Good afternoon,

Please see the attached comments on Technical Release 2023-01P from the Indiana Council of Community Mental Health Centers.

Thank you,

\

My working hours may not be your working hours. Please do not feel obligated to respond outside of your normal work schedule.

October 17, 2023

Center for Medicare and Medicaid
U.S. Department of Health and Human Services
Attention: CMS-9902-P
200 Independence Avenue, SW
Washington, DC 20201

Employee Benefits Security Administration
U.S. Department of Labor
Attention: RIN 1210-AC11

Internal Revenue Service
U.S. Department of the Treasury
Attention: REG-1207270-21

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

On behalf of Indiana Council of Community Mental Health Centers (ICCMHC), thank you for the opportunity to comment on the opportunity to comment on the Department of Health and Human Services, Employee Benefits Security Administration, and the Internal Revenue Service's (the "Departments") Technical Release 2023-01P, Request for Comment on Proposed Relevant Data Requirements for Non-quantitive Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act (hereinafter "Technical Release"). The Indiana Council of Community Mental Health Centers (Indiana Council) is a professional trade association that serves the interests of 24 community-based mental health providers across the state. Our member agencies offer a full range of health services such as adult, child and adolescent behavioral, addiction treatment and other programs aimed at improving the lives of citizens in their home communities. The Indiana Council promotes and preserves the best interests of its constituent members through public policy advocacy, member services, education and community relations.

As the primary legislative voice for its members on both state and federal issues, we direct and manage all public policy activities. This includes securing and maintaining appropriate behavioral health funding, developing legislative and administrative recommendations related to behavioral health services provisions and ensuring that Community-based Mental Health Centers (CMHC) are the principal providers for those in need of behavioral health services. We leverage our relationships with the legislature, various public health associations as well as other interested organizations to effectively represent our members. In addition to advocacy, we offer member agencies professional development opportunities and business support. These services include member and public education, technical assistance and training.

Founded in 1976, we are strategically headquartered in Indianapolis near the state's capital. Our knowledgeable staff is experienced in government affairs, member and community relations and business administration. Indiana Council is structured as a 501 (C)(6) organization directed by a board of directors comprised of representatives from various member agencies. Membership is exclusively

limited to those organizations certified as a CMHC under the Family and Social Services Agencies' Division of Mental Health and Addiction approval process.

We strongly support the Departments' proposed NQTL data collection requirements relating to network composition as part of the Departments' efforts to increase access to mental health and substance use disorder (MH/SUD) treatment. Such data collection is critical to ensure plans and issuers do not impose treatment limitations that place a greater burden on plan members' access to MH/SUD treatment than to medical/surgical (M/S) treatment. Combined with the accompanying proposed requirements related to the Mental Health Parity and Addiction Equity Act, the data collection requirements that are envisioned in the Technical Release would be powerful steps in the right direction to increasing access to MH/SUD treatment.

We appreciate the Departments' commitment to ensuring that the data plans/issuers will be required to collect are an accurate reflection of individuals' access to treatment. Given that the Departments' guidance to plans will likely need to evolve over time to ensure such accuracy, we urge the Departments not to proceed with a "safe harbor" for plans/issuers based on data collection that has yet to be validated as meaningful. As we describe below, we believe that a "safe harbor" should not be explored until data collection has been extensively validated. Otherwise, the Departments may give "safe harbor" to plans/issuers that impose discriminatory barriers that inhibit access to MH/SUD treatment.

Our full comments are as follows.

Out-of-Network (OON) Utilization

Studies indicate that the percentage of services received OON is a key indicator of the availability of in-network services. Due to the higher cost-sharing of OON services, individuals rarely choose to obtain care OON if adequate in-network services are available on a timely basis. The landmark Milliman report demonstrates the importance of such data and how frequently MH/SUD care is obtained OON compared to M/S care.

Percentage of In-Network Providers Actively Submitting Claims

Research studies indicate that collecting this data is critically important to determining the adequacy of a network. Evaluation of health plan networks often relies on plan provider directory data, which has, at times, been found to be inaccurate or out of date. Some plans/issuers have been found to pad their networks by having providers listed as in-network even if they aren't actively submitting claims. This metric can also be important in suggesting the existence of other reasons why providers listed as in-network might not be available, including low reimbursement that incentivizes providers to fill appointments with patients with insurance that pays more and/or cash-pay patients.

Time and Distance Standards

We strongly support the Departments' suggestion that they collect detailed data on the percentage of participants/beneficiaries/enrollees who can access specified provider types in-network within a certain time and distance. We strongly agree with the Departments' view that this data would help with the assessment of a plan/issuer's operational compliance with respect to any NQTLs related to network composition. We also recommend that the Departments collect data on appointment wait times, which are an essential metric to measure network adequacy and the most critical for plan members seeking

timely access to care. The Department of Health and Human Services has already put forward strong proposed standards for Medicaid managed care and the Children's Health Insurance Program ([CMS-2439-P](#)), which establish maximum appointment wait time standards for routine outpatient mental health and substance use disorder services of 10 business days and require such independent secret shopper surveys. We also recommend collecting specific data on time and distance to nonemergency care for out of network providers, as such care is generally not covered by most health maintenance organizations (HMOs) and exclusive provider options (EPOs).

Reimbursement Rates

We strongly support the Departments' suggested data collection relating to reimbursement rates, which are critical determinants of network adequacy and commend the Departments for requiring reimbursement rate data to be "compared to billed rates." These rates also profoundly affect the availability of MH/SUD providers longer term, as potential providers make decisions on whether to both enter and remain in the field based in part on compensation. Specifically, low in-network payments may discourage providers from joining networks, as the higher out-of-network payments incentivize providers not to contract with insurers, narrowing networks and reducing access for patients. We strongly recommend the Departments evaluate the ratio of paid in-network amounts to out-of-network billed market rates for MH/SUD and M/S. We further urge the Departments to avoid use of the Medicare Fee Schedule, which is discriminatory. Given that Medicare is not subject to MHPAEA, using the Medicare Fee Schedule effectively bakes in discrimination.

Aggregate Data Collection

We strongly support the Departments requiring relevant data to be collected and evaluated by a third-party administrator (TPA) or other service provider in the aggregate. We agree with the Department that individual plans may lack sufficient data.

Service Utilization Data

In assessing network composition and access to MH/SUD services, we urge the Departments to require plans to report on utilization rates for specific MH/SUD services and level of care. These utilization rates should be compared to estimates of participants/beneficiaries with these conditions, as well as utilization rates for medical/surgical services. Examples of services and levels of care on which we urge the Departments to collect utilization data include:

- Each of the levels (and sub-levels) of care described in The American Society of Addiction Medicine (ASAM) Criteria and the age-specific Level of Care Utilization System (LOCUS) family of criteria developed by the American Association of Community Psychiatrists and the Academy of Child and Adolescent Psychiatry, as well as the average length of stay / treatment units and denial rates by each of these levels of care;
- Service utilization by MH/SUD diagnoses;
- Service utilization via telehealth;
- Cognitive behavioral therapy;
- Dialectical behavioral therapy;
- Coordinated Specialty Care;
- Medications for opioid use disorder (MOUD);
- Medications for alcohol use disorder (MAUD);

- Medications for bipolar disorder, schizophrenia, major depressive disorder, and other MH/SUDs, including specific data collection on the use of 'step therapy' or 'fail first' protocols.

Safe Harbor

The Technical Release also requested feedback on the potential of a "safe harbor" for NQTLs related to network composition. We urge the Department not to proceed with a safe harbor at this time. We understand the desire to most effectively target the Departments' enforcement resources. However, a safe harbor has the potential to be harmful if the data collection requirements are not capturing a full and complete picture of participants/beneficiaries' access to MH/SUD services. Given the significant work that the Departments need to do – and likely refinements that are necessary over time – to ensure collected data is complete, accurate, and meaningful, a safe harbor should not be considered at this time. Such a safe harbor should only be considered when the Departments and key consumer stakeholders are confident that the data collected accurately captures actual access to MH/SUD services. If a safe harbor is put in place prior to this occurring, it could cause enormous damage by giving noncompliant plans/issuers a "safe harbor" against accountability. Furthermore, an issuer residing within such a "safe harbor" may escape meaningful oversight from any applicable State authority. The Departments note that the potential enforcement safe harbor would, if satisfied, provide sufficient evidence to demonstrate to the Departments that participants, beneficiaries, and enrollees in the plan or coverage would have comparable access to in-network MH/SUD and M/S providers. The Departments state that they would retain authority, under their authority to investigate plans and issuers, to request additional data, including data sufficient to analyze assertions made in a plan's or issuer's comparative analysis, or additional data if the Departments conclude that a plan or issuer has not submitted sufficient information as part of its comparative analysis. If a safe harbor provision is ultimately adopted, it is difficult to gauge the efficacy and fairness of such a provision without knowing all types of data used for this evaluation. Providing a comprehensive list of data points used would more narrowly and specifically define the contours of the provision, resulting in greater transparency for patients and plans/issuers.

Meaningful Data & Preventing Data Manipulation

To ensure that the proposed requirements relating to outcomes data and actions to address material differences in access are meaningful, we urge the Departments to issue standardized definitions on all data points and on methods for gathering and reporting data. For example, the Departments propose collecting data on the number and percentage of claims denials. Yet, there are many ways that plans can collect, and potentially manipulate, such "claims denials" data. For example, what constitutes a denial if a claim is only partially paid, and how would the Departments account for common practices of undocumented denials that occur verbally through peer-to-peer reviews? Additionally, plans can manipulate such data by approving each visit or day of treatment (thereby increasing the denominator) while telling the provider verbally that further visits/days will not be approved, which is another common occurrence. Such practices can result in meaningless data that bears little resemblance to what individual patients experience.

Disaggregating MH and SUD Data

We also encourage the Departments to make clear that MH and SUD data must be collected and analyzed separately. When MH and SUD data is simply aggregated, it can hide important discriminatory impacts.

Sincerely,

President and CEO
Indiana Council of Community Mental Health Centers (ICCMHC)