National Association for Behavioral Healthcare

Access. Care. Recovery.

6 December 2021

Xavier Becerra
Secretary
U.S. Department of Health and Human Services

Ali Khawar
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor

Mark J. Mazur
Deputy Assistant Secretary of the Treasury
For Tax Policy
U.S. Treasury Department

Douglas W. O'Donnell
Deputy Commissioner for Services and
Enforcement
U.S. Internal Revenue Service

Laurie Bodenheimer
Associate Director
Healthcare and Insurance
Office of Personnel Management

Re: Requirements Related to Surprise Billing; Part II
[CMS–9908–IFC: RIN 0938–AU62, RIN 1210-AC00, RIN 1545-BQ05, and RIN 3206-AO29]

Dear Mr. Becerra, Mr. Khawar, Mr. Mazur, Mr. O'Donnell, and Ms. Bodenheimer:

On behalf of the National Association for Behavioral Healthcare (NABH), I am writing to express serious concerns regarding the second set of regulations issued to implement the *No Surprises Act* in the Interim Final Rule (IFR) entitled "Requirements Related to Surprise Billing; Part II."[i]

NABH represents behavioral healthcare systems that provide mental health and addiction treatment across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other outpatient programs, including medication assisted treatment centers. Our membership includes behavioral healthcare providers in 49 states and Washington, D.C.

The Covid-19 pandemic has magnified the need for improved access to good quality behavioral healthcare. National surveys and research studies have repeatedly indicated significantly elevated levels of anxiety and depression and suicidal ideation during the pandemic.[ii, iii, iv, v] Drug overdoses have spiked to unprecedented levels with more than 100,000 deaths as of April 2021.[vi] Based on previous epidemics, we expect the current pandemic's impact on behavioral health will continue for years to come.[vii]

Furthermore, we know there are severe shortages of behavioral healthcare providers in many parts of the United States. According to the Health Resources and Services Administration, as of September 2, 2021, more than one-third of Americans (125 million people) lived in 5,788 mental health professional shortage areas.[viii] In these areas, the number of mental health providers available were adequate to meet about 27% of the estimated need.[ix] Increasingly during the Covid-19 pandemic, as the supply of psychiatric beds has declined, the wait for a transfer from emergency departments to specialized inpatient or other treatment setting has increased[x] with frequent reports of people waiting for weeks for a bed to become available. [xi]

In the context of these ongoing concerns, we appreciate the opportunity to comment on the Surprise Billing Part II IFR. We fear an unintended consequence of these new regulations will be to further reduce access to behavioral healthcare. Out-of-network providers are disadvantaged by the new rules that establish the in-network rate as the starting point for negotiations. This will incentivize health plans and issuers to keep reimbursement rates low,

further discouraging network participation.

As the preamble to Part I of the Surprise Billing rules noted, mental health and addiction treatment services are already more likely to be accessed out-of-network in an in-network hospital setting than other types of treatment.[xii] This finding is consistent with other research showing that, in general, individuals with mental health or substance use disorders are more likely to access treatment from out-of-network providers.[xiii] Provisions in the Part II IFR discussed below will discourage contracting between insurers and plans with providers and facilities. This will create additional barriers for people who need acute behavioral healthcare at a time when the need for this level of care has been increasing and availability has been decreasing.

Of primary concern in the IFR is the interpretation of the independent dispute resolution (IDR) provisions to highly favor health plans and issuers. The interim final rule requires IDR entities to presume that the plan or issuer's median in-network payment rate is the appropriate out-of-network reimbursement rate. This interpretation is contrary to the clear intent of Congress that required IDR arbiters to consider a long list of factors specified in the law including the median in-network rate. The statute lists the following factors that the arbiter should consider:

- median in-network payment rate,
- level of training, experience, and quality and outcomes measurements of the provider or facility,
- market share of each party,
- acuity of the individual,
- teaching status, case mix and scope of services of the provider/facility,
- demonstration of good faith efforts by the parties to enter into network agreements over the previous four years, and
- any other factors that the parties may wish to submit for consideration with several explicit prohibitions.[xiv]

However, the IFR singles out the median in-network rate as the appropriate price that must be rebutted. In addition to elevating one factor that is highly favorable to the plans and issuers in this way, the IFR further lessens the importance of the other factors by stating that they must be based on "credible information" and "clearly demonstrate" that the median in-network rate is not the appropriate out-of-network rate.

These provisions in the IFR are inconsistent with congressional intent regarding the IDR. That entity was supposed to evaluate the relative importance of all the factors, including the median in-network rate in choosing between the providers' and payers' out-of-network rate proposals with independence from plans/issuers and providers/facilities as well as federal and state agencies. The IFR undermines the independence of the IDR entity and is contrary to the statute's clear intent.

We are also concerned about provisions in the IFR regarding good faith estimates for uninsured and self-pay patients about the potential cost of care. It is unclear how these requirements align with the price transparency requirements established earlier this year. We urge you to issue additional guidance on how these two sets of rules overlap and differ.

Furthermore, it is unreasonable to expect providers to develop individualized estimates of cost for patients who are merely shopping for care. To generate an individualized good-faith estimate, a provider will have to gather a lot of information from multiple sources in a short period of time (one to three business days). These more detailed estimates should be reserved for patients who have been scheduled for care. Price estimator tools that provide more generic cost estimates, including those allowed under the hospital price transparency regulations, should be deemed sufficient for patients that are shopping for care.

In addition, we are concerned about compliance with requirements regarding including information from co-providers and co-facilities in any good-faith estimates of cost. There is no automated way for unaffiliated providers

or facilities to

share good-faith estimates. We encourage HHS to develop a standard technology to enable co-providers and co-facilities to share information efficiently and accurately to automate development of good-faith estimates.

Finally, we urge HHS to revise the threshold triggering a dispute resolution process when a provider's bill is above the good-faith estimate provided. The $400 threshold is far too low and will result in an excessive number of dispute resolution actions that may prevent patients with significantly inaccurate estimates from accessing this relief. A more appropriate threshold to ensure the dispute resolution process is reserved for significantly inaccurate estimates would be 10 percent above the good-faith estimate.

Thank you for considering our concerns and recommendations. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs, Kirsten Beronio at kirsten@nabh.org or 202-393-6700, ext. 115.

Sincerely,

Shawn Coughlin
President and CEO

About NABH

The National Association for Behavioral Healthcare (NABH) represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C.. The association was founded in 1933.

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[i] Office of Personnel Management, Department of Treasury, Department of Labor, Department of Health and Human Services: Requirements Related to Surprise Billing; Part II. 86 Fed. Reg. 55,980 (Oct. 7, 2021).

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[iii] Vahratian A, Blumberg SJ, Terlizzi EP, Schiller JS: Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. MMWR Morb Mortal Wkly Rep. ePub: 26 (March 2021).

[iv] Czeisler MÉ, Lane RI, Petrosky E, et al: Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1049–1057.

[v] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021.

[vi] Ahmad FB, Rossen LM, Sutton P: Provisional drug overdose death counts. National Center for Health Statistics. (2021).

[vii] Hawryluck L, Gold WL, Susan, S. SARS Control and Psychological Effects of Quarantine, Toronto, Canada, *Emerg Infect Dis*, July 2004, vol.10 no.7, 1206–1212; Sara Reardon, "Ebola's mental-health wounds linger in Africa: health-care workers struggle to help people who have been traumatized by the epidemic", Nature, vol. 519, no. 7541, 2015, p. 13; Emily Goldmann and Sandro Galea, "Mental health consequences of disasters," Ann Rev Public Health, Volume 35, pp. 169–83, 2014.

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[ix] Health Resources and Services Administration, National Center for Health Workforce Analysis: National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025 (November 2016).

[x] Mark T, Misra S, Howard J, et al. Inpatient Bed Tracking: State Responses to Need for Inpatient Care. Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Aug. 2019.

[xi] Rapoport R (2020, Dec. 23). Every day is an emergency: The pandemic is worsening psychiatric bed shortages nationwide, Stat News.

[xii] Pollitz K, et al: Surprise Bills Vary by Diagnosis and Type of Admission, Peterson-KFF Health System tracker, December 9, 2019.

[xiii] Davenport S, Gray TJ, Melek S: Addiction and mental health v. physical health: Widening disparities in network use and provider reimbursement. Milliman Research Report (Nov. 20, 2019).

[xiv] Public Health Services Act, Section 2799A–1(c)(5)(C).