ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

October 17, 2023

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

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

The Honorable Xavier Becerra
U.S. 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 Acting Secretary Su, and Secretaries Becerra and Yellen,

Please accept the below comments from the Association for Behavioral Health and Wellness (ABHW) on the U.S. Department of Labor (DOL), U.S. Department of Health and Human Services (HHS), and U.S. Department of Treasury's (collectively, "the Tri-Departments") 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"). The Technical Release relates to the Tri-Department's *Notice of Proposed Rulemaking CMS-9902-P Requirements Related to the Mental Health Parity and Addiction Equity Act* (NPRM or Proposed Rule).

ABHW is the national voice for payers managing behavioral health insurance benefits. Our member companies provide coverage to approximately 200 million people in the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness.

Since its inception, ABHW has been at the forefront of and an advocate for MH and SUD parity. ABHW was instrumental in drafting the legislative language of the initial MHPAEA of 2008, and

our members have worked tirelessly over the past 15 years to implement parity for behavioral health services.

ABHW strongly supports the efforts by the Tri-Departments to provide specific measures for the relevant data requirement, which provides that, unless qualifying for an exception, plans and issuers are required to include relevant data in the comparability and stringency analysis for each NQTL type in the "type, form, and manner" to be specified by the Tri-Departments in sub-regulatory guidance (referred to herein as "Relevant Data").[1] We encourage the Tri-Departments to revisit the measures and technical specifications for all NQTL types going forward. We appreciate the leadership that the Tri-Departments are taking and request that the measures selected and technical specifications that are adopted be found to pre-empt and supersede state efforts to develop comparable data measures for Mental Health Parity and Addiction Equity Act (MHPAEA) compliance purposes. We have prepared responses to each domain of the Technical Release below.

However, we have concerns about the lack of technical detail in the Technical Release itself, especially in light of the many questions the Tri-Departments still have about these measures or the Relevant Data requirements in the MHPAEA NPRM. We also have concerns about the short timeline that was provided to respond to the extremely broad and highly technical questions in the Technical Release. ABHW does appreciate the 15-day extension that the Tri-Departments granted to the original 60-day deadline for comments on the Technical Release and NPRM. Nonetheless, 75 days remains an extremely short time for health plans to simultaneously review and develop comments on the 305-page NPRM and the 26 pages of very broad and far-reaching questions of the Technical Release in addition to also reviewing and considering the substantial amount of new information and guidance in the 119-page 2023 MHPAEA Comparative Analysis Report to Congress. Given that the same MPHAEA experts were generally needed for all of these tasks in addition to ongoing federal and state reporting, investigations, and market conduct exam activities related to parity, many plans have not been able to simultaneously coordinate exploration and research regarding the many novel, challenging, and highly technical questions that are raised in the Technical Release.

ABHW is especially concerned about the rushed timeline for the Technical Release given that the Tri-Departments contemplate the introduction of new and untested quality measures that would create a variety of novel incentives that are challenging to fully evaluate and may pose a significant risk of unintended consequences. Additional time would have been useful in a number of areas in order to develop meaningful and well-supported responses.

ABHW also has concerns about the arbitrariness of creating a safe harbor for the Provider Network Composition NQTL type(s) only and not for any other NQTL type. Nothing in the statute

[1] Proposed 26 CFR 54.9812-1(c)(4)(iv)(A) and (C), 29 CFR 2590.712(c)(4)(iv)(A) and (C), and 45 CFR 146.136(c)(4)(iv)(A) and (C), and as referenced in subsequent sections.

or guidance suggests a reason to treat Provider Network Composition differently from other NQTLs. ABHW, therefore, asserts and recommends that the strategy for designing the MHPAEA safe harbors should include safe harbors for all NQTL types that have been identified by the Tri-Departments as priorities for enforcement.

In this letter, ABHW provides comments on the following topics raised in the Technical Release:

- **NQTL Definitions and Relevant Data:** the Tri-Departments should define the specific NQTL types that they find to be applicable to the Relevant Data metrics contemplated in the Technical Release.
- The Tri-Departments should implement **Notice-and-Comment Rulemaking on the "Type, Form, and Manner"** of the Relevant Data.
- Specific feedback on the proposed Relevant Data elements for:
    - **Out-of-Network Utilization:** Given the fact that many factors influencing out-of-network utilization are generally unrelated to the strength of the plan's provider network and the fact that many factors outside of the health plan's control may disproportionately influence patients to seek out-of-network care for MH/SUD conditions, it would be inappropriate to make MHPAEA compliance determinations regarding the plan's network composition strategy solely on the basis of plan or issuer performance on this measure.
    - **Percentage of In-Network Providers Actively Submitting Claims:** This metric has never been used or tested in any way to determine network adequacy or strength; ABHW believes it should not be used to demonstrate MHPAEA compliance.
    - **Time and Distance Standards:** ABHW recommends that the Tri-Departments credit the availability of telehealth providers toward meeting time and distance standards.
    - **Reimbursement Rates:** ABHW encourages the Tri-Departments to refrain from using the CPT-code comparison measures and instead recommends that the Tri-Departments 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 or FAIR health rates) for the same service.
    - **Aggregate Data Collection:** ABHW supports the proposal for all Relevant Data to be collected and evaluated by the relevant administrator in the aggregate for all plans or policies, as applicable, that use the same network of providers or reimbursement rates.
    - A future potential **Federal Enforcement Safe Harbor for NQTLs Related to Network Composition:** ABHW recommends that the Tri-Departments utilize Relevant Data metrics, including some of those called for in the Technical Release, as a safe harbor from having to perform the other NQTL documentation steps unless and until a material difference threshold is met.

- **Development of Comparable Additional Safe Harbors**: ABHW requests that comparable safe harbors be developed for all NQTL types that are identified by the Tri-Departments as priorities for enforcement.

I. NQTL Definitions and Relevant Data

⇨ **It is necessary for the Tri-Departments to define the NQTL types for which they will require health plans to report specific quantitative outcomes measures for the purposes of evaluating parity, given that Relevant Data is only "relevant" to the extent it is tied to a specific NQTL type. ABHW requests that the Tri-Departments define the specific NQTL types that they find to be applicable to the Relevant Data metrics contemplated in the Technical Release.**

The Technical Release uses the phrase "NQTLs related to network composition" to reference the NQTLs for which the collection and reporting of the Relevant Data measures in the Technical Release would be required. However, in order to comment on the Technical Release effectively, much less contemplate designing a MHPAEA compliance program, it is essential for the Tri-Departments to define the specific NQTL types that the Tri-Departments anticipate requiring the Relevant Data to connect to.

The proposed regulatory text generally refers to NQTLs related to network composition as a range of related NQTL types and states in the preamble of the Proposed Rule, "Network composition is the result of the design and application of a myriad of NQTLs."[2] However, two examples in the proposed regulatory text analyze "Standards for provider admission to a network" as though it were a single NQTL type,[3] and commentary in the preamble appears to require all NQTLs related to network composition to be analyzed jointly.[4] Neither the Proposed Rule nor the Technical

[2] Specific references to network composition in the proposed regulatory text include:

- The "illustrative, non-exhaustive list of nonquantitative treatment limitations" states that NQTLs include "Standards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage." The list does not state whether the range of concepts identified in this formulation are intended to be analyzed as one or more different NQTL types.
- The "Special rule for nonquantitative treatment limitations related to network composition" and related references throughout the proposed rules use the phrase "nonquantitative treatment limitations" in the plural, apparently suggesting that the Tri-Departments intend to require separate NQTL analyses for multiple concepts that are encompassed under the general rubric of "network composition."
- Example 4 analyzes "Methods for determining reimbursement rates" as a stand-alone NQTL type.

[3] Example 8 analyzes "Standards for provider admission to a network" generally. Example 13 analyzes "Standards for provider admission to a network" generally, and also refers to "nonquantitative treatment limitations related to network composition," apparently suggesting that these two phrases are intended to be synonymous.

[4] The preamble states, "The Tri-Departments are concerned that some plans or issuers may define their NQTLs related to network composition in a way that silos interrelated processes, strategies, and evidentiary standards that should be evaluated together under a plan's or issuer's standards related to network composition. In the Tri-Departments' view, all NQTLs related to network composition, taken together, must be designed and applied in compliance with

Release provides a specific list of the NQTL types related to network composition that health plans and issuers must analyze, explains how to analyze them jointly, or clarifies how to determine whether or not the data metrics from the Technical Release will be applicable to each separate but inter-related NQTL type. This uncertainty undermines the ability of stakeholders to appropriately comment on the measures contemplated in the Technical Release. For example, neither the Proposed Rule nor the Technical Release specifies whether or how to draw a line between provider network admission standards, credentialing requirements/procedures, provider network adequacy standards, provider contract negotiations, provider reimbursement methodologies, and value-based/alternative payment methodologies. The preamble to the Proposed Rule also identifies a new NQTL type referred to as "billing restrictions, such as a requirement for a licensed provider to bill through or under the supervision of another type of licensed provider,"[5] and any number of additional aspects of provider contracting and reimbursement could be determined to be separate NQTLs, separate variations of NQTLs, or separate Factors.

II. Notice-and-Comment Rulemaking on the "Type, Form, and Manner" of Relevant Data

- ⇨ **The Technical Release is not clear whether the measure concepts floated in the Technical Release will be subject to further public comment prior to finalization or whether future Relevant Data measures will be shared for public comment prior to adoption under the MHPAEA regulations. ABHW posits the Tri-Departments are legally required to proceed with a formal notice and comment period prior to finalizing the Relevant Data details. ABHW supports the Tri-Departments regularly revisiting the technical specifications for Relevant Data measures on a schedule similar to that taken by HHS in the quality measure reporting cycles.**[6]

The Technical Release does not itself directly provide formal technical specifications for each proposed measure, only citing a variety of data tools in Appendix 1 and raising numerous substantive questions for industry input. In the Proposed Rule, the Tri-Departments indicate that "[t]hese proposed rules would permit the Tri-Departments to specify the type, form, and manner

MHPAEA's parity requirements to ensure that networks do not materially disfavor access to mental health and substance use disorder benefits when compared to medical/surgical benefits." (88 FR 51576.) Further guidance is needed regarding the intended design of an analysis that encompasses all NQTL types related to network composition.

[5] 88 FR 51577.

[6] *See* The 2023 Hospital Outpatient Quality Reporting Program for hospital outpatient care (88 FR 49774); The Hospital Inpatient Quality Reporting Program, the Long-Term Care Hospital Quality Reporting Program and the PPS-Exempt Cancer Hospital Quality Reporting Program (88 FR 27074) the Inpatient Psychiatric Facility Quality Reporting Program (88 FR 21290), the Skilled Nursing Facility Quality Reporting Program (88 FR 21332), the End-Stage Renal Disease Quality Incentive Program (87 FR 67244), and the Inpatient Rehabilitation Facility Quality Reporting Program (88 FR 20985).

for this data collection and evaluation in future guidance,"[7] but does not specify whether these future technical specifications will be promulgated through regulatory or sub-regulatory guidance.

The details of the technical specifications for Relevant Data metrics will have a major impact on managed care operations. ABHW believes that the U.S. Supreme Court's 2019 decision in *Azar v. Allina Health Services* demands formal notice and comment review before such metrics can be finalized.[8] As contemplated in the Proposed Rule, the results of Relevant Data may be the basis of a substantive determination of compliance with MHPAEA. As such, the guidance on the "type, form, and manner" of the Relevant Data constitutes a "substantive legal standard" requiring notice and comment rulemaking. The Health and Human Services Office of the General Counsel (HHS-OGC) agrees with this interpretation in other areas of federal programs. In particular, HHS-OGC recently provided its interpretation of *Allina* and how violations of sub-regulatory guidance that were not promulgated through notice-and-comment rulemaking affect the ability of governmental enforcement agencies to bring enforcement actions.[9]

For these reasons, ABHW requests that the Tri-Departments publish and solicit public comments on the specific technical specifications, once developed, for each measure concept identified in the Technical Release and on any other measures considered in the future, prior to the final adoption of any measure as a required Relevant Data measure.

III. Relevant Data to be Collected and Evaluated with Comparative Analyses for NQTLs Related to Network Composition

A. *Out-of-Network Utilization*

The use of out-of-network claims amounts as a metric to evaluate the relative adequacy of provider networks is a potentially useful tool for high-level monitoring to guide network contracting and care management strategy and re-evaluate whether members/beneficiaries are receiving the promise of quality behavioral healthcare.

However, for the reasons explained further below in Appendix 1, ABHW objects to the use of this metric as a dispositive measure for the purpose of defining discrimination. To be clear, ABHW does not per se oppose the requirement that regulated issuers and plans collect and monitor a measure like this, including an obligation to investigate disparities in the data and to pursue contracting and/or care management efforts to encourage in-network access and use. However, ABHW opposes the use of this measure, or any other Relevant Data metric, as a per se basis for a legal determination of discrimination.

We have provided specific feedback on the questions posed in the Technical Release below in Appendix 1.

---

[7] Proposed 26 CFR 54.9812–1(c)(4)(i) and (ii), 29 CFR 2590.712(c)(4)(i) and (ii), and 45 CFR 146.136(c)(4)(i) and (ii).

[8] *See Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019).

[9] HEALTH & HUM. SERVS. OFF. OF THE GEN. COUNSEL, ADVISORY OPINION 20-05 ON IMPLEMENTING ALLINA 1 (Dec. 3, 2020), https://www.hhs.gov/sites/default/files/allina-ao.pdf.

B. *Percentage of In-Network Providers Actively Submitting Claims*

As explained further below in Appendix 1 in our feedback on the specific questions posed in the Technical Release, ABHW does not believe that this metric, as proposed, is an appropriate Relevant Data metric for use in considering MHPAEA compliance. In particular, the metric as contemplated in the Technical Release has never, to our knowledge, been used or tested in any way to determine network adequacy or strength. Although a few state regulators have required the collection of a comparable measure with regard to MH/SUD providers, ABHW is not aware that any comparable measure has ever been collected for M/S providers. The results may differ drastically depending on the specific provider types selected. Moreover, the results for both MH/SUD and M/S providers would be largely outside of the plan's control, and the new incentive to terminate providers that are not actively submitting claims means the measure may narrow rather than broaden access to MH/SUD providers.

As with the out-of-network claims measure above, ABHW is not opposed to the use of a measure to evaluate whether network providers are accepting new patients based on actual claims data. **However, ABHW opposes the imposition of a brand-new metric to almost all of the commercial health insurance market – as a potential basis for a *per se* determination – that has never even been collected before by any federal or state regulator, much less subject to rigorous validation testing. For this reason, ABHW opposes the adoption of the metric contemplated in the Technical Release.**

C. *Time and Distance Standards*

Time and distance standards are an industry standard approach taken by regulators across many markets and by issuers and plans themselves to establish standards for access. ABHW is unable to fully respond to the Technical Release discussion of using this measure of network adequacy for MHPAEA comparability purposes. The Technical Release does not describe in sufficient detail how the time and distance standards in the referenced sources (Medicare Advantage, qualified health plans (QHPs) on the Federally-facilitated Exchanges (FFEs), etc.) would be applied to determine compliance with MHPAEA within applicable benefit classifications.

Some issuers use the relative number of "gap reports" for time and distance standards (where "gaps" are defined to exclude waivers granted by the state due to appropriate use of telehealth services or due to an absence of available providers of the identified type in the relevant geographic area) as a metric of comparative network adequacy for MHPAEA self-monitoring purposes. **ABHW recommends that the Tri-Departments consider this measure for use in a comparability and stringency analysis.**

ABHW also recommends that the Tri-Departments refrain from referencing and incorporating network adequacy criteria from other regulatory agencies from other markets and applying them to products not subject to those regulations. Additionally, the Tri-Departments should not use MHPAEA Relevant Data analysis requirements to require issuers to exceed minimum thresholds set in those other regulatory requirements. Doing so would constitute a significant expansion of Tri-Department regulatory activity that far exceeds the scope of MHPAEA.

In addition, in Appendix 1 below, ABHW has provided detailed comments on this measure concept in response to the specific questions posed in the Technical Release.

D. *Reimbursement Rates*

ABHW contends that network-provider reimbursement methodologies are not appropriate for consideration as an independent NQTL type as they do not constitute a limit on the scope or duration of benefits. Treating in-network reimbursement as an NQTL type shifts the analysis of MHPAEA from being a patient-protection anti-discrimination law into a law focused on defending the economic interests of providers without regard to the potential adverse impact (through higher premiums and cost-sharing) on the patients themselves. Further, the absence of definitions of NQTL types renders this NQTL type nearly impossible to implement as a matter of MHPAEA compliance, as the extraordinary variety of reimbursement methodologies across the range of health care benefits is not conducive to simplification under the terminology of NQTL comparability and stringency.

Notwithstanding the above, health plans have experience analyzing reimbursement rates as a component of provider network contracting and related network management NQTLs. Among the reimbursement NQTL measure concepts floated in the Technical Release, **ABHW recommends that the Tri-Departments refrain from using the CPT-code comparison measures and instead recommends that the Tri-Departments 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 or FAIR health rates) for the same service (to the extent that the benchmark source covers the service)**. The CPT-code metrics contemplated in the Technical Release, as well as the other versions of CPT-code metrics referenced in Appendix 1, provide a very narrow and arbitrary picture of reimbursement methodologies. In particular, the CPT codes referenced in the Technical Release represent only a tiny subset of office-based services. Further, the codes proposed are restricted to psychiatrists and are generally not billable by the psychologists, nurses, and masters-level providers that deliver the vast majority of MH/SUD treatments and services.

Conversely, the measure concept of comparing the weighted average of base fee schedule rates against a benchmark rate for the same service is more likely to represent a meaningful picture of the comparability of the reimbursement methodologies for MH/SUD vs. M/S services. However, as with other metrics contemplated in the Technical Release, the Tri-Departments inappropriately contemplate performing the analysis on sub-classifications of providers that differ from the classifications of benefits provided by MHPAEA. This runs contrary to the broader structure of MHPAEA regulations and, if adopted as a required Relevant Data metric, would materially complicate MHPAEA compliance. **For this reason, ABHW recommends that any future metrics on reimbursement methodologies be developed at the classification level, as such classifications are defined in regulation.**

In addition, in Appendix 1 below, ABHW has provided detailed comments on this measure concept in response to the specific questions posed in the Technical Release.

E. *Aggregate Data Collection*

ABHW supports the proposal in the Technical Release that for all Relevant Data, data would be collected and evaluated by the relevant administrator in the aggregate for all plans or policies, as applicable, that use the same network of providers or reimbursement rates. This approach is reasonable 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. **ABHW further recommends that the Tri-Departments mandate that other regulatory entities implementing and enforcing MHPAEA at the federal and state levels similarly allow for aggregation for all plans and policies that use the same network.**

IV. Future Potential Federal Enforcement Safe Harbor for NQTLs Related to Network Composition

As expressed in our prior correspondence with the Tri-Departments, **ABHW strongly supports the use of Relevant Data in assessing the impact of NQTLs on participants', beneficiaries', or enrollees' access and utilization**. The Tri-Departments have made it clear throughout the Proposed Rule and Technical Release that they are aspiring to prioritize actual access and quality for participants, beneficiaries, or enrollees. However, the Proposed Rule and "safe-harbor" concept, as currently articulated in the Technical Release, would not only retain all of the laborious documentation requirements for NQTLs without regard to what Relevant Data shows about equal access, it would increase those requirements significantly compared to the current, already onerous environment.

In this context, **ABHW would like to reiterate our prior request that the Tri-Departments utilize Relevant Data metrics, including some of those called for in the Technical Release, as a safe harbor from having to perform the other NQTL documentation steps unless and until a material difference threshold is met.**[10] Doing so would bring MHPAEA into line with the rest of anti-discrimination law in America, including case law interpreting the Fourteenth Amendment Equal Protection Clause of the US Constitution, the Americans with Disabilities Act (ADA), and the Civil Rights Act which requires an analysis of potential discrimination upon the showing of some sort of factual proof that something discriminatory may be happening[11]. The use of Relevant Data tracking and analysis requirements presents an opportunity to do exactly this for MHPAEA. NQTL comparability and stringency analyses of factors, sources, and evidentiary standards would then be focused on investigating and analyzing specific design and operational requirements related to *material differences* in Relevant Data as opposed to the current regulatory regime and Proposed Rule approach, which require issuers and plans to prepare voluminous analytic documents with

[10] ABHW Letter to the Tri-Departments Recommending Safe Harbors for Parity Enforcement available at https://abhw.org/wp-content/uploads/2023/05/ABHW_Tri-Departments_Safe-Harbor-proposal-for-parity-enforcement_5.17.23.pdf

[11] *See* The United States Department of Justice, Title VI Legal Operations Manual; Section VI- Proving Discrimination-Intentional Discrimination; *Available at*: https://www.justice.gov/crt/fcs/T6Manual6.

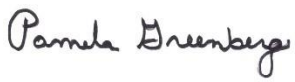
the intent of rebutting a *presumption of discrimination.* The Technical Release presents an important opportunity for the Tri-Departments to re-consider how to design the documentation requirements for NQTLs in a manner to truly focus on the actual impact on the participant's, beneficiary's, or enrollee's access and utilization and restructure the burden of proof of non-discrimination to a more rational and outcomes-based methodology.

V. Conclusion

ABHW strongly supports the effort to increase the focus of MHPAEA enforcement to outcomes but finds that the overall approach the Tri-Departments are proposing diverges from traditional concepts of proof for discrimination and the regulations of managed care. ABHW has provided written responses to each of the technical questions in Appendix 1 below. We hope that the technical feedback included herein is helpful.

Thank you for your efforts and your consideration of our Technical Release comments. ABHW welcomes the opportunity to collaborate with the Tri-Departments. We stand ready to provide further input and assistance and would appreciate meeting with you to discuss our responses and suggestions. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,



Pamela Greenberg, M.P.P.
President and CEO

Appendix 1
Responses to Specific Questions in the Technical Release

I. Out-of-Network Utilization

A. *How can the Tri-Departments ensure that the data would provide a meaningful representation of whether a plan or issuer is designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers?*

A: The primary design issues with the version of the measure referenced in Appendix 1 to the Technical Release are (1) missing claims data and a lack of testing for validity and reliability and (2) plan design types.

With regard to the validity and reliability of the proposed measure, out-of-network service utilization is driven by a wide variety of factors, and surveys have consistently shown that only a minority of this out-of-network service utilization is motivated by lack of availability of in-network providers.[12] Thus, even to the extent that one accepts the premise that network composition constitutes a "treatment limitation within the scope of MHPAEA, out-of-network utilization is not strongly correlated to network composition. [Many of these reasons that contribute to out-of-network provider utilization are outside the scope of control of the entity that created the provider network. These reasons include 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 perceived or real stigma regarding their condition. Given the fact that many factors influencing out-of-network utilization are generally unrelated to the strength of the plan's provider network and the fact that many factors outside of the health plan's control may disproportionately influence patients to seek out-of-network care for MH/SUD conditions, it would be inappropriate to make MHPAEA compliance determinations regarding the plan's network composition strategy solely on the basis of plan or issuer performance on this measure.

Regarding the application of this measure to different plan design types, the versions of the out-of-network utilization measure included in Appendix 1 of the Technical Release expressly exclude any plan design type *other than* Preferred Provider Organizations (PPOs). The Technical Release narrative itself does not acknowledge or address this issue but should. Excluding or otherwise addressing Health Maintenance Organizations (HMOs) and other restricted network plan designs is necessary because the out-of-network utilization rate presumes that the underlying network benefit design contemplates out-of-network use as a general matter. This alone significantly

[12] See, e.g., Kelly A. Kyanko, Leslie A. Curry, and Susan H. Busch, Out-of-Network Providers Use More Likely in Mental Health than General Health Care Among Privately Insured, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4707657/, finding that "***Fewer than 10%*** of respondents who used out-of-network mental health services reported that they went to an out-of-network mental health provider due to problems with the size or general composition of the network (as opposed to inclusion of a specific provider)" [emphasis added].

restricts the utility of the measure. The reporting documents being utilized in New Mexico contemplate the addition of a new measure (not mentioned in the Technical Release) for out-of-network exception requests/approval rates as a supplement to the out-of-network utilization metric for HMO plan designs. This measure was not raised in the Technical Release and has never been through any validity and reliability testing.

ABHW recommends the testing of metrics similar to the exception request metric that may be representative for HMO plan designs.

B. ***Should the Tri-Departments require plans and issuers to collect and evaluate relevant out-of-network data on specific items and services as outlined above, or should the Tri-Departments also require data on certain subsets of items and services?***

A: ABHW has significant concerns about the approach of evaluating out-of-network data only on specific items and services. MHPAEA's classifications of benefits and process of identifying and classifying benefits on the basis of diagnosis and not provider type is the result of years of policy debate about the appropriate way to consider equity in benefits administration. As the Tri-Departments know better than anyone, comparing the stringency of limits by provider type rather than benefit/diagnosis presents significant challenges that obscure the beneficiary protection purpose of MHPAEA. The Tri-Departments addressed this issue in the 2013 Final Rule, saying that "Cross-walking or pairing specific mental health or substance use disorder benefits with specific medical/surgical benefits is a static approach that the Tri-Departments do not believe is feasible, given the difficulty in determining "equivalency" between specific medical/surgical benefits and specific mental health and substance use disorder benefits and because of the differences in the types of benefits that may be offered by any particular plan."[13]

For this reason, ABHW recommends that the Tri-Departments perform data validation testing for a version of this metric that compares out-of-network utilization according to MHPAEA's established classifications of benefits.

C. ***Should the Tri-Departments require plans and issuers to collect and evaluate relevant out-of-network utilization data from the two most recent and complete calendar years that ended at least 90 days prior to the start of the plan or policy year during which the request for a comparative analysis was made? Should the Tri-Departments consider a different look-back period for this data collection?***

A: ABHW does not have concerns about the look-back period proposed, provided that the data aggregation suggestions presented above are adopted.

[13] 78 FR 68243.

D. ***Should different categories of items and services be used instead of the categories described above?***

A: As discussed above, ABHW has significant concerns about the approach of evaluating out-of-network data on specific items and services rather than on the classifications of benefits called for under MHPAEA and the current and proposed rule.

E. ***Should 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? Why?***

A: The unit of measure that best aligns with the patient experience of care may be a "provider encounter," where an encounter is defined to mean all claims for a specific provider (defined by the provider's Taxpayer ID Number) at a specific location (defined by the provider's address) on a specific date of service, regardless of the number or dollar value of such claims for that provider, location, and date of service.

Whether the unit of measure is specified for categories of items and services or for classifications of benefits, there is a significantly higher volume of utilization and variety of M/S compared to MH/SUD services. As such, the use of percentage ratios for Relevant Data metrics is essential to the design of appropriate metrics. For this reason, the use of the number of claims or total dollar amounts is not an appropriate comparator.

F. ***If the data is collected in terms of a number of claims, what should count as a "claim" in cases where multiple items and services are listed in one claim?***

A: ABHW recommends that a consistent use of the term "claim" be used across all Relevant Data metrics. ABHW recommends the Tri-Departments define "claim" to reflect covered services from within the geographic service area (including telehealth), each claim line (as opposed to overall claim), and that the definition only includes finalized un-duplicated claims. If the Tri-Departments intend to analyze authorization requests as a component of a "claim" calculation, ABHW objects to this approach and recommends only analyzing finalized, unduplicated claim lines.

G. ***How should the Tri-Departments control for treatment received from MH/SUD providers where no claim for benefits was made (i.e., because the participant, beneficiary, or enrollee did not submit a claim for services furnished by an out-of-network provider)?***

A: ABHW recommends that the Tri-Departments perform validation studies to identify the relative rates of member out-of-network service utilization where no claim was submitted and as stated elsewhere in our comments, refrain from any consideration of out-of-network data as dispositive on compliance and only as a potentially relevant indicator.

H. ***How should the Tri-Departments control for claims that are otherwise not covered or for duplicate submissions or incomplete claims?***

A: ABHW recommends that duplicate and incomplete claims be excluded from consideration to avoid duplication and allow consistent implementation according to any reasonable methodology that the plan or issuer may be able to apply. As to claims that are otherwise not covered, HMO-style or other closed network plans should be excluded from the use of the measure, and as an initial policy, claims for non-covered or medically unnecessary services should also be excluded. If the Tri-Departments want to include claims for services that are deemed to be not covered, this should be the subject of an additional validation study to identify whether non-covered service claims are submitted in comparable ratios between MH/SUD and M/S services.

I. ***How should the evaluation of out-of-network utilization data take geographic area into account? How should the Tri-Departments define geographic areas? Should the Tri-Departments do so in a manner that is consistent with other data elements described in this document?***

A: ABHW recommends that geographic service areas and variations by geography only be addressed by each issuer in response to investigations of the results of the measure in their specific circumstances. As such, ABHW does not believe that the Tri-Departments need to define geographic service area or take it into account in the technical specifications for the metric. As noted above, ABHW recommends that the Tri-Departments allow for aggregation of data to the book of business that utilizes the same network and network management activities. ABHW recommends that the Tri-Departments take a consistent approach to the geographic area across all Relevant Data metrics.

J. ***What data, if any, would be analogous to out-of-network utilization for plans or issuers that generally do not provide out-of-network benefits for non-emergency care (such as health maintenance organizations, exclusive provider organizations, and closed network plans)?***

A: As noted above, the reporting documents being utilized in New Mexico contemplate the addition of a new measure (not mentioned in the Technical Release) for out-of-network exception requests/approval rates as a supplement to the out-of-network utilization metric for HMO plan designs. This measure was not raised in the Technical Release and has never been through any validation testing.

K. ***If there is no analogous data, would the other relevant data described in this document for NQTLs related to network composition meaningfully reflect whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?***

A: As described above and in ABHW's comments on the Proposed Rule, ABHW strongly believes that any outcome measure is not, in isolation, an appropriate basis for any conclusion about discrimination. In the context of a metric being used to monitor access and to help identify

potential disparities in design and serve as a target for continuous improvement, the other metrics, subject to greater clarification and technical specifications, can certainly provide meaningful insights.

L. ***What data, if any, would be analogous to out-of-network utilization for plans or issuers that do not utilize a traditional network of providers (such as reference-based pricing plans)? If there is no analogous data, would the other relevant data described in this document for NQTLs related to network composition meaningfully reflect whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?***

A: Plans and issuers that do not use a traditional network do not utilize the NQTL types contemplated by the Technical Release. It would be inappropriate to require the collection and reporting of metrics related to network management by plans or issuers that do not use these NQTL types.

M. ***Are there other plan or benefit designs that may need additional guidance or alternatives for the relevant data on out-of-network utilization that a plan or issuer would be required to collect, evaluate, and include as part of its comparative analyses for NQTLs related to network composition?***

A: ABHW has not identified any such plan or benefit designs.

N. ***Are there ways in which out-of-network utilization data are susceptible to manipulation that could create the appearance that plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits when that is not the case?***

A: The measure concept floated in the Technical Release does not include enough technical detail for ABHW to opine on potential opportunities for inappropriate manipulation.

O. ***What terminology is important for the Tri-Departments to define precisely to facilitate the collection and evaluation of out-of-network utilization data?***

A: As described above, it is essential that the Tri-Departments specify the definition of the unit of measurement (e.g., "claim") and "out-of-network" as well as the types of network designs subject to the measure. Also, as noted above, it is essential that the Tri-Departments define the NQTL types subject to this type of data metric.

P. ***Which existing models or methodologies (including, but not limited to, those in the Appendix) should the Tri-Departments consider when specifying the out-of-network 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? If there are existing methodologies, what are the advantages and disadvantages of these methodologies?***

A: ABHW recommends that the Tri-Departments also consider the technical specifications used for defining a claim used by the Maryland Department of Health for oversight of the Medicaid delivery system. It has the advantage of including greater specificity in the definitions of terms. https://health.maryland.gov/mmcp/Pages/Mental-Health-Parity.aspx#:~:text=MHPAEA%20requires%20parity%20in%20the,(M%2FS)%20benefits. In addition, there are some terms we recommend also be defined, as described above (e.g., the definition of the unit of measurement, the term "claim," the term "out-of-network," and the applicable NQTL types).

II. Percentage of In-Network Providers Actively Submitting Claims

A. ***How can the Tri-Departments ensure that the data would provide a meaningful representation of whether a plan or issuer is designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers?***

A: ABHW does not believe that this metric, as proposed, is an appropriate Relevant Data metric for use in considering 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 excess network capacity, 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 payors, excess capacity in the plan's provider network, ethnic and cultural matching preferences, and active discrimination by the provider against the plan or issuer's members (generally in violation of the provider's network participation contract, though these clauses are difficult to enforce). Without testing for measure validity and reliability to determine whether meaningful conclusions can be drawn from these data, ABHW recommends that this measure not be used to determine MHPAEA compliance.

The concept of evaluating the network to identify provider participation and willingness to accept new patients from the plan or issuer is theoretically reasonable and is something that issuers analyze for purposes other than MHPAEA. As such, any use of a metric like this for MHPAEA purposes should be the subject of significant reliability and validity testing prior to requiring its use by regulated plans or issuers. Note that the metric, even as contemplated in the Technical Release, is only relevant for outpatient office-based providers.

The proposed measure may also generate perverse consequences. Plans with open provider networks (i.e., that admit any provider to the network that is willing to accept the plan's standard contract terms and rates) may be forced to close their network for MH/SUD providers and may be unfairly penalized in states with an "any willing provider" law. Plans may also be incentivized to terminate MH/SUD providers that are not actively participating in the network but are, in fact, available (or may become available). Thus, the proposed measure, if implemented, may have the impact of narrowing rather than broadening access to MH/SUD providers. ABHW, therefore, suggests that the Tri-Departments refrain from requiring or suggesting the use of this measure for a parity compliance safe harbor or as an outcome measure for parity compliance purposes.

B. ***Should the Tri-Departments require plans and issuers to collect and evaluate relevant data on the groups of MH/SUD providers or M/S providers as outlined above, or should the groups of providers be categorized differently? How should the Tri-Departments approach the required comparisons between MH/SUD providers and M/S providers for purposes of ensuring the NQTLs related to network composition comply with MHPAEA?***

A. As discussed in our response to the questions about the out-of-network utilization concept, ABHW has significant concerns about the approach of evaluating network provider claims data only on specific items and services. For this reason, ABHW recommends that the Tri-Departments perform data validation testing for a version of this metric according to MHPAEA's established classifications of benefits.

C. ***Which NQTLs impact the percentage of in-network providers actively submitting claims, and how should the Tri-Departments analyze these data to understand whether a plan or issuer complies with MHPAEA?***

A: As noted above, a variety of factors influence the volume of claims that a provider may bill to a given plan or payor at a given time, many of which are outside the plan's control and/or otherwise do not constitute NQTLs. For this reason, ABHW recommends that the Tri-Departments refrain from using the percentage of in-network providers actively submitting claims as a required outcomes measure.

D. ***Should the Tri-Departments also require plans and issuers to collect and evaluate data on the total number of active in-network providers per participant, beneficiary, or enrollee in order to determine not only the percentage but also the number of providers actively submitting claims? If so, how will this aid in evaluating compliance of NQTLs related to network composition?***

A: The outcome of any quantitative measure should be tested for statistical significance, which is influenced in this case by the raw number of providers submitting claims.
As an alternative, ABHW recognizes the potential value in combining network adequacy data and/or provider-to-enrollee ratios with a measure of the percentage actually submitting claims. However, particularly given that such a measure has never been tested, measure reliability and validity testing would be needed before being adopted for the purposes of determining parity.

E. ***How should the evaluation of the percentage of in-network providers actively submitting claims take into account the place of service or availability of telemedicine benefits? How should the Tri-Departments define the settings in which care is provided?***

A: As noted above, ABHW does not support the use of this measure as contemplated in the Technical Release without significant changes and validation testing. However, should such a metric be used, it should exclude telemedicine-only practitioners due to the often-large supply of telemedicine providers that may be available, many of which are included for the express purpose of creating excess capacity. However, telemedicine claims by a provider with an in-area presence should be included.

F. ***How should the evaluation of the percentage of in-network providers actively submitting claims take geographic areas into account? How should the Tri-Departments define geographic areas? Should the Tri-Departments do so in a manner that is consistent with other relevant data described in this document?***

A: ABHW recommends that geographic service areas and variations by geography only be addressed by each issuer in response to investigations of the results of the measure in their specific circumstances. As such, ABHW does not believe that the Tri-Departments need to define geographic service area or take it into account in the technical specifications for the metric. As noted above, ABHW recommends that the Tri-Departments allow for aggregation of data to the book of business that utilizes the same network and network management activities. ABHW recommends that the Tri-Departments take a consistent approach to the geographic area across all Relevant Data metrics.

G. ***Should the Tri-Departments also require plans and issuers to collect and evaluate data as part of their comparative analysis for NQTLs related to network composition on the percentage of in-network providers actively submitting claims who are accepting new patients?***

A: Not currently. However, ABHW recommends that the Tri-Departments perform validation and reliability testing of the viability of collecting this metric in a consistent and accurate manner. In ABHW members' experience, it is currently extremely difficult operationally to collect accurate data on each provider's willingness to accept new patients. However, as technology evolves, it is possible that this metric may become more feasible to collect accurately in the future.

H. ***What data, if any, would be analogous to the percentage of in-network providers actively submitting claims for plans or issuers that generally do not utilize a traditional network of providers (such as reference-based pricing plans)? If there is no analogous data, would the other relevant data described in this document meaningfully reflect whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?***

A: Plans and issuers that do not use a traditional network do not utilize the NQTL types contemplated by the Technical Release. It would be inappropriate to require the use of these metrics for plans or issuers that do not use these NQTL types.

I. ***Are there other plan or benefit designs that may need additional guidance or alternatives for the relevant data on the percentage of in-network providers actively submitting claims that a plan or issuer would be required to collect, evaluate, and include as part of its comparative analyses for NQTLs related to network composition?***

A: ABHW has not identified any such plan or benefit designs.

J. ***Are there ways in which data on the percentage of in-network providers actively submitting claims is susceptible to manipulation that could create the appearance that plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits when that is not the case?***

A: The measure concept floated in the Technical Release does not include enough validation and reliability testing experience for ABHW to opine on potential opportunities for inappropriate manipulation.

K. ***What terminology is important for the Tri-Departments to define precisely to facilitate the collection and evaluation of data on the percentage of in-network providers actively submitting claims?***

A: As described above, it is essential that the Tri-Departments perform significant data validation and reliability testing of this metric before requiring its use.

L. ***Which existing models or methodologies (including, but not limited to, those in the Appendix) should the Tri-Departments consider when specifying the data on the percentage of in-network providers actively submitting claims that plans, and issuers would be required to collect and evaluate as part of their comparative analyses for NQTLs related to network composition? If there are existing methodologies, what are the advantages and disadvantages of these methodologies?***

A: Provider-to-enrollee ratios, as discussed above, are a well-tested and commonly used metric for network adequacy criteria. ABHW recommends the Tri-Departments test this measure for use in NQTL comparability and stringency analyses. The U.S. Government Accountability Office (GAO)

study on network adequacy approaches includes a useful discussion on this measure: https://www.gao.gov/assets/gao-23-105642.pdf.

III. Time and Distance Standards

A. *How can the Tri-Departments ensure that the data would provide a meaningful representation of whether a plan or issuer is designing and applying NQTLs related to network composition in a manner that places greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers? Are there other measures, such as wait times, that should be used to determine whether NQTLs related to network composition are designed and applied in compliance with MHPAEA?*

A: The discussion of time and distance standards in the Technical Release is incomplete and does not describe in sufficient detail how the time and distance standards in the referenced sources (Medicare Advantage, QHPs in the FFEs, etc.) would apply to a MHPAEA compliance determination within the MHPAEA benefit classifications, or how those standards (which provide a quantitative minimum threshold by provider type) would be used to identify disparities. ABHW would support a finding that a plan or issuer meets a safe harbor for Provider Network Composition NQTLs where the plan either met or obtained a waiver from an applicable regulator to acknowledge a lack of providers for each time and distance standard applicable to the MH/SUD providers in the plan or issuer's network according to all applicable regulators for that provider network.

As an alternative, ABHW recommends that the Tri-Departments consider permitting issuers to analyze the relative number of "gap reports" for applicable time and distance standards to meet the safe harbor standard (where "gaps" are defined to exclude waivers granted by the state or otherwise demonstrated with appropriate evidence to show the appropriate use of telehealth services, an absence of available providers of the identified type in the relevant geographic area, and/or reasonable attempts to contract with available providers).

B. *Should the Tri-Departments require plans and issuers to collect and evaluate the ratio of providers to participants, beneficiaries, and enrollees (also known as provider-to-enrollee ratios)? Are there models, either from Federal network adequacy or state network adequacy requirements, that could inform such a measure?*

A: Provider-to-enrollee ratios, as discussed above, are a well-tested and commonly used metric for network adequacy criteria. ABHW recommends the Tri-Departments test this measure for use in NQTL comparability and stringency analyses. The GAO study on network adequacy approaches includes useful discussion on this measure: https://www.gao.gov/assets/gao-23-105642.pdf.

C. ***Should the Tri-Departments incorporate as additional relevant data elements on providers accepting new patients in these time and distance standards? Do plans and issuers have the necessary information to collect and evaluate such information as part of their comparative analyses for NQTLs related to network composition?***

A: Not currently. However, ABHW recommends that the Tri-Departments perform validation and reliability testing of the viability of collecting this metric in a consistent and accurate manner. In ABHW Member's experience, it is currently extremely difficult operationally to collect accurate data on each provider's willingness to accept new patients. However, as technology evolves, it is possible that this metric may become more feasible to collect accurately in the future.

D. ***How should a plan or issuer determine from where a participant, beneficiary, or enrollee is traveling? How should these data account for the availability and/or use of public transportation or other alternate forms of transportation?***

A: ABHW recommends that the Tri-Departments align with the geo-coding software utilized by the applicable regulatory or accreditation regime applicable to the issuer or plan administrator and allow for the use of one or more of the industry-standard geo-analytics vendors.

E. ***How can the Tri-Departments account for any difficulties that underserved and minority groups face that may not be accounted for in traditional time and distance measures?***

A: ABHW recommends that the Tri-Departments raise any concerns with time and distance standards and equity with the applicable stewards of those network adequacy regulatory or accreditation regimes and not seek to use MHPAEA to address any perceived concerns regarding regulatory requirements in other markets.

F. ***Should the time and distance metrics be adjusted to account for access to providers who offer telehealth services only or providers who offer telehealth in addition to in-person services in plans' and issuers' networks? If so, how?***

A: ABHW 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.

G. ***How should the Tri-Departments develop specific categories of MH/SUD and M/S providers for purposes of requiring plans and issuers to collect and evaluate these data as on time and distance as part of their comparative analysis for NQTLs related to network composition? Should the Tri-Departments use the categories specified in the National Uniform Claim Committee (NUCC) taxonomy to group provider and facility types as the relevant comparison groups for MH/SUD providers and M/S providers? If so, are any variations from this taxonomy necessary for group health plans or health insurance issuers? Is there an alternate method that could be used to categorize MH/SUD providers and M/S providers?***

A: ABHW cannot opine on the specific taxonomy without understanding the implications of changes contemplated in the Proposed Rule related to the definition of Mental Health Conditions for the purpose of MHPAEA, as the proposed change will have a material impact on what taxonomy of providers would be most appropriate to use. Similarly, ABHW would need to know the specific approach the Tri-Departments seek to use for assessing time and distance standards for purposes of NQTL comparability and stringency analyses. ABHW notes that it would be inappropriate to require plans and issuers to meet time and distance standards for every one of the provider types identified in the NUCC taxonomy code set, given the significant overlap in expertise across identified specialties (i.e., given that a single provider could meet member needs for a range of different NUCC specialties), and given that provider contracting and claims data systems do not identify these taxonomy codes.

H. ***How should provider groups with multiple providers on staff, or where multiple providers bill under a group National Provider Identifier (NPI), be counted? Are there other unique aspects of certain provider or facility structures that the data should account for?***

A: As with other topics, ABHW cannot opine without understanding what the Tri-Departments intend to do with regard to the source of the time and distance standards and related requirements that would be used for evaluating network adequacy. As a general rule, ABHW recommends alignment with the reporting standards for existing time and distance standards.

I. ***Should the Tri-Departments require plans and issuers to collect and evaluate data separately for different county-type designations, similar to existing CMS standards, or some other method of accounting for different geographic areas?***

A: As with other topics, ABHW cannot opine without understanding what the Tri-Departments intend to do with regard to the source of the time and distance standards and related requirements that would be used for evaluating network adequacy. As a general rule, ABHW recommends alignment with the reporting standards for existing time and distance standards.

J. ***What data, if any, would be analogous to time and distance data for plans that generally do not utilize a traditional network of providers (such as reference-based pricing plans)? If there is no analogous data, would the other relevant data described in this document for NQTLs related to network composition meaningfully represent whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?***

A: Plans and issuers that do not use a traditional network do not utilize the NQTL types contemplated by the Technical Release. It would be inappropriate to require the use of these metrics for plans or issuers that do not use these NQTL types.

K. ***Are there other plan designs that may need additional guidance or alternatives for the relevant data on time and distance that a plan or issuer would be required to collect, evaluate, and include as part of its comparative analyses for NQTLs related to network composition?***

A: ABHW has not identified any such plan or benefit designs.

L. ***Are there ways in which time and distance data are susceptible to manipulation that could create the appearance that plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits when that is not the case?***

A: The measure concept floated in the Technical Release does not include enough detail about the time and distance standards or how comparability would be tested for ABHW to opine on potential opportunities for inappropriate manipulation.

M. ***What terminology is important for the Tri-Departments to define precisely to facilitate the collection and evaluation of time and distance data?***

A: The measure concept floated in the Technical Release does not include enough detail about the time and distance standards or how comparability would be tested for ABHW to opine on what additional definitions might be necessary.

N. ***Which existing models or methodologies (including, but not limited to, those in the Appendix) should the Tri-Departments consider when specifying which categories of MH/SUD and M/S providers should be used for a comparative approach to examining access in terms of time and distance to MH/SUD providers that plans and issuers would be required to collect and evaluate as part of their comparative analyses for NQTLs related to network composition? If there are existing methodologies, what are the advantages and disadvantages of these methodologies?***

A: ABHW recommends 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. State Tri-Departments of Insurance are generally better positioned to account for the state's demographics, provider mix, and utilization trends in order to appropriately define network adequacy measures that are best suited to that state, pursuant to opportunities for public input from local stakeholders with direct knowledge of the above factors..

IV. Reimbursement Rates

A. *How can the Tri-Departments ensure that the data would provide a meaningful representation of whether a plan or coverage is designing and applying NQTLs related to network composition in a manner that places greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers?*

A: As discussed above, ABHW contends that network-provider reimbursement methodologies are not appropriate for consideration as an independent NQTL-type as they do not constitute a limit on the scope or duration of benefits. Treating in-network reimbursement as an NQTL type shifts the analysis of MHPAEA from being a patient-protection anti-discrimination law into a law focused on defending the economic interests of providers without regard to the potential adverse impact (through premiums and cost-sharing) on the patients themselves. Further, the absence of definitions of NQTL types renders this NQTL type nearly impossible to implement as a matter of MHPAEA compliance, as the extraordinary variety of reimbursement methodologies across the range of health care benefits is not conducive to simplification under the terminology of NQTL comparability and stringency.

Notwithstanding these threshold issues, the Technical Release presents two different methodologies for evaluating in-network reimbursement as an NQTL. Among the reimbursement NQTL measure concepts floated in the Technical Release, ABHW recommends that the Tri-Departments refrain from using the CPT-code comparison measures and instead recommends that the Tri-Departments focus on measures that compare negotiated allowed amounts as a percentage of an external benchmark (such as Medicare or FAIR health rates) for all services that are covered by the plan and included in the benchmark source.

B. *Are there different or additional CPT codes than those outlined above (99213, 99214, 90834, and 90837) that would help plans and issuers evaluate their reimbursement rate structures?*

A. The CPT-code metrics contemplated in the Technical Release, as well as the other versions of CPT-code metrics referenced in Appendix 1, provide a very narrow and arbitrary picture of negotiated reimbursement. In particular, the CPT codes referenced in the Technical Release represent only a tiny subset of office-based services. In many analyses, the findings for these codes differ significantly by code and do not present a clear trend. Adding a small number of additional codes is generally insufficient to generate an average that is representative of the actual total reimbursement received by most providers due in part to significant variability in billing patterns across providers. Further, the codes proposed are generally not billable by the psychologists, nurses, and masters-level providers that deliver the vast majority of MH/SUD treatments and services.

C. ***Which specific types of MH/SUD and M/S providers should be considered for purposes of the comparative analysis data collection and evaluation requirement on reimbursement rates for NQTLs related to network composition? Which types of M/S providers are the appropriate comparators to which particular types of MH/SUD providers for this purpose?***

A. As with other metrics contemplated in the Technical Release, the Tri-Departments inappropriately contemplate performing the analysis on sub-classifications of providers that differ from the classifications of benefits provided by MHPAEA in an apparent attempt to seek "apples-to-apples" analogies. For the same reasons that the Tri-Departments chose to eschew this methodology in the 2013 MHPAEA regulations, ABHW urges the Tri-Departments to once again reject this approach for the present guidance. These attempts to seek apples-to-apples comparisons run contrary to the broader structure of MHPAEA regulations and, if adopted as a required Relevant Data metric, would materially undermine the fundamental structure of the MHPAEA compliance analyses. For this reason, ABHW recommends that any future metrics on reimbursement methodologies be developed at the classification level, as such classifications are defined in regulation.

D. ***In determining average in-network payments, average billed charges, and average allowed amounts, should the average be calculated as a mean, a median, or a mode?***

A. ABHW recommends that the average in-network payment rates be calculated as the average allowed amounts, weighted by utilization.

E. ***How should these data points account for non-fee-for-service payments, quality incentives, facility fees, or other similar payments that are not accounted for in reimbursement rates?***

A. This question raises one of the issues that ABHW has discussed in our comments on the Proposed Rule related to the treatment of reimbursement rates as an independent NQTL-type, as it is unclear whether the items mentioned in the question would constitute different NQTLs or variations of a single NQTL type requiring analysis under the predominant type and discriminatory factor tests described in the Proposed Rule. For the purpose of the Technical Release, ABHW recommends that these payments be excluded from the measures initially included in the Technical Release as Relevant Data, as neither measure has a mechanism to incorporate these other payments. ABHW also notes that these non-fee-for-service payments generally comprise a relatively small proportion of total spending and, thus, despite adding significant complexity to both the qualitative and quantitative comparisons, would be unlikely to materially change the ultimate outcome regarding the impact on member access to covered services. If the Tri-Departments are interested in addressing value-based payment and non-fee-for-service payments not addressed in a benchmark fee schedule, ABHW recommends that any alternative measures be subjected to validation and reliability testing and proposed for public comment.

F. ***Is the National Medicare Fee Schedule helpful to compare reimbursement rates, and if not, why not?***

A. Among the available options for a reference fee schedule, the Medicare fee schedule is a commonly used basis that is produced according to a public and data-driven process. However, there are a number of limitations to using the Medicare fee schedule as the reference for preparing an allowed-to-benchmark ratio. In particular, the Medicare fee schedule is subject to regular political intervention by Congress in its year-over-year updates. Second, as increased amounts of Medicare expenditures go through Medicare Advantage and value-based payment programs in Original Medicare, the fee schedule no longer serves as a true reflection of Medicare reimbursement for a majority of the country. In addition, there are important levels of care, especially MH/SUD services like residential addiction treatment, that are not eligible providers under Medicare and, therefore, do not have a fee schedule. For these reasons, ABHW suggests that the FAIR Health fee schedule may serve as a more useful reference point, as it is a reflection of commercial rates across the country (the reference population for the Tri-Department regulations) and includes reference rates for the full range of MH/SUD and M/S services.

G. ***How should the evaluation of reimbursement rate data requirements take geographic area into account? How should the Tri-Departments define geographic areas? Should the Tri-Departments do so in a manner that is consistent with other data elements described in this document?***

A. ABHW recommends that geographic service area and variations by geography be addressed by each issuer in response to investigations of the results of the measure in their specific circumstances. As such, ABHW does not believe that the Tri-Departments need to define geographic service areas or take them into account in the technical specifications for the metrics. As noted above, ABHW recommends that the Tri-Departments allow for aggregation of data to the book of business that utilizes the same network and network management activities. ABHW recommends that the Tri-Departments take a consistent approach to the geographic area across all Relevant Data metrics.

H. ***Should the Tri-Departments require plans and issuers to collect and evaluate relevant reimbursement rate data from the two most recent and complete calendar years that ended at least 90 days prior to the start of the plan or policy year during which the request for a comparative analysis was made? Should the Tri-Departments consider a different look-back period?***

A: ABHW does not have concerns about the look-back period proposed, provided that the data aggregation suggestions presented above are adopted.

I. ***What data, if any, would be analogous to reimbursement rate data for plans that do not utilize a set schedule of reimbursement rates? If there are no analogous data, would the other relevant data described in this document for NQTLs related to network composition meaningfully reflect whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does***

not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?

A: Plans and issuers that do not use a set schedule do not utilize the NQTL type contemplated by the Technical Release. It would be inappropriate to require the use of these metrics for plans or issuers that do not use these NQTL types. That being said, it is also difficult to answer the question without a clear understanding of what the Tri-Departments mean by this NQTL type absent a definition.

J. ***Are there other plan designs that may need additional guidance or alternatives for the relevant data comparing reimbursement rates that a plan or issuer would be required to collect, evaluate, and include as part of its comparative analyses for NQTLs related to network composition?***

A: ABHW has not identified any such plan or benefit designs.

K. ***Are there ways in which reimbursement rate data are susceptible to manipulation that could create the appearance that plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits when that is not the case?***

A: The use of an external benchmark (such as Medicare or FAIR health negotiated allowed amounts) for the same service (to the extent that the benchmark source covers the service) would not generally be susceptible to manipulation.

L. ***What terminology is important for the Tri-Departments to define precisely to facilitate the collection and evaluation of [reimbursement rate] data?***

A: The most important gap is a lack of any definition of the NQTL type(s) that is/are of interest to the Tri-Departments here. In addition, guidance will be necessary on the exclusions of invoiced and other non-fee-for-service expenses and retrospective recoupments/offsets, among other technical specifications for the calculation of the paid-to-benchmark ratio. As mentioned above, ABHW advises against using the CPT code comparison metrics.

M. ***Which existing models or methodologies (including, but not limited to, those in the Appendix) should the Tri-Departments consider when specifying the reimbursement rate data that plans, and issuers would be required to collect and evaluate as part of their comparative analyses for NQTLs related to network composition? If there are existing methodologies, what are the advantages and disadvantages of those methodologies?***

A: As noted above, ABHW recommends the use of an external benchmark (such as Medicare or FAIR health negotiated allowed amounts) for the same service (to the extent that the benchmark source covers the service) as a reference for assessing the percentage paid across each classification of benefits. Although the Medicare fee schedule is a commonly used basis for

comparison, ABHW suggests that the FAIR Health fee schedule may serve as a more useful reference point, as it is a reflection of commercial rates across the country (the reference population for the Tri-Department regulations) and includes reference rates for the full range of MH/SUD and M/S services.

V. Overarching Questions

A. *What challenges would plans and issuers face in providing the data elements the Tri-Departments are considering requiring? Are there ways to mitigate those challenges? How can the Tri-Departments best assist plans and issuers with obtaining the necessary data from TPAs and other service providers?*

A: As noted above, ABHW is not able to fully analyze the impact of providing the data elements considered in the Technical Release due to the multiple domains of uncertainty on material technical details. Some of the potential measure concepts floated in the Technical Release would be impossible to implement, while others would allow for a simplification of the process compared to current cross-market variability. However, the actual impact and challenges will need to be assessed in a follow-up Request for Information (RFI) or a future notice-and-comment rulemaking process about actual proposed measures.

B. *Do any of the data elements potentially require information technology system changes or builds? If so, what would be the estimated cost, and what would be a reasonable timeline by which those changes or builds could be modified or created?*

A: As noted above, ABHW is not able to fully analyze the impact of providing the data elements considered in the Technical Release due to the multiple domains of uncertainty on material technical details. Some of the potential measure concepts floated in the Technical Release would be impossible to implement, while others would allow for a simplification of the process compared to current cross-market variability. One specific challenge with using Medicare as a benchmark for service pricing comparisons is that certain key MH/SUD services are not currently reimbursable by Medicare. Benchmarking to Medicare is also challenging for inpatient and facility-based services that are priced at the provider level based in part on provider costs—many plans and issuers do not have the technical capability to determine the Medicare-allowable amounts for their commercial claims for these providers in order to calculate their commercial reimbursement rates as a percentage of Medicare. However, the actual impact and challenges will need to be assessed in a future notice-and-comment rulemaking process about actual proposed measures.

That being said, certain measures hypothetically floated in the Technical Release would certainly require massive investment by plans and issuers. For instance, if the Tri-Departments proceed with finalizing a national reference set of time and distance standards without regard to other applicable requirements, this would require a major investment and duplicative systems development.

C. ***What would be a sufficient period of time to allow plans and issuers to establish data collection systems and collect the data outlined above to meet the requirements of any future guidance?***

A: As noted above, ABHW is not able to fully analyze the impact of providing the data elements considered in the Technical Release due to the multiple domains of uncertainty on material technical details.

The profound complexity of the elements of the Proposed Rule has already led ABHW to request a delay in the implementation deadline of any finalized regulations to January 1, 2026. The final consideration on implementation of Relevant Data requirements would be dependent on many of the details of the Proposed Rule.

D. ***In addition to aggregate data described above, should the Tri-Departments also require plan-level data or product-level data for any of the data elements described above (including reimbursement rates)? If so, for insured plans, should the data for this data collection be provided at the plan or product level (as the terms product and plan are defined in 45 CFR 144.103)?***

A: ABHW supports the data aggregation proposal in the Technical Release and would oppose any requirement to analyze provider network adequacy and reimbursement data at the plan level, given that the underlying strategies for developing and monitoring provider networks are almost always designed at the market level and rarely differ by plan or by-product in any material way. Furthermore, ABHW members find that plan-level or product-level data is frequently not statistically valid, which undermines the purpose of collecting data.

E. ***What additional or different data elements should the Tri-Departments consider including in the comparative analysis data collection and evaluation requirements that are relevant when analyzing NQTLs related to network composition for operational compliance? What additional or different data elements should the Tri-Departments include to ensure that a plan has a comparable network of MH/SUD providers relative to M/S providers? Specifically:***

1. Are plans and issuers currently collecting data in each of the categories described in this Technical Release? If not, are plans and issuers presently collecting other data that provide insight into the issues described in this Technical Release that could be used in lieu of or in addition to the data elements that are not already collected?

A: ABHW members collect a wide variety of data for the purpose of MHPAEA compliance, and we have provided reference to some of those metrics within our responses to the questions above.

2. Do plans and issuers have access to data showing the percentage of providers in relevant service areas and categories that participate in the plan's or coverage's network of providers? Do plans and issuers make representations

as to the percentage of providers in their respective market who participate in their networks?

A: ABHW members have explored the possibility of evaluating the relative share of licensed practitioners and facilities in each geography that hold network contracts. Unfortunately, ABHW members have not identified any database or directory that would identify all licensed providers in a given area, and ABHW members do not make representations to the public as to the percentage of providers in the market who are in-network.

One alternative measure that ABHW members have explored is to analyze the number of providers within the plan's geographic area in each classification that hold a network contract as a percentage of all Medicare-enrolled providers in that geographic area and classification. One indicator of the reliability of this measure is the very high proportion of providers across specialties that participate in Medicare. An alternative approach is to analyze the number of participating providers as a relative share of all providers that have submitted claims to the plan network administrator (at the market level, not the plan level) within the past five years (or a comparable look-back period). This measure is reasonable given that it reflects the pool of providers that the plan's members have demonstrated that they want to see.

3. Do plans and issuers that contract with facilities currently have reasonable methods to determine the number of MH/SUD and M/S providers that participants, beneficiaries, and enrollees can access through those contracted facilities?

A: ABHW members all maintain provider network registries in multiple formats and provide personal assistance through call centers and care managers to help members access contracted providers and facilities. ABHW members do not generally have existing methodologies to determine the number of individual MH/SUD and M/S practitioners that may be seen or accessed through contracted facilities, and note that a number of data-matching challenges may arise from any attempt to do so. ABHW cannot fully respond to this question without better understanding the reason why regulators would wish to determine the number of practitioners associated with a given contracted facility.

4. Do plans and issuers currently calculate provider-to-member ratio data?

A: Many ABHW members currently calculate provider-to-enrollee ratios as a part of network management, state licensure, and health plan accreditation.

5. What types of providers and geographic areas do plans and issuers use to calculate and report the categories of data mentioned in this guidance?

A: ABHW members utilize the provider categories and geographic territories mandated by applicable regulators of network adequacy, accreditors, or, in the absence of the above, for specific employer sponsors on a case-by-case basis.

F. ***What data currently collected by States (including, but not limited to, those in the Appendix) is particularly useful to demonstrate parity in how plans and issuers establish provider networks and show that NQTLs related to network composition applied to MH/SUD benefits are comparable to, and are applied no more stringently than, such NQTLs applied to M/S benefits, or demonstrate the comparability of plans' and issuers' MH/SUD networks as compared to their M/S networks?***

A: ABHW has identified a number of specific recommendations above for examples of data collection. Further, ABHW has provided suggestions for needed guidance and recommendations on reasonable and useful approaches currently in use.

G. ***How should the Tri-Departments control for differences in specialties and subspecialties that exist between M/S providers and MH/SUD providers with respect to the data elements above? What level of specificity should the Tri-Departments provide with respect to the data elements and standards?***

A: As discussed above, ABHW recommends that the Tri-Departments align their oversight and collection of data to the classification approach that is the bedrock of MHPAEA's other tests and requirements, as that system is designed specifically to address and avoid the issues associated with defining comparable provider types.

H. ***How should the Tri-Departments define "in-network" and "out-of-network" in the context of these data requirements?***

A: ABHW recommends that the Tri-Departments defer to the plan or issuer to define these terms in accordance with the terms of the health plan. However, if the Tri-Departments intend to define these, ABHW recommends using industry-standard terms and soliciting public comment on the identified definitions.

I. ***Would the use of the data standards for the potential enforcement safe harbor create perverse incentives that could hinder, rather than promote, MHPAEA's objectives?***

A: For some plans and issuers, the proposed focus on data standards related to provider reimbursement may increase MH/SUD provider reimbursement without materially enhancing network participation rates. This may occur for plans that already have very widespread participation by MH/SUD providers in the network and/or where moderate changes to reimbursement rates are not material to decisions by many non-participating MH/SUD providers about whether to join the network. In these circumstances, the increases to MH/SUD reimbursement rates will increase out-of-pocket costs for members seeking MH/SUD services (including coinsurance and pre-deductible costs) that may deter some patients from seeking medically necessary MH/SUD care without necessarily delivering any additional value to plan enrollees.

The proposed focus on the proportion of network providers actively submitting claims may create perverse incentives for provider network administrators to terminate providers that are not

currently serving a significant volume of plan members but might otherwise provide value to plan enrollees in the form of additional network capacity (especially in areas with fluctuating service demand) and/or specialization or cultural competencies that are infrequently sought but would be useful when needed and also diminish the range of choices available to a patient seeking a new provider. The incentive for health plans to terminate infrequently used providers also creates an unnecessary administrative burden for these providers due to the churn of having to seek to be re-credentialed and execute a new participation agreement as soon as it becomes practical to do so.

J. ***How should the Tri-Departments account for MH/SUD or M/S professional or facility shortage areas or other external factors when designing the type, form, and manner of these data elements and the standards to qualify for the enforcement safe harbor?***

A: As discussed above, ABHW recommends that the results of any Relevant Data metrics be treated at most as an obligation to investigate the underlying causes of the data to determine if it is the result of an underlying discriminatory aspect of the NQTL. As such, any disparities in the Relevant Data that are the result of a shortage area or external factor would be identified as such in this investigation. This presumes that the results of Relevant Data analyses would not be used as a *per se* basis for a non-compliance finding. Specifically with regard to geo-access standards and related measures of network adequacy, regulators should conclude that an apparent data disparity due to a provider shortage or other external factors related to the supply of MH/SUD providers in an area does not indicate non-compliance where the plan has made reasonable efforts to contract with any available providers in the area and/or where the plan demonstrates that no provider is available to contract with.

K. ***How should the Tri-Departments account for regions or specialties where the care is typically provided by one dominant health care system, as compared to small practices and solo practitioners, for any or all of the data elements and standards?***

A: If the question is intended to anticipate how a plan or issuer should address a dominant system that refuses to contract with a plan or demands exorbitant reimbursement rates as a condition of contracting and distorts the data, ABHW recommends the same approach described in the prior question (i.e., that the results of any Relevant Data metrics be treated at most as an obligation to investigate the underlying causes of the data to determine if it is the result of an underlying discriminatory aspect of the NQTL).

L. ***How can the Tri-Departments better specify the data, or the required statistical analysis, on these data elements plans and issuers would be required to collect and evaluate as part of their comparative analyses for NQTLs related to network composition?***

A: ABHW has provided specific recommendations associated with each measure concept above. ABHW recommends further discussion, validation and reliability studies, and notice-and-comment rulemaking prior to the adoption of any metric for the purpose of the Relevant Data analysis.

M. ***Should the Tri-Departments require plans and issuers to utilize any particular format in including these data elements and standards? Are there particular templates that plans and issuers currently use and could rely on?***

A: ABHW members collect a wide variety of data for the purpose of MHPAEA compliance, and we have provided references to some of them within our responses to the questions above.