January 25, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments on HHS Notice of Benefit and Payment Providers for 2023 (CMS-9911-P)

Dear Administrator Brooks-LaSure,

We are leading national health and mental health and substance use disorder advocacy organizations writing to provide comments on the network adequacy standards as proposed in the HHS Notice of Benefit and Payment Providers for 2023 and detailed in the 2023 Draft Letter to Issuers in the Federally-facilitated Exchanges.

We want to begin by applauding CMS for setting national standards for network adequacy, including appointment wait times and strong geographical travel time and distance metrics for outpatient clinical behavioral health professionals. Adequate behavioral health provider networks will be vital to addressing the unprecedented levels of anxiety, depression, substance use, and overdose deaths.[1] Recent reports have documented the need to strengthen these standards to achieve appropriate and equivalent access to mental health and substance use disorder care, and our organizations are deeply grateful to CMS for responding and recognizing the power of national standards to drive meaningful change in this critical area.[2]

Our recommendations to further improve standards and oversight fall into the following nine areas:

1. CMS should require that Qualified Health Plans have sufficiently available providers and treatment facilities for both substance use disorder and mental health care and that metric compliance is tracked separately for those two conditions.

2. Qualified Health Plans should ensure that they have adequate networks to provide pediatric mental health care and pediatric substance use treatment services as well as adult services.

3. We support and are grateful for the increase in percentage of essential providers that must be part of contracts and the inclusion of substance use disorder treatment centers in the category of Other ECP providers, and we urge CMS to retain these provisions. In addition, CMS should examine network provider shortages in low-income and predominantly BIPOC communities, and increase the ratio of required Essential Community Provider contracts as needed to adequately serve all neighborhoods.

4. We support and are grateful for the addition of the appointment wait time standards. We urge you to strengthen requirements for timely access to mental health and substance use conditions by creating a metric for urgent and emergency services, in addition to the proposed non-urgent Behavioral Health Services metric.

5. We urge the adoption of standards for minimum numbers of participating providers, in addition to time/distance and appointment wait time standards for QHPs. Beyond meeting the minimum standards, plans should also be required to disclose the actual number of participating providers of mental health and substance use disorder treatments.

6. We have some concerns about whether the five county type designations for geographical travel time and distance will allow for sufficient granularity in some states, and ask that you monitor these for possible future refinement.

7. We urge CMS to develop procedures to monitor compliance at the start of a plan year, on an ongoing basis, and in response to complaints. We further urge CMS to develop remedies when 90 percent of a plan's enrollees do not have access within network standards.

8. Consumers need a clear remedy when they cannot access an in-network provider within travel time and distance or appointment wait time standards. Research has demonstrated that patients access mental health and substance use disorder care from out-of-network providers at a disproportionate rate compared to other medical services.[3] To ensure affordable access to this essential health benefit, plan members must be allowed to go to a non-participating provider at no greater cost than seeing an in-network provider. This should be reflected in regulations, guidance, and consumer education materials.

9. CMS should consider setting standards that encourage integrated primary and behavioral health care in the future, as well as encourage the inclusion of behavioral health support by trained peers and by community health workers.

Finally, we note that most of the proposed standards and compliance measures are in guidance rather than the regulations themselves. After an initial year of experience with these standards, we urge CMS to incorporate more of them into the regulations, where they will be subject to notice and comment and easily accessible to consumers and regulators.

We further describe our recommendations below.

1. Travel time, distance, and appointment wait time standards should require sufficient availability of substance use disorder treatment providers, as well as sufficient availability of other behavioral health care providers.

We support the inclusion of specific metrics for mental health and substance use disorder providers in the travel time and distance and appointment wait time standards. We are particularly supportive of the quantitative values required for travel time/distance for Outpatient Clinical Behavioral Health professionals. Conforming those values to the time/distance values for Primary Care (adult and pediatric) providers appropriately reflects that many patients with mental health and substance use conditions rely on their behavioral health provider as their "primary care" practitioner and enter the health care system through those providers. The relatively short travel time and distance values also recognize the dire need for readily accessible outpatient therapeutic services and should incentivize QHPs to expand provider networks for these services. Similarly, the discrete appointment wait time value for Behavioral Health highlights the urgent need for care and delivery system reform.

We are concerned that, as currently drafted, the travel time and distance standards could allow insurers to meet network adequacy standards if they had sufficient psychiatrists, psychologists, and licensed mental health providers located within specified travel time and distances for 90 percent of enrollees, even if they did not have addiction providers within those travel and distance standards. (For appointment wait time standards, a plan could meet the proposed behavioral health standard of 10 calendar days if 90 percent of the time it met the standard even if the plan failed to provide 90 percent of substance use disorder appointments within 10 days.) We urge CMS to ensure adequate access to substance use disorder services and, in future rules, include additional specialties for both mental health and substance use disorder providers, recognizing that a range of outpatient community-based services are not captured by either the individual specialty or facility types. Deaths due to drug overdoses skyrocketed in the last few years, reaching 101,263 predicted deaths for the 12 months ending June 2022, the highest on record, and disproportionately affected many people of color.[4] Of the people who reported a SUD in 2019, only 10 percent reported receiving care and 24 percent reported not knowing where to seek services; 2020 data indicated continued and worsening problems with access to treatment.[5]

Addiction medicine is a specialty area, and not all behavioral health treatment centers or mental health professionals are trained or certified to provide addiction services. A few states recognize this in their network adequacy standards. New Jersey requires 90 percent of covered persons to have access to residential substance use treatment within 45 miles or 60 minutes driving time.[6] New Hampshire has set time and distance standards for core, common and specialized addiction services defined as follows: "Core services include: alcohol or drug treatment in ambulatory setting for crisis intervention, detoxification or medical or somatic treatment; assessment, case management, group counseling, IOP, methadone or equivalent treatment, subacute detox, medication training and support, BH or SUD comprehensive community support services, BH or SUD comprehensive medication services, BH counseling or therapy, BH partial hospitalization, BH short-term residential. Common services include general psychiatric care on inpatient basis, psychiatric diagnostic evaluation with medical services;

specialized services include alcohol or drug acute detox." New Hampshire requires behavioral health services to be available in non-life-threatening emergencies within 6 hours and in urgent situations within 48 hours.[7] We urge CMS to set travel time, distance, and appointment wait time standards that examine the adequacy of networks of substance use disorder treatment providers separately from networks of mental health providers, to ensure the network is adequate to deliver the full range of covered behavioral health services.

CMS asks for input on how to ensure health equity. We strongly recommend that plans be required to submit data by race and ethnicity on the population living in geographic areas that do not have access to providers within travel time and distance standards. Particularly in underserved areas that are primarily BIPOC, plans should submit plans to address the provider shortages, such as by contracting with more essential community providers.

2. Qualified Health Plans should have adequate pediatric mental health and substance use disorder networks.

As currently drafted, the proposed standards do not examine the number of behavioral health providers serving children and adolescents. The regulations and letter to issuers should both require that plans can meet travel time, distance, and appointment wait standards for pediatric mental health and substance use disorder care. Absent adequate networks in QHP and other private health plans, families frequently seek to enroll their child in Medicaid, which in many states offers more comprehensive behavioral health benefits.

COVID-19 has been particularly hard on youth with significant increases in anxiety and depression as well as emergency room use. Networks are particularly inadequate for youth seeking mental health and substance use disorder care. For example, child and adolescent psychiatrists are very difficult to access in-network with some describing them as "unicorns." A map of child and adolescent psychiatrists per 100,000 population shows that virtually the entire country is in an acute shortage area.[8] If HHS's goal is to ensure that everyone has access to services, it should recognize the significant differences and even more acute shortages in behavioral health services for youth and require separate reporting of the standards for that population.

3. CMS should further modify the standards to ensure sufficient provider availability for neighborhoods that are predominantly low-income and/or predominantly BIPOC.

We support and are grateful for the increase in percentage of essential providers that must be part of a contract and urge CMS to retain this new standard. In addition, as stated above, QHPs serve large numbers of people with incomes under 200 percent of FPL, as well as many enrollees who are Black, Indigenous, and People of Color (BIPOC). These are populations that experience a disproportionate need for behavioral health services, and frequently rely on essential community providers to access care. HHS

proposes that for PY 2023 and beyond, the required ECP provider participation standard be raised from 20 percent to 35 percent of available ECPs based on the applicable PY HHS ECP list. We generally support this proposal, and propose some modifications to better ensure that QHPs, especially those who have low-incomes and those who are Black Indigenous and People of Color (BIPOC), have full access to essential health benefits.

First, we recommend that HHS add a requirement that QHPs demonstrate that they can meet the 35 percent participation threshold for each ECP category, rather than across all types of ECPs. The current measure lumps all of the ECP types together, which could easily result in an uneven distribution of ECP types within a plan's network that hinders access to care. To this end, the 35 percent threshold should also be applied to each of the ECP types that fall within the category of "Other ECP Providers," since these provider types are quite different -- someone seeking substance use disorder or mental health services, for example, is unlikely to receive adequate service from a hemophilia treatment center.

Second, HHS also seeks feedback on whether it should define the category of "Other ECP Providers" in the regulatory text. We urge HHS to do so, and support the addition of "Substance Use Disorder Treatment Centers" to this category.

Finally, we support the amendments to require QHPs with tiered networks to meet the ECP threshold in the lowest cost-sharing tier. We also support the current regulatory text that treats multiple providers at a single location as one ECP. These are important clarifications that will ensure that low-income, BIPOC, and other underserved populations have access to the care they need.

4. Standards for minimum numbers of providers are also necessary.

While time-distance standards and appointment wait times offer a measure of access proximity and provider availability, they do not measure network adequacy. For example, in a large metro area that is 40 miles square and where millions of people reside, a health plan could satisfy time-distance standards by contracting with just a handful of centrally-located providers. It is also important to require plans to contract with a minimum number of qualified and available providers to assure access and reasonable choice for enrollees.

Meaningful standards for minimum numbers of providers for a contract period must take into account the estimated number of plan enrollees and estimates of enrollee care needs, among other factors.

While such standards are being developed, we also urge CMS to require QHPs to disclose the actual number of contracted providers (both individual professionals and facilities) offering outpatient mental health and substance use treatment services. Numbers should disclose providers by their specialty designation and whether they offer

adult or pediatric services. These simple data points will help CMS identify plans based on overall size of MH/SUD provider networks and can inform oversight. Disclosure of provider numbers should also be made available to the public, including on HealthCare.gov.

5. Wait time standards for urgent mental health and urgent substance use care.

We appreciate that HHS has identified a "short list of critical service categories" to which appointment wait times should apply and would also set a 10-calendar day metric for behavioral health services. We recommend that HHS clarify that the 10-day metric applies to all appointments, not just the initial appointment, as carriers in some states seek to apply an appointment wait time metric to the initial appointment alone. Indeed, California just enacted legislation[9] to ensure all appointments are subject to its timely access standards after some carriers created "intake" appointments to meet standards for initial appointment times, while follow-up appointments were often unavailable for weeks and even months.

We also recommend that HHS add Urgent Care to this list to address conditions requiring immediate care, which are not emergency medical conditions, but are far more acute than conditions covered by the "routine" behavioral health services metric. The experience of people during the COVID-19 pandemic has highlighted the crucial role that Urgent Care centers provide in delivering care to people who need it quickly, especially those with urgent behavioral health needs, but whose condition does not rise to the level of an emergency, when other provider offices are not open.

In addition, HHS should consider setting wait time standards for in-office wait time and QHP customer service phone lines. Long wait times on the phone to set an appointment, or to see a provider once someone has arrived for their appointment, discourage people from accessing needed care, and this is especially true for many people with behavioral health conditions.

6. Consumers should have a clear complaints and appeals process if services are not available and accessible within reasonable appointment wait and travel time and distances.

The consumer's remedy if non-emergency services are not available within reasonable appointment wait times and distance requirements remains unclear in this regulation. If timely care is not available in-network, plans should make arrangements for members to see out-of-network providers. Consumers should be able to request authorization for out-of-network services in those instances (even in closed-network plans), and they should be able to contest failure to make such arrangements both by contacting regulators (per NAIC's model act)[10] and through filing external appeals. This should be explained in plan handbooks, consumer education materials provided on healthcare.gov, and on good faith estimates to self-pay patients. We request the addition of an example to the external appeals rule to clarify this.

Notice of appeal rights, while critical, will, all too often, provide an inadequate remedy for consumers with mental health and substance use disorders, who cannot wait for the resolution of a complaint to get life-saving care. QHPs should hold members harmless from out-of-network costs when they approve a member's request to access services from a non-participating provider based on an inadequate network. Seventeen (17) states[11] bar balance billing for non-HMO plans in this context, ensuring that the member pays no more than the in-network cost sharing. We urge HHS to adopt this standard, at a minimum, for mental health and substance use disorder services.

We strongly support HHS's proposal to require QHPs with tiered networks to meet the network adequacy standards in the lowest cost-sharing tier. To truly demonstrate that QHP networks are adequate, QHP issuers must be able to ensure that enrollees always have the option to use an in-network or first-tier provider for all covered services. At the same time, we urge HHS to also clarify that in any situation where a QHP network does not comply with network adequacy standards in its first tier, the QHP may not charge the enrollee more than the first-tier cost-sharing for seeing an out-of-network or higher tier provider. This protection is necessary to ensure that the promise of first-tier network adequacy is real.

Even the most robust networks will occasionally be unable to provide extremely rare and specialized services, and may experience times when providers are temporarily unavailable, which can result in enrollees' traveling further and waiting longer to access care. We have collectively lived out this phenomenon over the last three years as many regions have experienced ongoing health care provider shortages due to COVID impacts.[12] We urge HHS to make clear that, in these situations, QHPs must hold their enrollees financially harmless for seeking care from out-of-network or higher tier providers. The promise of network adequacy is gutted by an exclusion that allows consumers to be balance billed by higher tier or out-of-network providers whom they had no choice but to use. HHS has already imposed such a requirement on emergency services.[13] Similarly, the NAIC's Network Access and Adequacy Model Act includes provisions prohibiting insurers from charging excess cost-sharing when services are not available in-network, and several states have adopted similar provisions.[14] HHS should also make clear that, in these situations, QHPs have an obligation to affirmatively assist their enrollees in identifying an appropriate provider, and executing a single-case agreement if possible. Again, the NAIC Model Act would require plans to arrange for the provision of covered services by out-of-network providers when the service is not available in-network, as do several states.[15]

In addition, QHPs that are unable to meet geographic access standards should be encouraged to provide regularly scheduled or as-needed transportation from areas within a designated area to network behavioral health care providers, hospitals, and clinics, as necessary to ensure that such facilities remain reasonably accessible. Further, Exchanges should urge these QHPs to dispatch mobile health care vans to locations

within the designated area at regular scheduled times, at least quarterly, or more frequently if medically necessary.

7. CMS should monitor the county-type designations for time and distance standards to ensure sufficiently granular reporting in each state.

The proposed county-type designations for measuring time and travel distance are modeled on the Medicare Advantage network adequacy standards. We are aware that, based on population density and distribution in some states, the five designations may result in a disproportionate number of counties falling into just one or two of the county classifications and, thereby, set a very low bar for travel time/distance satisfaction with a minimal number of providers. In such cases, members would have limited access to mental health and substance use services and would have no leverage to require the inclusion of additional providers. We urge CMS to monitor whether the county designations are appropriate across the states to ensure meaningful provider availability.

The availability of telehealth services can help ease provider gaps in less urban and medically underserved communities and can help individuals with lower incomes gain access to care. Telehealth has been a lifeline to care for individuals with mental health and substance use disorder conditions during the pandemic, and higher rates of utilization will likely continue post-pandemic. We strongly support HHS's plan to collect data from QHPs regarding provider use of telehealth. We urge HHS to collect information on the utilization of both audio/visual and audio-only telehealth, as the latter platform is critical to ensure equitable access to services for lower income individuals, BIPOC communities, and people with limited technology literacy. For this reason, Medicare authorizes the use of audio-only telehealth for substance use disorder and mental health services as long as the provider has the capability to provider audio-visual telehealth services.

We also urge CMS to study the recently adopted Medicare telehealth credit system before adopting that standard for QHPs. In developing future standards, we strongly support HHS's admonition to carriers that telehealth cannot be offered in place of in-person services. As in the Medicare program, a telehealth visit should only be counted for satisfaction of network adequacy metrics if the member agrees to use a telehealth appointment.

8. CMS should monitor compliance at the start of a plan year, on an ongoing basis, and in response to complaints.

Plans should submit data at time of certification showing that they meet network adequacy standards. In addition, CMS should develop a robust, ongoing monitoring process:

a) CMS should develop a complaint hotline for consumers and providers to submit complaints about any lack of available providers. We understand from Consumer Assistance Programs that, since consumers seldom know about their rights to seek authorization to go out-of-network when an in-network provider is not available, complaints and appeals often emerge after the fact when consumers are billed for a service. Other providers who are seeking care for their patients are often the ones to complain, so a complaint hotline should be advertised to both patients and providers.
b) CMS should check the accuracy of provider directories by determining that the providers listed are submitting claims and by conducting secret shopper surveys to determine that providers are actually available to take new patients, and that access is timely. CMS should monitor mid-year changes in provider networks.
c) CMS should expand 1311(e) claims data collection regarding out-of-network services. Currently CMS requires QHPs to report data on submitted and denied in-network claims, but only claims denial data for out-of-network claims. Plans must be required to submit complete data on claims submissions and denials. In addition to summary claims data reporting, CMS should require QHPs to report on key services - including for mental health services and for substance use treatment services - to track the rate at which consumers seek such services out-of-network and the rates at which plans pay or deny such claims. CMS must also begin to use these health plan transparency data for oversight, scrutinizing any outliers for follow up investigations.
d) CMS should especially require plans to take action to remedy any Parity Act violations. We recommend that HHS require QHPs that submit a justification for not meeting travel time and distance or appointment wait time metrics for mental health and substance use disorder providers to include (as part of the justification) its analysis that demonstrates that its network admission and adequacy practices comply with the Mental Health Parity and Addiction Equity Act.[16] CMS should closely scrutinize plans' parity analyses to ensure they meet the requirements of the Consolidated Appropriations Act, 2021 amendments to the Parity Act, particularly given the glaring deficiencies of recently submitted parity analyses documented in the Departments' January 2022 report to Congress.[17] Provider shortages in mental health and substance use treatment networks may be an indicator that plans are not paying these providers at parity with physical health providers, have more stringent credentialing requirements for these providers, or more stringent administrative and utilization management requirements that deter some mental health and substance use providers from participating in networks.

9. CMS should consider setting standards that encourage integrated primary and behavioral health care in the future, as well as encourage the inclusion of behavioral health support by trained peers and by community health workers.

To reduce barriers to access, more efficiently leverage the health and behavioral health workforce, and to improve outcomes, we believe it is essential to move toward more

integrated and comprehensive models of physical and behavioral health care in community-based settings, including co-located primary care and behavioral health practitioners, use of consulting psychiatrists to advise primary care practitioners on appropriate treatment, and use of peer support services. We urge CMS to begin collecting data about use of these approaches in private insurance and use this data to help inform future standards and payment models that encourage integrated treatment in community-based settings. ASPE's November 2021 report, "Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing Standards," also recommends this.

Thank you for considering these comments. Please contact David Lloyd at david@thekennedyforum.org or Ellen Weber at eweber@lac.org if you wish to get in touch with us.

Sincerely,

Families USA
Inseparable
The Kennedy Forum
Legal Action Center
Mental Health America
National Alliance on Mental Illness
National Health Law Program

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[1] https://www.mhanational.org/research-reports/2021-state-mental-health-america.

[2] https://bipartisanpolicy.org/report/behavioral-health-2021/ and the Legal Action Center report, https://www.lac.org/resource/spotlight-on-network-adequacy-standards-for-substance-use-disorder-and-mental-health-services.

[3] Melek, S., Davenport, S. & Gray, T.J., Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement (Nov. 19, 2019), https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.

[4] https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#dashboard, based on data available for analysis on 1/2/2022; and https://www.kff.org/policy-watch/substance-use-issues-are-worsening-alongside-access-to-care/

[5] https://www.kff.org/policy-watch/substance-use-issues-are-worsening-alongside-access-to-care/, ibid.

[6] NJ AC 11:24A-4.10.

[7] N.H. Code Admin. R. Ins 2701.04-.10 (2010) Current through March. 1, 2020, as cited in https://www.lac.org/resource/spotlight-on-network-adequacy-standards-for-substance-use-disorder-and-mental-health-services.

[8] https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

[9] https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB221.

[10] The NAIC Network Adequacy Model Act provides for this under 5C, https://content.naic.org/sites/default/files/MO074.pdf. In states that have not adopted this model, enrollees should be able to contact the FFE for help with compliance.

[11] Arkansas (Ark. Admin. Code 054.00.106-5(C) (2014)); California (Cal. Health & Safe. Code § 1374.72(d) (2021); Colorado (Colo. Rev. Stat. Ann. 10-16-704(2)(a) (2020)); Connecticut (Conn. Agencies Regs. § 38a-472f-3(a) (2018)); Delaware (Del. Code Ann. tit. 18, § 3348(b) (2001), 18 DE ADC 1403-11.3.1.2); Hawaii (Haw. Rev. Stat. § 431:26-103(c)(1) (2019)); Illinois (215 Ill. Comp. Stat. § 124/10(b)(6) (2017)); Maine (02-031-850 Me. Code R. §7(B)(5) (2012)); Minnesota (Minn. Stat. § 62Q.58(4)(b) (2001)); Mississippi (Miss. Admin. Code 19-3:14.05(1) (2011)); Montana (Mont. Code Ann. § 33-36-201(2) (2003)); New Hampshire (N.H. Code R. Ins. 2701.10(b) (2018)); New York (N.Y. Ins. Law § 4804(a)); South Dakota (S.D. Codified Laws § 58-17F-6 (2011)); Tennessee (Tenn. Code Ann. § 56-7-2356(c) (1998)); Vermont (Vt. Code R. § H-2009-03(5.1)(K)(3) (2017)); and West Virginia (W.V. Code § 33-55-3(c)(1));

[12] *See, e.g.,* Scott Aronson et al., Off. Ass't Sect'y Preparedness & Response, *Healthcare Provider Shortages* (2021), https://files.asprtracie.hhs.gov/documents/healthcare-workforce-strategies-for-managing-a-surge-in-healthcare-provider-demand.pdf; Michael Dill, *We Already Needed More Doctors. Then COVID-19 Hit*, Am. Ass'n Medical Coll. (June 17, 2021), https://www.aamc.org/news-insights/we-already-needed-more-doctors-then-covid-19-hit.

[13] 45 C.F.R. § 147.138(b).

[14] Nat'l Assn. Ins. Comm'nrs, *Health Benefit Plan Network Access and Adequacy Model Act* § 5(C), https://content.naic.org/sites/default/files/inline-files/MDL-074_0.pdf; *see also* Ark. Admin. Code Rev. § 054.00.106-5(c); 19 Miss. Admin. Code Pt. 3, R. 14.5(A)(1); Mo. St. § 354.603; Neb. Rev. Stat. § 7105(1)(a);

N.H. Code Admin. R. Ins. § 2701.04(d); and S.D. Stat. § 58-17F-6.

[15] Nat'l Assn. Ins. Comm'nrs, *Health Benefit Plan Network Access and Adequacy Model Act* § 5(C), https://content.naic.org/sites/default/files/inline-files/MDL-074_0.pdf; *see also* Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(7)(B); Colo. Rev. Stat. Ann. § 10-16-704(2)(a); 50 Ill. Admin. Code § 2051.310(a)(6)(H)-(I); Wash. Admin. Code § 284-170-200(5).

[16] 42 U.S.C § 300gg-26(a)(8) requiring health plans to conduct and document annually compliance analyses for non-quantitative limitations and to submit the analyses to regulators upon request.

[17] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.