Release does not provide health plans with sufficient details, methodology or time for comment.

Recommendation:

BCBSA recommends that the Departments issue their proposed approach for any comparisons through a white paper process for public comment that details their proposed methodology prior to proposing standards in rulemaking.

Rationale:

The Departments ask dozens of important and complicated questions in the Technical Release that many health plans will not have adequate time to comment on appropriately. Given the highly technical nature of these questions and the potential for comparisons to be used as indications of noncompliance, the Departments should provide adequate time for public comment through a white paper process on the methodology for any comparisons the Departments move forward with.

The Administrative Procedure Act, 5 U.S.C. § 553, gives federal agencies substantial flexibility to conduct outreach and communications in connection with informal rulemaking. The Administration has encouraged agencies to take additional steps to seek public input outside of a formal comment period on several occasions, including through the 2023 Executive Office of the President memorandum[16] that states the expectation agencies go beyond required notices when communicating with the public and the 2023 Executive Order on Modernizing Regulatory Review, which notes the need for regulatory actions to be informed by input from the affected members of the public.[17] Other previous communications encouraged agencies to offer the public increased opportunities to participate in policymaking.[18]

The Departments have previously established similar informal or white paper processes that have been used successfully for other data-dependent processes, such as development of adjustment models. There are several recent instances in which the Departments have sought additional public comment in ways similar to that which BCBSA is proposing for this Technical Release:

- In connection with implementing the ACA risk adjustment rulemaking, HHS created a white paper for which comments could be submitted at any time, including after the close of the NPRM comment period.[19]
- When HHS was developing the essential health benefits (EHB) under the ACA, the Institute of Medicine (IOM) submitted a white paper that the HHS held listening sessions

[16] https://www.whitehouse.gov/wp-content/uploads/2022/04/M-22-10.pdf
[17] https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/06/executive-order-on-modernizing-regulatory-review/
[18] https://obamawhitehouse.archives.gov/the-press-office/transparency-and-open-government
[19] https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/risk_adjustment_implementation_issues#:~:text=This%20white%20paper%20serves%20both,and%20Risk%20Adjustment%20Notice%20of

for stakeholders to raise concerns. From the IOM white paper, HHS also commissioned a study that recommended "the criteria and methods for determining and updating the EHB." Final Rule, 78 Fed. Reg. 12834 (Feb. 25, 2023).[20]

- The DOL's MHPAEA self-compliance tool serves as an example of an informal process outside of the rulemaking comment period whereby the Departments have collected comments and engaged stakeholders.

We believe that by engaging in a similar white paper process, the Departments would allow the public to more meaningfully comment on these proposals. Such a process could be used to gather more meaningful information on the technical questions that could not be sufficiently addressed in the 75-day Technical Release comment period, including:

- Whether out-of-network utilization data be provided in terms of the percentage of claims, number of claims, total dollar amounts of all claims, and/or something else.
- How the Departments should control for treatment received from MH/SUD providers where no claim for benefits was made.
- The existing models or methodologies the Departments consider when specifying the OON utilization data that plans and issuers would be required to collect and evaluate as part of their comparative analyses for NQTLs related to network composition.
- The CPT codes that would help plans and issuers evaluate their reimbursement rate structures.

[20] https://www.federalregister.gov/documents/2013/02/25/2013-04084/patient-protection-and-affordable-care-act-standards-related-to-essential-health-benefits-actuarial