October 3, 2022

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street #810
Boston, MA 02118

Sent by email to kevin.beagan@mass.gov and rebecca.butler@mass.gov

Re: Comments Regarding Chapter 177 of the Acts of 2022 - Annual Mental Health Wellness Exams

Dear Deputy Commissioner Beagan and General Counsel Butler,

On behalf of Health Care For All (HCFA), Health Law Advocates (HLA) and the Massachusetts Association for Mental Health (MAMH), thank you for holding listening sessions and for the opportunity to comment on various provisions of Chapter 177 of the Acts of 2022, *An Act addressing barriers to care for mental health*. Please find below responses to the questions the Division of Insurance ("Division") has asked stakeholders to respond to in developing further guidance on the requirement for health insurance carriers to cover an annual mental health wellness exam (M.G.L. 175, § 47SS; M.G.L. c. 176A, § 8UU; M.G.L. c. 176B, § 4UU; M.G.L. c. 176G, § 4MM).

Coverage of an annual mental health wellness exam can help further the goal of strengthening behavioral health prevention and early identification of issues. We look forward to working with the Division to ensure effective and impactful implementation of this benefit. Please do not hesitate to contact us with any questions or to discuss our comments further. Thank you.

Sincerely,

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1) Are the definitions of "licensed mental health professional" or "primary care provider" understood or do certain terms need clarification? Would all the noted providers have the appropriate training to conduct the wellness visit?

The terms "primary care provider" and "licensed mental health professional" are generally understood and there appears to be consensus among stakeholders that the definitions of each of these terms within Chapter 177 are accurate. We cannot comment on the specific training and capabilities of each of these provider types, however, it would appear that all the noted providers should have at least the minimal training or experience required to conduct the screening or assessment portion of a mental health wellness exam, in order to allow for referral to appropriate treatment. In the event that any provider feels that they do not have the appropriate training or experience to conduct such an assessment or screening, the provider should be allowed to make a "warm handoff" to another "primary care provider" or "licensed mental health professional" who can complete the exam, without any additional patient cost-sharing. Because these services and these providers are expressly spelled out in Chapter 177's statutory mandate for coverage, carriers should not attempt to administratively limit the capacity of these providers to furnish these services.

2) Annual mental health wellness examinations are covered. Similar to a physical examination, does this mean no more than once every 12 months? How will different providers who may do the mental health wellness examination know that an examination may already have been done by a different provider within the past 12 months?

Generally, we agree that Chapter 177 requires coverage for a no-cost mental health wellness exam once every 12 months. However, there should be some flexibility as to the exact timing of the service. This is particularly important in light of the fact that the current workforce crisis extends to primary care providers (PCPs). This shortage of providers may delay access to annual appointments and may make a provision that ties access to wellness exams to a rigid schedule impossible. Patients should not be penalized or deprived of an exam because of scheduling challenges facing the primary care workforce.

Thus, just as one's annual "physical" or preventive visit with a PCP may occur in September one year and July the next year, for example, so too should the mental health wellness exam be allowed flexibility (whether it is conducted as part of the overall annual preventive visit or independent of it). One annual mental health wellness exam should be covered at any time during each calendar year. Furthermore, new members of a plan should not have to wait 12 months before they are eligible to receive coverage for their first mental health wellness exam.

Further, while this is not explicitly included in the statutory language, the Division should consider encouraging insurers to approach coverage of mental health wellness exams differently for children, who see their PCP more often than once a year for well child visits, especially in the

earliest years of life.[1] In the context of primary care, if a plan covers more than one wellness or preventive care visit for medical conditions per year without cost-sharing, the plan may need to cover multiple mental health wellness visits per year without cost-sharing as well, as a matter of compliance with state and federal parity laws.[2]

> *3) Does there need to be clarity about how to bill carriers for annual mental health wellness examinations? When the mental health wellness examination is part of an annual preventive visit, could reimbursement for the examination be part of the primary care provider's bundled rate of reimbursement?*

Carriers and providers should work together to develop clear standards and either a single code or set of codes to bill for annual mental health wellness exams that are consistent across payers, including the Group Insurance Commission (GIC), state-regulated private insurance and MassHealth. When the wellness exam is part of an annual preventive visit, whether or not it is included in the bundled rate, it should be reimbursed at an adequate rate to incentivize primary care practices to conduct the wellness exam and promote appropriate preventive behavioral health services. Primary care practices should be compensated adequately for providing the additional mental health screening, assessment, education, and referral services required under the wellness exam during annual preventive visits.

> *4) The annual examination is a screening or assessment to identify any behavioral health needs and appropriate resources for treatment. The definition notes that this includes the following: observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports, and discussion of potential options for medication. Do any of these listed items need further clarification? Are there other types of services that are part of an annual mental health examination that should be considered to be identified so that it is clear that they are part of such examination? Is there a standard screening tool that is used for such examinations?*

The range of clinical activities that could constitute a behavioral health wellness examination is flexibly but broadly defined by the clear terms of the statute. In some cases, the examination may constitute a formal screening that uses a questionnaire or other tool. In other cases, it could be a far more informal set of clinical interactions, such as "age-appropriate observations to understand a covered person's mental health history, personal history and mental or cognitive state [with] input through interviews and questions." M.G.L. c. 176G, § 4MM. Health insurance carriers should not attempt to limit coverage or payment for annual wellness exams that include some, but not all, of the categories of clinical activities listed in the statute as possible components of the examination.

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[1] American Academy of Pediatrics Bright Futures Well-Child Visit Periodicity Schedule: https://www.aap.org/periodicityschedule.

[2] The Massachusetts state mental health parity law (M.G.L. c. 175, § 47B; c. 176A § 8A; c. 176B, § 4A; c. 176G, § 4M) likely mandates coverage of a second or subsequent medically necessary behavioral health wellness examination as a service that is a "mental health benefit[] for the diagnosis and medically necessary treatment of any mental disorder . . . ." or for the "diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders" for "children and adolescents under the age of 19…." In addition, the federal mental health parity law prohibitions on quantitative treatment limits (QTLs) could preclude plans requiring cost-sharing for multiple behavioral health preventive visits if the plan does not require cost-sharing for multiple medical surgical preventive care visits per year.

Some patient populations may feel uncomfortable discussing their mental state and, in such cases, a questionnaire may be clinically inadvisable. This flexibility also is important for providers to be able to deliver therapeutic and trauma-informed care in ways that are responsive to the linguistic and cultural needs of their patient populations. In addition, patients should have the right to choose whether to participate in all or part of a mental health wellness exam. In such situations, examiners should be cautioned to both respect patient rights and ensure that patients receive evidence-based assessment services.

As referenced in the statutory definition, the wellness visit may include observation, education, consultation, referrals to services and supports and a discussion of medication options. This list of activities should not become a means for carriers to aggressively audit provider conduct and practices in order to limit payment or coverage of services when some formalized set of activities may be left out. The extent of the activities in the mental health wellness exam should be determined by patient/family need. For example, an observation by a provider followed by a discussion of behavioral health concerns and help with access to subsequent treatment resources would be ample to meet the requirements of the statute.

For families, the mental health wellness exam is also an opportunity to provide anticipatory guidance about healthy development of their children and address familial issues that impact the child and the family as a whole. While Chapter 177 requires insurance *coverage* of mental health wellness exams – including without cost-sharing barriers to care – we are hopeful that this new benefit will become a pathway to encouraging more providers to integrate behavioral health promotion, prevention and early intervention activities into their practices. We address screening tools for children and adolescents in Question 5, and we generally recommend flexibility on the screening tools used based on patient/family circumstances, age and professional judgment of the provider conducting the mental health wellness exam. The Division should work with MassHealth and the GIC, as well as with entities such as the Department of Mental Health, to help align policies around screening tools and other aspects of the benefit.

Coverage for an annual mental health wellness exam should apply for an individual in active behavioral health treatment. The wellness exam could prove helpful as a touchpoint with one's PCP, for example, about the status of treatment (e.g., areas of improvement, strategies learned) and documentation of relevant treating providers, as well as identifying additional factors impacting the wellbeing of a particular individual and in facilitating a more holistic treatment plan.

Colorado passed a similar law requiring coverage of annual mental health wellness exams in 2021.[3] It could be helpful to understand the key challenges that state is facing and successful strategies they are using to implement their law.

> *5) The annual examination also includes the following: age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions. Do any of these listed items need further clarification? Are there any federal or other guidelines regarding what are considered age-appropriate screenings or*

[3] See: https://leg.colorado.gov/bills/hb21-1068.

types of screenings should be done at or by certain ages? Are there other types of services that are part of age-appropriate screenings that could be identified so that it is clear that they are part of such age-appropriate screening?

Pursuant to Early, Periodic Screening, Diagnosis and Treatment (EPSDT) and Preventive Pediatric, Health-Care Screening and Diagnosis (PPHSD), MassHealth requires pediatric PCPs to conduct behavioral health screenings for children, adolescents and young adults under age 21.[4] Age-appropriate behavioral health screenings for children also include *developmental* screenings. For many years, MassHealth has required PCPs to choose from a specific list of tools vetted by national and local experts.[5] Beginning in 2023, MassHealth will discontinue the aforementioned list of specific behavioral health tools and instead instruct providers to use the Bright Futures Toolkit from the American Academy of Pediatrics, require a specific code for the screening, and offer additional payment for autism screening for children at their 18 and 24 month visits.[6] All standardized screeners are normed and validated for specific age ranges, including for adolescents.

Pediatric mental health wellness exams are also an opportunity to understand the family context, which is very important for children and adolescents. The health and wellbeing, including mental health, of parents/caregivers and other family members is linked to the health and wellbeing of the child. Coverage for a child's mental health wellness exam should allow for both screening of caregivers in the postpartum period and adult input, interviews and questions, as appropriate, related to the wellness of their child, especially important for young children. Providers should follow established privacy and confidentiality protocols around adult engagement depending on the age of the patient and other factors, such as sexual orientation and gender identity.

6) The law applies as policies are issued or renewed within or without the commonwealth. Is this clear or would it be helpful to do a Q&A with examples of what this means? How will covered persons and providers know whether or not the law applies to them?

We are pleased to hear the Division's concern that Massachusetts residents whose health insurance coverage is affected by these new rights under Chapter 177 must have some reasonable way to understand whether and how these rights apply to them. As one way to address this issue, we strongly recommend that the Division exercise its existing authority to require carriers to include on plan member ID cards a notation that the plan is "regulated by the insurance laws of Massachusetts" or similar language. Having this information readily available on member ID cards would allow providers and advocates working with Massachusetts residents to more easily determine if an individual has coverage for an annual mental health wellness exam and to inform them about these new rights.

Educating consumers and providers about new benefits, consumer protections or rights, including the mental health wellness exam, is much more difficult without readily available information about whether a person has a fully-insured plan subject to Massachusetts law. Such transparency about

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[4] MassHealth Provider Manual, Appendix W: https://www.mass.gov/doc/appendix-w-epsdt-services-medical-and-dental-protocols-and-periodicity-schedules/download.

[5] See: https://www.mass.gov/info-details/learn-about-the-approved-masshealth-screening-tools.

[6] See: https://www.mass.gov/doc/all-provider-bulletin-348-updates-to-developmental-and-behavioral-health-screening-tools-and-codes-in-pediatric-primary-care-0/download.

the plans being regulated by Massachusetts insurance laws would also help prevent providers from collecting a copay for a mental health wellness exam when doing so would be prohibited under Chapter 177, thus saving consumers from inappropriate medical debt, and reducing the administrative burden on providers.

> *7) The law requires that there be no cost-sharing unless the coverage is in a plan which would lose IRS tax-exempt status if there was a prohibition of this cost-sharing. Is this clear or would it be helpful to do a Q&A with examples of what this means? How will covered persons and providers know when a plan will need to charge cost-sharing because of the IRS tax issue?*

Yes, it would be helpful for the Division to develop a Q&A with examples as to what this means. The Division should also require carriers to provide their members with educational materials and clear information about who to contact with questions, so that individuals and families don't encounter unexpected cost-sharing.

During the listening session, representatives of some of the commercial carriers suggested that the IRS Code that regulates a high-deductible health plan paired with a Health Savings Account requires cost-sharing particularly when the services are diagnostic or treatment-oriented in nature, and that the IRS governs what is considered "preventive" for these plans. Technical guidance that describes, as clearly as possible, the distinguishing features of such plans will help both providers and consumers understand whether their cost-sharing obligations are eliminated or not by this new law. It would also be helpful if the Division could research and publish some information on the prevalence of these plans that are exempted from the cost-sharing waiver under Chapter 177 due to IRS law or regulations, so that providers and consumers could have some sense of how common or rare such coverage might be. Further, if the Division could investigate such plans and publish some guidance that helps easily identify such plans for consumers and providers, that could also help eliminate any future uncertainty that could cause inappropriate cost-sharing by plans or providers. For instance, if all such plans must have a high deductible of a certain amount, and also must be accompanied by some other plan features, then guidance that describes these necessary features could help consumers navigate and access benefits more easily.

> *8) What types of provider and member education may be helpful to educate providers and members about the availability and scope of the examination, as well as a clarification about which types of plans are required to make this examination available?*

This new benefit was created under Chapter 177 for all state-regulated payers – private insurance carriers, the GIC and MassHealth. In order to simplify implementation of the benefit, the Division should work with the GIC, MassHealth, payers and providers to use consistent terminology and billing codes regarding the mental health wellness exam. Giving this new benefit a consistent name and definition will help facilitate education of both providers and consumers about the availability of mental health wellness exams. Creating a new and/or uniform billing code (in a manner consistent with the requirement under M.G.L c. 176O, § 5A and § 5B, if applicable) entails only minor effort by payers and will reduce unnecessary administrative burdens upon providers.

We also recommend that the Division consider issuing consumer-facing and provider-facing regulatory guidance outlining the contours of this benefit, including the following issues:

- Instructing providers about whether this benefit is covered, how they can most easily determine if cost-sharing should be applied, or whether the consumer is in a plan that does not allow a waiver of such cost-sharing (also see response to Question 7 above). We urge IT developments to facilitate information sharing to providers regarding patient cost-sharing obligations. In the absence of a sufficient IT system to communicate this information to providers (including any system developed by the Division under its authority under M.G.L. c. 176O, § 26, or otherwise), guidance by the Division could include some sample questions that a provider could ask health insurance carriers directly and/or their patients.
- Instructing providers about which services are considered to be part of this benefit and which services would not be considered part of this benefit. During the listening session, some stakeholders proposed that these wellness exams must include only services that are entirely "preventive" in nature, and thus any services that are "diagnostic" or even initial treatment would not fall under this wellness examination. We disagree with the recommendation that the Division create a "preventive-but-not-diagnostic-or-treatment" bright-line test, because it would not be workable in the real world, and it would conflict with the statute. The statute describes this annual wellness exam to include "...a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment." As such, a clinician or physician taking steps to "identify any behavioral or mental health needs" may need to make a preliminary diagnosis as a logical outcome in some cases. The exam could also include the provider making a determination that the patient could benefit from medical intervention, such as a "discussion of potential options for medication" as expressly allowed under the statute. Instead of a "bright line" test, we recommend that the Division adopt a more flexible "substantial majority-of-services" approach, meaning that when the substantial majority of services provided to a patient during a visit are the "annual wellness examination" services outlined in the statute (and perhaps as described more fully through regulations or guidance), the visit should be covered with no cost-sharing, even if the visit ultimately results in a diagnosis or referral to further treatment. This approach generally aligns with the preventive services provisions in the Affordable Care Act.[7] Other services, such as prescribing of appropriate medication, may also constitute independent, billable services by the provider, but this should be administered without any additional cost-sharing obligations for the consumer when such additional services are attendant to, and immediately and directly resulting from, the wellness examination.
- Instructing providers, consumers and carriers about appropriate steps to be taken in the billing process if the provider mistakenly waives cost-sharing when the IRS code precludes such waiver, or if the provider mistakenly charges cost-sharing when it should have been waived.
- Working with stakeholder groups to come to consensus on messaging and terms used to describe the mental health wellness exams across payers.

[7] See 45 CFR §147.130. List of preventive services without cost-sharing under the Affordable Care Act: https://www.healthcare.gov/coverage/preventive-care-benefits/.

- The Division, MassHealth and the GIC should each post easy-to-understand materials on their websites and carriers should include clear information on their websites and web portals about these new services.
- Engaging organizations that work directly with individuals and families on health care issues are informed about the mental health wellness exam benefit and other benefits that Chapter 177 requires to be covered. For example, during the roll-out of "Behavioral Health for Children and Adolescents," key stakeholders such as the Children's Mental Health Campaign (including HCFA and HLA), the Autism Insurance Resource Center, the Federation for Children with Special Needs and the Parent/Professional Advocacy League were at the table with DOI, DMH and MassHealth to discuss consumer-facing materials and implementation considerations. The Division should consider working with these groups and others (such as the MA League of Community Health Centers, American Academy of Pediatrics - MA Chapter, Association for Behavioral Healthcare, National Association of Social Workers - MA, MA Psychological Association, MA Psychiatric Society, MA Medical Society, etc.) to develop clear and consistent messaging for consumers to help them understand these benefits and also who to contact if they have problems accessing these services. These types of organizations can also be helpful in developing an outreach plan to ensure that the messaging is not only understandable to different audiences, abut also that it is broadly disseminated through various channels.

  9) Are there any barriers or privacy concerns that should be considered regarding data on the mental health examination? Are there things that should be considered about sharing data with providers about the fact that the member has received the mental health screening?

Provision of the mental health wellness exam should follow all established privacy protections currently required under law, regulation and/or as required by codes of ethics and practice requirements for primary care providers and licensed mental health professionals. These protections should be shared with consumers, including minors, when appropriate.