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October 17, 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**

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

On behalf of the more than 200 children's hospitals nationwide, we appreciate 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 Nonquantitative Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act*. (Technical Release). We 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 children and teens' access to MH/SUD treatment than to medical/surgical (M/S) 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 Mental Health Parity and Addiction Equity Act (MHPAEA) comparisons. In addition, the Departments should develop uniform definitions and methodologies for the collection of all data points so that valid data are collected and can be compared across plans/insurers.

We also urge the Departments to require that all data be collected, analyzed and reported by age group, including children and adolescents, by geographic area and by race/ethnicity (where possible). As you move forward on the

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establishment of those data requirements, we urge you to work closely with pediatric mental health experts to ensure that they adequately reflect those differences, so children and youth have true access to mental health services as promised under the MHPAEA.

The nation's children's hospitals are dedicated to advancing child health through innovations in the quality, cost and delivery of care—regardless of payer—and serve as a vital safety net for uninsured, underinsured and publicly insured children. We are regional centers for children's health, providing highly specialized pediatric care across large geographic areas.

While mental and behavioral health conditions can and do occur at any age, children and youth are uniquely vulnerable. Stigma, lack of awareness and inadequate access to resources can delay care by weeks, months or even years. Mental health disorders diagnosed during adolescence often arose years earlier during childhood.

The mental health challenges facing the nation's children continue to grow and our hospitals are seeing it firsthand in their emergency departments. Visits for youth suicide attempts have increased dramatically, eating disorder visits have doubled and we are seeing an increase in suicide rates for children and teens, with national data showing steeper increases among Black boys and girls under age 12. As essential providers dedicated to providing the highest quality pediatric care, addressing the children's mental health crisis is our top priority.

Tragically, far too many children are waiting for needed mental and behavioral health care and “boarding” in emergency departments until an appropriate placement becomes available. This is not limited to one state or one community—children in states across the country face similar challenges accessing the necessary mental health care to address their needs.<sup>1</sup> Fifty percent of all mental illness begins before age 14<sup>2</sup> and children often wait years between the appearance of symptoms and when they begin treatment, a delay that too often results in worsening conditions and outcomes. While the COVID-19 pandemic certainly contributed to the crisis in child and adolescent mental health, we know that this problem and its root causes, which includes inadequate and restrictive insurance practices and a lack of a youth-specific mental health care across the full continuum of service needs, predate the pandemic.

Our comments below focus on data that will inform the oversight of the adequacy of plan's pediatric mental health provider network across the continuum of services to help ensure that the MHPAEA meets its promise for the nation's children and youth.

### **Key Elements of Pediatric Provider Networks**

Children are not little adults and require in-network pediatric MH/SUD providers who have the specific expertise, capacity and experience to appropriately screen, diagnose, treat and connect them with supportive services in the community. However, in many parts of the country there is significant lack of access to specialty pediatric behavioral health providers, including providers that treat eating disorders, service providers for children and youth with substance use needs, and intensive in-home services, such as multi-systemic therapy and family functional therapy. Plan mental health provider networks that lack the full range of pediatric mental health providers puts families' financial well-being at risk and threatens children's long-term quality of life.

To assure children have access to the mental health care they need, provider networks must:

- Reflect children's unique developmental, social and mental health needs.

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<sup>1</sup> Ibid.

<sup>2</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), [Adolescent Mental Health Service Use and Reasons for Using Services in Specialty, Educational, and General Medicaid Settings](#), March 5, 2016.

- Not penalize the child and their family/guardian, through extra cost-sharing or administrative hurdles when that child must use an out-of-network provider.
- Meet a broad set of objective and measurable network adequacy standards that reflect the unique needs of children and youth, including those with complex needs.
- Assure access to providers for the full range of mental health services in the lowest cost-sharing tier of tiered networks.
- Include providers across the continuum of care, including prevention, intermediate levels of care, inpatient, crisis and community-based service providers, as well as providers that offer integrated mental health services in primary care settings.

We appreciate the Departments' commitment to ensuring that the data plans/issuers will be required to collect are an accurate reflection of enrollees' access to treatment.

Our detailed comments are below.

### **Out-of-Network Utilization**

We agree that the collection of data on out-of-network (OON) care is an important tool to evaluate the availability of in-network services and offer several recommendations that will help ensure that adequate data is collected on OON utilization by children and youth. The out-of-network data should be compared with wait-time and claims data to fully assess the impact of out-of-network utilization on access.

As noted above, all data should be disaggregated by age groups, so that utilization by children and adolescents can be distinguished from adults. In addition, the data should be disaggregated by race/ethnicity, as well as by the following:

- Geographic location of provider (e.g., urban, rural, etc.)
- Type of out-of-network service utilized (i.e., emergency department, hospital inpatient, hospital outpatient, partial hospitalization program, community-based clinic, individual child psychiatric service, individual counselling service)
- Out-of-state vs. in-state OON utilization, particularly for high-acuity services, such as residential treatment services, day programs or partial hospitalization and intensive outpatient services.

The collection of this data will provide key information about the extent to which plans' networks are not meeting the unique mental health needs of children and youth. In particular, children's hospitals have shared that children and youth often have to travel to other states far away from their families and communities to get needed care, which is OON. In addition, it is not uncommon for plans to exclude providers of intermediate levels of care, such as partial hospitalization programs, from their network. Having to go OON for those services can be major barriers that prevent children and teens from returning to their homes and communities after crisis or other more intensive care.

### **Percentage of In-Network Providers Actively Submitting Claims**

The percent of in-network providers actively submitting claims is an important tool to assess the adequacy of a network as it can indicate where a plan's provider directory includes providers that are not actually seeing in-network patients. To ensure that this data shows the full picture, it is vital that all data is disaggregated by children and adolescents versus adults, as well as by geography and race/ethnicity.

We appreciate that the Departments have included a list of the specific provider types for which claims data should be collected but urge you to include a broader list of providers with the expertise to treat infants, children and teens. Specifically, the full range of pediatric mental health providers, including social workers, counselors, and other types of providers who can care for children and teens with lower-level needs, in addition to child psychiatrists, psychologists and

developmental pediatricians, must be specified on the list of mental health providers for which data is collected. Furthermore, data should be collected by facility/service type, as it is not always the clinician who submits a claim. For example, for children it is critically important to assess whether inpatient claims are being submitted by pediatric inpatient and outpatient programs, primary care (including integrated primary care) settings, and intermediate levels of service providers, such as day treatment programs and intensive hospital outpatient programs. Additionally, data on M/S pediatric subspecialists and related facilities must be added to the lists (e.g., pediatric cardiologists, pediatric neurologists, etc.) for purposes of assessing parity.

Finally, we encourage the departments to require insurers to collect data on claims denials and claims processing timelines/delays. While not directly related to network composition, we know that complex claims procedures and related administrative hurdles are disincentives to providers joining networks. Comparisons of these processes with M/S claims procedures can be indicative of parity, or lack thereof, related to network composition NQTLs. Children's hospitals often face numerous challenges navigating health plan payment policies for MH/SUD services that are more complicated and restrictive than those imposed on M/S benefits. In particular, the administrative burden associated with medical management policies (such as prior authorizations), claims processes and approvals for care transitions, often do not exist to the same extent for coverage of treatment for physical health conditions. These additional requirements are time-consuming for providers to navigate and can lead to slower claims processing. We know that those administrative requirements and delays can be disincentives for providers to join a network, leading to key network gaps. In addition, they lead to delays in needed care for children.

### **Time and Distance Standards**

We support the Departments' proposal that plans collect detailed data on the percentage of enrollees who can access specified provider types in-network within a certain time and distance. For rural and frontier regions, this data should be based on road mileage rather than absolute mileage.

At the same time, it is critical to recognize that time and distance data will not give a full picture of children's access to needed services as it is not uncommon for children and youth to have to travel long distances or out-of-state for appropriate care, as noted earlier. Therefore, we urge the Departments to also require insurers to collect data on appointment wait times (including relative wait times between referrals and appointments) and ratios of contracted providers to enrollees in different regions, which are essential metrics to measure network adequacy and critical for children seeking timely access to care. Furthermore, the Departments should require data to be collected on routine and crisis appointments, including for follow-up and ongoing care.

The Centers for Medicare and Medicaid Services recognized the importance of using wait times to assess network adequacy in its proposed rule, "*Managed Care Access, Finance, and Quality*," ([CMS-2439-P](#)), which establishes maximum appointment wait time standards for routine outpatient mental health and substance use disorder services under Medicaid. The rule also acknowledges the differences between adult and pediatric services by requiring states to develop network adequacy standards for both pediatric and adult appointments in the area of outpatient behavioral health.

We believe the Departments should align with, and build upon, the CMS rule by requiring plan data to be disaggregated by age, geography, and race/ethnicity for each of the provider types for which data would be collected. Specifically, data collection requirements should clearly specify that pediatric-specific data should be collected for all types of child and adolescent providers and spell out those provider categories (i.e., psychiatry, psychology, outpatient therapy, family therapy, inpatient care, residential treatment, crisis response and stabilization, substance use disorder treatment providers, eating disorder providers and autism-spectrum disorder providers).

Furthermore, time and distance, wait time and provider/enrollee ratio data should also be collected for intermediate levels of care, including partial hospitalization, intensive outpatient services and day programs. Children's hospitals report

children's lack of access to these intermediate levels of care that can prevent hospitalizations and help children transition back home after more intensive treatment.

### **Reimbursement Rates**

We applaud the Department for acknowledging that lower reimbursement rates for MH/SUD providers contribute to the difficulty enrollees have finding in-network MH/SUD providers as compared to in-network M/S providers. We strongly support the collection of data related to reimbursement rates to allow for the evaluation of network composition NQTLs to determine whether those differences may signal that methodologies to determine reimbursement rates are not comparable between MH/SUD and M/S providers.

Rates of reimbursement have historically been lower for mental health services, particularly in pediatrics, leading to fewer providers entering the field – a significant barrier to care for children. Low rates contribute to challenges recruiting and retaining pediatric mental health providers, as potential providers make decisions on whether to enter the field based in part on compensation.

We also commend the Departments for requiring reimbursement rate data to be “compared to billed rates” rather than to Medicare rates. Medicare rates are not a meaningful basis for comparison when it comes to evaluating parity between MH/SUD and M/S services for children and adolescents since only a small handful of children are covered by Medicare<sup>3</sup>.

Furthermore, as we note above, it is critically important that data is collected on payment practices, including claims processing timelines/delays and other policies that may increase the financial and administrative burden on providers. For example, data should be collected on time to payment, complicated and differing claims submission requirements, different requirements and processes for different services that are covered by the same payer.

Finally, we encourage the Departments to require the collection of data on payment rates and processes for both adult and child-focused integrated mental health programs and other innovative care models. Unlike traditional models, pediatric-based mental health integration programs improve access to effective services for children and youth identified with mild and high-moderate behavioral health needs.

### **Additional Data Elements**

We encourage the departments to consider adding the following data collection requirements to help evaluate network composition NQTLs and determine if a plan has a comparable network of MH/SUD providers related to M/S providers.

- **Distribution of Professions**  
We recommend gathering data (on both the MH/SUD and M/S sides) on the percentage of each of the top 10 professions that make up the network. A robust network has a full range of different pediatric mental health professions and training levels as well as general mental health professionals who treat children's needs across the care continuum to handle the varying needs and more complex problems of the child and adolescent patient population. This data will demonstrate the network's robustness or lack thereof.
- **Service Utilization Data**  
We urge the Departments to require plans to report on utilization rates for specific MH/SUD services and levels of care for a range of conditions, including disorders commonly diagnosed in childhood (e.g., attention-deficit/hyperactivity disorder, obsessive-compulsive disorder, anxiety and depression). These utilization rates should

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<sup>3</sup> Fewer than 10,000 children are covered by Medicare because they have end-stage renal disease, the sole group of children who are enrolled in the program.

be compared to estimates of enrollees with these conditions, as well as utilization rates for M/S services, and be disaggregated by age, geography and race/ethnicity. As appropriate, data on average length of stay per treatment unit and denial rates by each service/level of care should be collected.

Examples of services and levels of care for which data should be collected include:

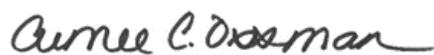
- Utilization within each of the levels (and sub-levels) of care described in The American Society of Addiction Medicine (ASAM) Criteria and the age-specific Level of Care Utilization System (LOCUS) family of criteria developed by the American Association of Community Psychiatrists and the Academy of Child and Adolescent Psychiatry, including:
  - Service utilization by MH/SUD diagnoses
  - Cognitive behavioral therapy
  - Dialectical behavioral therapy
  - Coordinated Specialty Care
  - Medications for bipolar disorder, schizophrenia, major depressive disorder, and other MH/SUDs.
  - Crisis services
  - Emergency Department utilization, including length of stay.

### **Safe Harbor**

The Technical Release also requests feedback on the potential of an enforcement “safe harbor” for insurers that include data in their comparative analyses that demonstrates that they meet or exceed all standards related to their network composition NQTLs. We urge the Department not to proceed with a safe harbor at this time. Network adequacy has always been difficult to define and easy to mismeasure. Therefore, it is critical to capture a full and complete picture of children’s access to MH/SUD services. A safe harbor should only be considered when the Departments and key consumer stakeholders are confident that the data collected by insurers accurately captures actual access to MH/SUD services.

Thank you for the opportunity to provide our comments on the collection of plan data related to network composition. We look forward to working with you to ensure that these data collection requirements and the full implementation of the MHPAEA fulfill their promise of ensuring mental health parity for the close to 44 million children with commercial insurance. Should you have any questions or need further information, please reach out to Jan Kaplan at [jan.kaplan@childrenshospitals.org](mailto:jan.kaplan@childrenshospitals.org) or 202-753-5384.

Sincerely,



Aimee Ossman  
Vice President, Policy  
Children’s Hospital Association