



September 27, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Lisa M. Gomez
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20002

The Honorable Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
U.S. Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Comments on Technical Release 2023-01P Relating to Plans' Required MH/SUD Data Collection

Dear Secretary Becerra, Assistant Secretary Gomez, and Deputy Commissioner O'Donnell;

The National Board for Certified Counselors, Inc. and Affiliates (NBCC) appreciates the opportunity to comment on the Department of Health and Human Services, Employee Benefits Security Administration, and the Internal Revenue Service's (the "Departments") Technical Release 2023-01P, Request for Comment on Proposed Relevant Data Requirements for Non Quantitative Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act (hereinafter "Technical Release").

NBCC is the certification organization that provides national certification and the nationally normed examinations for state licensure for counselors. Our affiliate, the NBCC Foundation, leverages the resources of NBCC and Affiliates for capacity-building to expand mental health services in traditionally underserved and never-served communities, administers the Minority Fellowship Program (MFP) for counselors, provides community capacity grants, and facilitates community-based mental health education and stigma-reduction programs. NBCC maintains standards and processes that ensure

that counselors who become nationally certified have achieved the highest standard of practice through education, examination, supervision, experience, and ethical guidelines. Established as a not-for-profit, independent certification organization in 1982, NBCC has decades of commitment to expanding access to and utilization of mental and behavioral health services in communities across the globe. NBCC provides the examinations used for professional counseling licensure by all 50 states, Puerto Rico, Guam, and the Virgin Islands. These examinations include the National Counselor Examination (NCE) and the National Clinical Mental Health Counseling Examination (NCMHCE).

We strongly support the Departments' proposed NQTL data collection requirements relating to network composition as part of the Departments' efforts to increase access to mental health and substance use disorder (MH/SUD) treatment. Such data collection is critical to ensure that plans and issuers do not impose treatment limitations that place a greater burden on plan members' access to MH/SUD treatment than to medical/surgical (M/S) treatment. Combined with the accompanying proposed requirements related to the Mental Health Parity and Addiction Equity Act (MHPAEA), the data collection requirements that are envisioned in the Technical Release would be powerful steps in the right direction to increasing access to MH/SUD treatment. We urge the Departments to require that the data points for MH services and SUD services be separately collected, analyzed, and reported, consistent with MHPAEA statutory and regulatory requirements. Data should also be collected for M/S services to facilitate MHPAEA comparisons. We also urge the Departments to require that all data be collected, analyzed, and reported by age group, including children and adolescents, and by race/ethnicity (where possible). The Departments should also develop uniform definitions and methodologies for the collection of all data points so that valid data are collected and can be compared across plans/issuers.

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

Our full comments are as follows.

Out-of-Network Utilization

Studies indicate that the percentage of services received out of network (OON) is a key indicator of the availability of in-network services. Due to the higher cost-sharing of OON services, individuals rarely choose to obtain care OON if adequate in-network services are available on a timely basis. The Milliman Report demonstrates the importance of such data and how frequently MH/SUD care is obtained OON compared to M/S care. The data should be disaggregated by age groups, so that utilization by children and adolescents can be distinguished from adults. This is particularly important given that half of lifetime mental health conditions begin at age 14 and our country's ongoing youth mental health emergency.

Percentage of In-Network Providers Actively Submitting Claims

Research studies indicate that collecting this data is critically important to determining the adequacy of a network. Plans/issuers frequently pad their networks by having providers listed as in-network even if they aren't actively submitting claims. This metric can also be important in suggesting the

existence of other reasons why providers listed as in-network might not be available, including low reimbursement that incentivizes providers to fill appointments with patients with insurance that pays more and/or cash-pay patients. Again, this data should be disaggregated by children and adolescents. While we welcome the Departments' reference to child psychiatrists and psychologists, all types of mental health providers, including counselors, should be included.

Time and Distance Standards

We strongly support the Departments' suggestion that the Departments collect detailed data on the percentage of participants/beneficiaries/enrollees who can access specified provider types in-network within a certain time and distance. We strongly agree with the Departments' view that this data would help with the assessment of a plan/issuer's operational compliance with respect to any NQTLs related to network composition. We also recommend that the Departments collect data on appointment wait times, which are an essential metric to measure network adequacy and the most critical for participants/beneficiaries seeking timely access to care. The Department of Health and Human Services has already put forward strong proposed standards for Medicaid-managed care and the Children's Health Insurance Program that establish maximum appointment wait time standards for routine outpatient MH/SUD services of 10 business days and require such independent secret shopper surveys. These standards align with appointment wait time metrics that have been adopted for Qualified Health Plans.

In collecting data, the Departments should collect data on routine and crisis appointments, including for follow-up and ongoing care. When only initial appointment wait times are measured, plans/issuers can manipulate their practices to have initial "intake" appointments while having long delays in the delivery of ongoing services. Data should be disaggregated by age group to assess wait times and travel distance for children and adolescents.

Network Availability and Distribution of Professions

We applaud the Departments for focusing on whether providers are accepting new patients (Section (iv)(2)), which is a crucial issue in light of the high demand for MH/SUD services. Given that demand, we think that it is important to add a "limited availability" category based on our understanding that few MH/SUD providers have broad availability. A MH/SUD provider with just a few time slots available does not add significant capacity to plans/issuers' networks.

It is also important to require metrics on the number of available providers who fill high-demand needs in the network, such as those seeing children and adolescents, those who specialize in care for LGBTQ patients, and those who meet the language needs of the population served by the network. While the service utilization metrics in these same categories would address how much certain services are being utilized, it may be that while there is a reasonable level of, for example, eating disorder services provided by network providers, those providers may be completely full. Thus, it is also important to assess whether new patients with these specialized needs can find available providers, such as counselors. A robust network has a full range of different professions and training levels to handle the varying needs and more complex problems of the patient population. Thus, we recommend gathering data (on both the MH/SUD and M/S sides) on the percentage of the top 10 different professions that make up the network.

Network Admissions

In assessing network composition and access to MH/SUD services, we urge the Departments to review the criteria and processes by which plans/issuers determine which providers to admit into networks and/or how plans/issuers define when a network is considered “full” or “closed.” Reports from MH/SUD providers suggest that they are often denied participation in networks due to the networks being “closed” or “full,” even though patients are unable to find appropriate providers in that network. Other providers who are eventually admitted into networks report having to wait as long as 9 months to be added.

Plans/issuers should not be allowed to claim a workforce shortage as a reason for access to care issues and simultaneously keep networks locked or slow to accept new providers. Collection of information about processes and criteria will reveal how much responsibility plans/issuers bear for the lack of access to MH/SUD services. For example, plans/issuers should provide metrics on how many providers applied to the network, what percentage were rejected, the reasons for the rejection (e.g., network full, provider not qualified), and the time it takes to bring providers into the network from when they first apply).

Reimbursement Rates

We applaud the Departments’ suggested data collection relating to reimbursement rates, which are critical determinants of network adequacy; many studies show the strong correlation between network access and reimbursement rates. We also commend the Departments for requiring reimbursement rate data to be “compared to billed rates.” These rates also profoundly affect the availability of MH/SUD providers longer term, as potential providers make decisions on whether to enter the field based in part on compensation. We strongly recommend the Departments evaluate the ratio of paid in-network amounts to OON billed market rates for MH/SUD and M/S. The billed rates of OON providers are the most accurate representation of the market rate.

Aggregate Data Collection

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

Service Utilization Data

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

- Service utilization by MH/SUD diagnoses
- High-demand needs such as services for children and adolescents
- Coordinated Specialty Care

Safe Harbor

The Technical Release also requested feedback on the potential of a “safe harbor” for NQTLs related to network composition. We urge the Department not to proceed with a safe harbor at this time. We understand the desire to most effectively target the Departments’ enforcement resources. However, network adequacy has always been difficult to define and easy to mismeasure. Thus, a safe harbor has the potential to be harmful if the data collection requirements are not capturing a full and complete picture of participants/beneficiaries’ access to MH/SUD services. Given the significant work that the Departments need to do—and likely refinements that are necessary over time—to ensure collected data is complete, accurate, and meaningful, a safe harbor should not be considered in the near future. Such a safe harbor should only be considered when the Departments and key consumer stakeholders are confident that the data collected accurately captures actual access to MH/SUD services. If a safe harbor is put in place prior to this occurring, it could cause enormous damage by giving noncompliant plans/issuers a “safe harbor” against accountability. Furthermore, an issuer residing within such a “safe harbor” would almost certainly escape meaningful oversight from any applicable state authority.

Meaningful Data and Preventing Data Manipulation

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

Disaggregating MH and SUD Data

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

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Kylie Dotson-Blake at NBCC at dotson-blake@nbcc.org.

Sincerely,



Kylie Dotson-Blake, PhD, NCC, LCMHC
President and CEO
National Board for Certified Counselors, Inc. and Affiliates