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October 17, 2023

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**Administration**

Saul Levin, M.D., M.P.A.  
*CEO and Medical Director*

**Re: Requirements Related to the Mental Health Parity and Addiction Equity Act:  
Proposed Rule, File 1210-AC11**

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

The American Psychiatric Association (APA), the national medical society representing over 38,000 psychiatric physicians and their patients, appreciates the opportunity to comment on [Requirements Related to the Mental Health Parity and Addiction Equity Act: Proposed Rule](#). We applaud the Administration's efforts to improve and strengthen mental health parity requirements and ensure that people with private

health insurance can access benefits for mental health and substance use disorders (MH/SUD) under their insurance plans. Despite MHPAEA being the law for more than 15 years and a top enforcement priority for the Departments, the Departments' most recent [Report to Congress](#), issued in July 2023, states that "nearly all plans or issuers audited for MHPAEA compliance could not demonstrate compliance with the law's obligations in response to an initial request for NQTL comparative analyses." Studies continue to show that people cannot access benefits for care of MH/SUD. These validate ongoing concerns that insurance plans and insurers are still not compliant with the federal parity law.

**We strongly support the Administration's efforts to help bring insurers into compliance with MHPAEA immediately and appreciate this opportunity to recommend clarifications and improvements to the proposed rule so that people can access high-quality and effective MH/SUD care without encountering illegal and discriminatory barriers to that care.**

### **Amendments to Existing MHPAEA Regulations**

- *New and revised definitions*

APA supports the incorporation of new and revised definitions of key terms, such as "evidentiary standards", "factors", "processes" and "strategies" for purposes of the NQTL rules. We also support clarifying that MH/SUD benefits must be defined consistently with the most current version of the ICD or DSM, which include neurodevelopmental disorders, such as autism. This amendment will put an end to plans/issuers categorizing autism as a medical/surgical (M/S) disorder in order to avoid MHPAEA protections for autism treatment benefits that have resulted in barriers to accessing this care.

- *Requiring meaningful benefits in each classification*

APA applauds the requirement that if plans/issuers provide benefits within any classification, those benefits must be "meaningful." **We recommend "meaningful" be defined to ensure that the right level and range of services be accessible to the patient in question. For people who are experiencing early psychosis or serious mental illness, "meaningful benefits" include access to medications, and psychosocial support including cognitive behavioral therapy, individual and family therapy, supported employment, supported education, and care co-ordination, all of which are evidence-based practices.** Historically these services have not been accessible to privately insured people resulting in those suffering from early psychosis or SMI boarding in emergency rooms, entering the criminal justice system, experiencing job loss and homelessness and being re-hospitalized.

People experiencing first episode psychosis or serious mental illness need access to coordinated specialty care and while issuers/plans cover some elements of this care, they do not cover other important parts of this care, such as supported education and employment. Without these services, plans/issuers are not providing "meaningful benefits" for first episode psychosis. New York State's Medicaid program covers these services and as a result, people who are covered by Medicaid can access this care. Yet, psychosis does not respect income levels. If a person is covered by Medicaid, they can access coordinated specialty care for early psychosis but if a person has employer sponsored coverage, they cannot access these services. Our members report people are often advised to remove their over 18-year-old child from their health plan and pursue coverage for these services under Medicaid. This delays peoples' ability to access care for treatment of early psychosis, an illness where time is of the essence for best outcomes.

The Departments have expressed an interest in feedback specific to mobile crisis services. Mobile crisis and other crisis services are covered by Medicaid but are almost never covered by private insurance. As a

result, if a person needs these services and is able to access them, these services are paid for by Medicaid or county health agencies. By not covering these services, plans/issuers are effectively shifting these costs to the taxpayers.

- *Applying the substantially all/predominate test to NQTLs.*

We support the Departments' proposal to extend the substantially all and predominate tests -- which already apply to quantitative and financial limitations -- to NQTLs. MHPAEA's statutory language makes it clear that the test for all limitations applied to a MHSUD benefit under the law is that they must not be more restrictive than the predominate limitation applied to substantially all the MS benefits. Under the proposed rule, an NQTL applicable to MH/SUD benefits will also need to apply to substantially all (two-thirds) of all M/S benefits, determined on the basis of cost data, and the level of the NQTL for the MHSUD benefits can be no more restrictive than the predominant level (the most common or frequent level) for M/S benefits, again based on cost data. As a practical matter, given that the processes for utilization management are complex and nuanced, finding the predominant variation of an NQTL may not be workable in many real-life situations; however, requiring plans/issuers to apply the substantially all test is the most impactful test.

- *Eliminate or narrow the exceptions to applying the NQTL tests*

The proposed rule provides an exception to the requirements for NQTLs, if the plan/issuer "applies a nonquantitative treatment limitation that impartially applies independent professional medical or clinical standards or applies standards to detect or prevent and prove fraud, waste, and abuse." Neither of these exceptions are found in MHPAEA's statutory language or its amendments. Further, we have serious concerns that the proposed exceptions will inadvertently undermine the strength of the regulations. **We recommend that the exceptions be eliminated from the final rule and evaluated within the NQTL framework.** Alternatively, we recommend the Departments provide more clarity, as discussed below, to the terms including what it means for these standards to be "impartially" applied.

- *Independent standards exception*

We appreciate the Departments' efforts to ensure that beneficiaries are able to access MH/SUD care that is consistent with generally accepted standards of care. However, instead of ensuring this through the use of an exception, **we recommend the Departments strengthen the requirements for NQTLs related to medical necessity by, for example, requiring plans to analyze and document whether and how they used any standard that was different from an independent medical/clinical standard, requiring them to collect and analyze data related to medical necessity, and requiring plans to provide their criteria and guidelines as part of their MHPAEA compliance.** Strengthening the NQTL requirements around standards/medical necessity would cut down on plans limiting or denying services that are medically necessary in a manner that is not consistent with generally accepted standards of care.

This approach is consistent with the Departments' 2013 decision to remove the exception for "clinically appropriate standards of care" from the Final Rules. In removing this exception from their 2010 interim final regulations, the Departments reasoned that:

The interim final regulations also contained an exception to the NQTL requirements allowing for variation "to the extent that recognized clinically appropriate standards of care may permit a difference." A few commenters expressed support for the exception, emphasizing inherent differences in treatment for medical/surgical conditions and mental health conditions and substance use disorders. Many other commenters raised concerns

that this exception could be subject to abuse and recommended the Departments set clear standards for what constitutes a “recognized clinically appropriate standard of care.” For example, commenters suggested a recognized clinically appropriate standard of care must reflect input from multiple stakeholders and experts; be accepted by multiple nationally recognized provider, consumer, or accrediting organizations; be based on independent scientific evidence; and not be developed solely by a plan or issuer. Additionally, since publication of the interim final regulations, some plans and issuers may have attempted to invoke the exception to justify applying an NQTL to all mental health or substance use disorder benefits in a classification, while only applying the NQTL to a limited number of medical/surgical benefits in the same classification. These plans and issuers generally argue that fundamental differences in treatment of mental health and substance use disorders and medical/surgical conditions, justify applying stricter NQTLs to mental health or substance use disorder benefits than to medical/surgical benefits under the exception in the interim final regulations.

The Departments also recognized that plans and issuers would continue to have the flexibility contained in the NQTL requirements to take into account clinically appropriate standards of care when determining whether and to what extent medical management techniques and other NQTLs apply to medical/surgical benefits and mental health and substance use disorder benefits, as long as the processes, strategies, evidentiary standards, and other factors used in applying an NQTL to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those with respect to medical/surgical benefits.

**We urge the Departments to keep clinical appropriateness within the NQTL analysis instead of providing it as an exception** – an exception that is not found in MHPAEA’s statutory language or the Consolidated Appropriations Act, 2021 amendments.

**Alternatively, we recommend that the Departments clarify that for purposes of this exception “independent professional medical or clinical standards” must be: (1) an independent standard that is not developed solely by a single health plan or plans; (2) based on input from multiple stakeholders and experts, such as academic researchers, senior practicing clinicians, and consumer and advocacy leaders with subject matter expertise in addition to a health plan or its advisory panels; (3) recognized or accepted by multiple nationally recognized physician or patient organizations; and (4) based on objective scientific evidence, such as peer-reviewed publications of control group research trials or expert consensus panels.** There is ample evidence to support this practice given CMS’s reliance on similar input for Medicare national coverage determinations and through the work of the Medicare Coverage Advisory Committee (MEDCAC). This will prevent the application of arbitrary exclusions simply to circumvent the regulations as written.

Requiring the standards be “independent, peer-reviewed, or unaffiliated with plans and issuers”, as described in the Departments’ example, does not go far enough and could allow nontransparent, proprietary criteria created and licensed by for profit businesses to be used to establish the medical or clinical standards exception. These proprietary standards that plans/issuers rely on when conducting utilization management, have not been recognized by national physician organizations and should not be included as acceptable standards for this exception. These standards are not independent -- they are created by businesses seeking licensing with managed care organizations. Neither are they peer reviewed -- the reviewers are typically not identified and are not publicly vetted about their expertise and potential

conflicts of interest. Nor are they “unaffiliated with plans and issuers,” as these companies have a business relationship with plans/issuers.

In some instances, some plans/issuers are denying medically necessary care if it does not include all the treatment options listed in APA treatment guidelines. For example, care has been denied when family therapy is not included in applied behavioral analysis. This is a misuse of the APA guidelines. APA practice guidelines provide evidence-based recommendations for the assessment and treatment of psychiatric disorders and are intended to assist in clinical decision making by presenting systematically developed patient care strategies in a standardized format. APA’s guidelines are not a standard of care, the evidence base is constantly changing, and the treatments are not necessarily right for every patient.

- *Fraud, waste, and abuse exception*

We support and appreciate the Departments efforts to combat fraud, waste, and abuse in healthcare, which pose significant costs to all Americans. However, we are concerned that this exception could be misused by plan/issuers to escape MHPAEA protections. **We recommend fraud, waste and abuse be kept within the NQTL framework and be evaluated as factors to be considered in creating and applying NQTLs and subject to MHPAEA’s comparability and stringency tests for MH/SUD and M/S.** Like the professional and medical standards exception, MHPAEA’s statutory language and its amendments do not provide for a fraud, waste, and abuse exception. Alternatively, we urge the Departments to provide more clarity around what constitutes fraud, waste and abuse, as we have serious concerns that waste could include care for people who are struggling with serious mental illness and do not initially respond to treatment.

### **New MHPAEA Regulations**

We applaud the Departments’ adding minimum standards to developing NQTL comparative analyses and setting forth content elements of the comparative analysis for plans and issuers.

- *Prohibition on relying on “discriminatory factors and evidentiary standards.”*

We support the proposed prohibition against plan/issuers relying on discriminatory factors and evidentiary standards when designing and applying NQTLs. This concept is inherent in MHPAEA. We recommend the Departments provide more clarity around what would be considered “discriminatory factors and evidentiary standards.” Plans/issuers have historically relied on Medicare fee schedules in setting reimbursement rates. Medicare reimbursement rates have historically undervalued MH/SUD services and are not subject to parity laws and, as such, are inherently discriminatory. These rates have also contributed to psychiatrists opting out of Medicare. As reported in MedPAC’s 2023 Report to Congress, “in 2022, behavioral health clinicians accounted for 40 percent of clinicians who opted out of Medicare, a higher rate than for other types of clinicians. Indeed, psychiatrists have the highest opt-out rate of all physician specialties.”<sup>1</sup> **We recommend that the Departments clarify that relying on Medicare fee schedules, while a good place to start in assessing reimbursement rates, needs to account for the fact that they are inherently discriminatory in their analysis.**

- *NQTL list is non exhaustive; recommend adding “scope of services” to the list of NQTLs*

We applaud the Departments’ providing an updated and non-exhaustive list of NQTLs and recommend adding “scope of services” to this list. Access to MH/SUD is illusory if people cannot access the right level and range of care that they need for their illness, including access to a continuum of clinical services in numerous settings, such as private offices, community mental health centers, specialty clinics, and

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<sup>1</sup> [Jun23 MedPAC Report To Congress SEC.pdf](#)

hospitals as well as in the workplace, schools, and correctional facilities. Psychiatric care should be fully integrated with the rest of medicine in primary care settings and in hospitals.

- *Requiring the use of outcomes data and addressing “material differences”*

APA applauds the proposed requirement that when a plan/issuer is designing and applying an NQTL, it must collect and evaluate outcomes data and consider the impact of that NQTL to accessing MH/SUD benefits in its comparative analysis. **We recommend that the Departments provide standardized definitions of the data points and methodologies for collecting the data. We also recommend that data for MH and SUD be collected and analyzed separately, as access to SUD benefits is frequently worse than it is to MH.**

We also support the requirement that if the outcome data, demonstrates a “material differences” in access to MH/SUD benefits as compared to M/S benefits, this will be considered a strong indicator of a violation of MHPAEA and will require plans/issuers to take “reasonable action” to address that material difference and document those actions. However, the term “material difference” is not defined and it is unclear how that compares to “no more restrictive” test of MHPAEA. **We recommend that the Departments provide more clarity on the definition of “material differences” that is statistically based.**

**We also recommend the Departments provide more clarity around what is considered “reasonable action” to address the material differences in access as necessary to ensure compliance, in operation.**

According to the Milliman study, where discriminatory disparities are found in fee schedules, a plan/issuer “should increase its payment levels to behavioral healthcare providers. That increase in payment could also lead to an increase in the desire of behavioral health providers to join the health plan’s provider network.”<sup>2</sup> We agree, however, raising rates is only a partial solution. Plans/issuers must also address the high levels of administrative burden and the legacy issues that discourage medical students from joining networks by actively providing information about the benefits of and process involved in joining networks, streamlining their credentialing processes, and making meaningful outreach efforts to recruit clinicians to their network panels. Our member psychiatrists tell us that some plans/issuers have used a telecommunications vendor to make phone calls to psychiatrists for recruitment purposes and this effort is neither effective nor appreciated.

- *Special Rule for NQTL’s related to Network Composition*

We applaud the Departments’ proposed special provisions regarding network composition. We agree that the use of NQTLs such as provider network admission standards, methods for determining reimbursement rates, and credentialing standards impacts the ability of a person to access in network MH/SUD care. We agree that data such as in-network and out-of-network utilization rates (including data related to provider claim submissions), network adequacy metrics (including time and distance data, and data on providers accepting new patients), and provider reimbursement rates (including as compared to billed charges) can provide insight into whether beneficiaries are able to access MHSUD benefits. Collecting and analyzing this data must be a required part of a compliant comparative analysis. We support the proposed rule that when that data demonstrates “material differences” in access, it is considered a strong indicator that the plan/issuer violates MHPAEA. We know from our psychiatrists members that when insurers set burdensome levels of unpaid administrative tasks and have low reimbursement rates, they effectively force psychiatric clinicians out of the network and leave patients unable to find care or maintain continuity

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<sup>2</sup> [Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement \(milliman.com\)](https://www.milliman.com)

of care. Mandating the collection, evaluation and production of this data should result in improved review of plans/issuers' policies and process and ultimately improved parity outcome for beneficiaries. Medicare reimbursement rates can be used as a benchmark for comparing reimbursement rates. However, its use should account for historical discrimination in these rates.

**We recommend that plans/issuers be required to go beyond the minimum network adequacy standards promulgated by accreditation organizations and other Federal or state programs to ensure that they do not result in less favorable treatment for MH/SUD benefits.** As discussed in a recently released report on state, federal and private accreditation network access standards and their impact on access to MHSUD care, these standards are inherently unreliable because they do not measure care that was sought but not received and are often based on inaccurate and/or out of date health plan network directory information. Further, accrediting bodies, such as URAC and NCQA defer to health plans to define and monitor specific measures of adequacy and do not require MHSUD specific network access standards.<sup>3</sup> These standards are not designed with parity in mind. If plans/issuers rely on these standards, they must be required to address these issues and their impact on access.

While we agree that there currently exists a general shortage of MH/SUD providers, plans/issuers cannot simply rely on this reality when they fail to achieve outcomes for MH/SUD that are comparable to those for MS benefits. There are also shortages of other medical specialists.<sup>4</sup> Yet, we do not hear reports of people being unable to find clinicians of cardiology, critical care, and oncology. Further, the high level of out of network utilization of MH/SUD services undercuts the plans/issuers' claims that it is impossible to have an adequate network because there are no clinicians. MH/SUD clinicians exist, and they want to serve and help patients. They want to join insurance networks and ensure that insured people, regardless of income, will have access to quality care for MH/SUD. However, administrative practices of insurance networks and poor reimbursement rates – which violate MHPAEA – preclude them from doing so.

**We recommend that plans/issuers be required to demonstrate how they are addressing these practices and actively recruiting psychiatrists, particularly those in medical school and residencies, into their networks.** Many psychiatrists newly graduated from medical school and residencies report plans/issuers make no effort to recruit them into their panels and provide them with no information about what joining a network entails. **We also recommend that plan/issuers be required to demonstrate how they are accelerating credentialing.** Our members report that credentialing into a network panel takes many months, and, in the meanwhile, they are earning a living providing psychiatric care on a cash basis. By the time their credentialing is completed, their practices are established, and they do not want to join the network only to be reimbursed at lower rates and responsible for higher levels of unreimbursed administrative tasks.

- *Requirement that the analysis be certified*

We applaud the requirement that the comparative analysis include a certification by one or more named fiduciaries who have reviewed the comparative analysis, stating whether they found the comparative analysis to be in compliance with the content requirements. We agree that this will help to ensure that

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<sup>3</sup> [Equitable Access to Equitable Care for Mental Health and Substance Use Disorders: Standards, Measures, and Enforcement of Network Adequacy, September 2023, Access-to-Care-091223.pdf \(pathforwardcoalition.org\)](#)

<sup>4</sup> [The Complexities of Physician Supply and Demand: Projections From 2018 to 2033 \(aamc.org\)](#)

plan fiduciaries meet their obligations to review the comparative analysis and monitor their plans for compliance with MHPAEA.

- *Notice to plan members of a final determination of noncompliance*

We support the proposed requirement that plans/issues provide participants/beneficiaries with information summarizing the changes the plan/issuer “has made as part of its corrective action plan following the initial determination of noncompliance, including an explanation of any opportunity for a participant or beneficiary to have a claim for benefits reprocessed.” We urge the Departments to ensure that the burden of notice is on the plans/issuers and not the beneficiaries by mandating that the plans/issuers describe in the notice the process they will follow and the time frames for reprocessing claims. We also recommend that the Departments require plans/issuers, as part of their corrective action plan, identify affected participants/beneficiaries, reprocess any claims and take any other necessary steps to rectify any other harm caused.

- *Final Determinations of Non-Compliance*

We applaud the Departments’ recognizing that a final determination of non-compliance could include a plan/issuer’s failure to provide a sufficient comparative analysis. We recommend that the Departments clarify that upon a final determination of noncompliance, the Departments **shall** direct the plan or issuer to not impose the NQTL that is subject of the comparative analysis. We also recommend adding “and applicable state authority” to the regulatory language to ensure that the states, particularly those who have played leading roles in MHPAEA enforcement, have the same authority.

- *Closing a loophole to MHPAEA protections -- self-funded, non-Federal governmental plan elections to opt out of compliance with MHPAEA*

APA strongly supports the sunset of the opt out of compliance for self-funded, non-Federal governmental plans. This loophole to MHPAEA has allowed nonfederal government employees, many of whom are front line workers, such as firefighters, police and teachers, to face discriminatory barriers to accessing needed MHSUD care.

**APA provides the following responses to the Departments’ Request for Information on Ways To Improve Mental Health and Substance Use Disorder Benefits Through Other Consumer Protection Laws that are most meaningful to its members:**

*Group health plan sponsors depend on administrative service providers, health insurance issuers, and other TPAs to design and manage their plans in a manner that complies with MHPAEA among other Federal consumer protections. However, plan sponsors are generally responsible for ensuring compliance and could, in certain circumstances, be liable for penalties for any violations. Are there ways that TPAs could be further incentivized to facilitate compliance with MHPAEA on behalf of the plans that they design and administer?*

We recognize that the Departments have limited direct enforcement authority over other service providers (including, for example, Managed Behavioral Healthcare Organizations or the Third Party Administrator (TPA) or TPAs of a self-insured health plan). We recommend that employers be encouraged to include language in their contracts with TPAs delegating responsibility to the TPA for compliance with MHPAEA requirements and providing appropriate indemnification for noncompliance. We also recommend that TPAs that are found non-compliant should be referred to and held accountable by state



licensing authorities and recommend that these state authorities develop serious consequences for TPAs who fail to comply or demonstrate an unwillingness to comply with MHPAEA.

*Section 108 of Title I of Division BB of the CAA, 2021 requires the Departments to issue a rule implementing the provider nondiscrimination provisions in PHS Act section 2706(a). In 2014, the Departments published a request for information on provider nondiscrimination, followed by FAQs on these requirements.<sup>[178]</sup> Following the enactment of the CAA, 2021, the Departments held a listening session on January 19, 2022 regarding implementation of the provider nondiscrimination provision, in order to foster an exchange of information and views and afford interested individuals and organizations an opportunity to share their perspective on what should be included in forthcoming proposed rules. As the Departments continue to work on proposed rules implementing the provider nondiscrimination provisions, are there ways that the Departments can enhance access to mental health and substance use disorder benefits through their implementation of PHS Act section 2706(a)?*

Plans/issuers need to have sufficient talent at all levels of care to meet the demands for MH/SUD services. Psychiatrists are uniquely situated to care for patients with serious MH/SUD needs because of their high level of education and training. Higher levels of training and education also correspond to higher quality care. Yet, there are no metrics that measure outcomes in complex MH/SUD patients who require care from a physician trained in specialty fields of MH/SUD. The field needs support to create these metrics. The feedback from our members is that they stay in network so that they can keep caring for their established patients in in network. Yet, reimbursement rates have not been raised in some time and plans have made no effort to offer rates even close to market rates. Medicare rates are insufficient because they do not capture the total cost of care. As a result, our members report, they will sometimes continue to remain in network to treat established patients but will no longer take new in network patients. Other members report they are leaving the networks entirely.

*Code section 9820(a) and (b), ERISA section 720(a) and (b), and PHS Act section 2799A–5(a) and (b), as added by section 116 of title I of Division BB of the CAA, 2021, establish standards related to provider directories. The Departments intend to undertake notice and comment rulemaking to implement the provider directory requirements. Are there ways that the Departments can improve the coverage of and enhance access to mental health and substance use disorder benefits through their implementation of these provider directory requirements, particularly in underserved or rural areas where there may be limited access to the internet?*

Access to MH/SUD benefits could be expanded with accurate provider directories. While auditing directories with secret shopper studies could be helpful, we also recommend that directory information be updated at least annually, if not more frequently, and include information such as workplace setting, insurance types accepted, and whether a practice is taking new patients. We urge CMS to require plans/issuers to work with licensing boards to obtain up-to-date information without relying on clinician reporting. We also recommend that directories be required to include information such as whether the clinician participates in an integrated behavioral health model such as Collaborative Care. Because the Collaborative Care team is led by a primary care provider, a consumer may be able to use that information to select not only a PCP, but also have an opportunity to access a psychiatrist, improving health outcomes and reducing stigma. This information would be key in areas that have either a workforce or appointment

shortage as well as in communities that have shown to be less likely to seek mental health care due to cultural or social stigma.

Long term, we support CMS's work to establish a national physician directory system that aligns with the standards established by the Office of the National Coordinator for Health Information Technology for interoperability and generates data that is high-quality, consistently accurate, and widely accessible to facilitate increased access to care, reduces the burden on patients and clinicians, reduces administrative costs and eases the time it takes to connect patients with a clinician.

*Under the internal claims and appeals and external review rules implementing the Affordable Care Act, which are generally applicable to all non-grandfathered group health plans and non-grandfathered group and individual health insurance coverage, claim denials related to medical judgment (including for mental health and substance use disorder benefits) are eligible for external review.<sup>[181]</sup> The internal claims and appeals rules also provide that claimants (or their authorized representatives) are entitled to, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with information about the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan. How can the Departments leverage ERISA's and the Affordable Care Act's existing claims procedure requirements to help facilitate access to mental health and substance use disorder benefits? For example, if a plan or issuer denies a mental health or substance use disorder benefit based on the plan's or issuer's determination that a lower level of care would be more appropriate, should the plan or issuer be required to identify the relevant lower level of care? Should plans and issuers be required to provide an explanation of how a particular NQTL was applied to particular benefits, beyond what is currently required by the claims procedure rules or other related provisions?*

APA recommends the Department's strengthen participants/beneficiaries' ability to challenge a plans/issuers denial's by:

- Requiring plans/issuers to provide reasons and a detailed rationale for why they are denying the care, including how a particular NQTL was applied to that benefit;
- Requiring the plan/issuer to identify a lower level of care that it believes would be more appropriate along with information related to the coverage of such service in the plan, the availability of network providers to deliver the lower level of service;
- Executing meaningful enforcement mechanisms to ensure that plans/issuers fulfill their obligation to provide participants/beneficiaries with legally required information, upon request, and include meaningful consequences for their failure to do so.
- Reinforcing to plans/issuers that they are required to provide, upon request, comparative analyses to beneficiaries; and
- Requiring that the explanation of benefits include instructions on how to request and receive any NQTL compliance analysis(es) related to an adverse benefit determination and include a phone number, email, and address where such a request could be submitted.

*As HHS oversaw the transition to 988 as the new easy-to-remember 3-digit code to access life-saving services through the Suicide & Crisis Lifeline, ( <https://www.samhsa.gov/find-help/988>), there has been*

*increased attention to current gaps in access to and provision of a full continuum of behavioral health crisis services. Final rules under MHPAEA do not specifically address mobile crisis services. Similarly, in the establishment of EHBs as part of required benefits for non-grandfathered individual and small group coverage under the Affordable Care Act, there is no specific reference to behavioral health crisis services as part of the EHB categories. The Departments are interested in determining if there are questions as to how these services fit within the existing categories for either MHPAEA, or the EHB categories. Are there aspects of community-based behavioral health crisis services that the Departments should address in the context of MHPAEA? Should the Departments ensure that community-based behavioral health crisis services are classified in the same way as particular medical/surgical services, and what are those particular services? Should crisis call/text/chat center services, mobile crisis and stabilization services be specifically included as EHBs? Are there ways the Departments can increase access to crisis services with current authorities, including in rural or underserved areas in which there are several challenges to accessing care? How can parity be strengthened across the behavioral health crisis services landscape, including in areas with shortages for behavioral health providers? How can the Departments collaborate with State and local agencies to improve access to existing and future behavioral health crisis services?*

**We recommend that crisis services be included as an essential health benefit.**

There is a huge disparity in how mental health emergencies are dealt with as compared to M/S emergencies. If a person experiences an M/S emergency and 911 is called, an ambulance with trained people responds and takes the person to an emergency room to be cared for. They are admitted, if needed. However, if 911 is called for a person experiencing a MH/SUD emergency, this all too often results in a police response, and an increased incidence in the person experiencing distress being shot or incarcerated. If an ambulance responds, the ambulance can take the person only to the emergency room in order to get paid. Once arriving at the emergency room, there is often no one to care for the person because most ERs do not have MH staff or services to treat serious mental illness. We need a comparable system for crisis services for behavioral health.

The new 988 crisis line, while an important step, needs crisis services built out to support it. We understand that the state of Arizona has started building such a system on top of their Medicaid system, and anyone in crisis, regardless of payer, is covered. The person experiencing distress is responded to by an interdisciplinary MH clinician team and stabilized, often without unnecessarily having to go into the hospital. If they need a higher level of services, they can be brought to a crisis facility - similar to an urgent care facility for MS. These centers provide care to people who arrive in ambulances, police vehicles or walk in and they provide a range of services, including urgent care, 24 hours observation (like observation provided to someone experiencing chest pain but is not having a heart attack), medication, stabilization, peer support, and if substances are involved, time for the substance to clear from their system and connecting the person to community based services; post crisis wrap around services to link the person to follow up appointments and prescriptions, and care from lower acuity facilities for step down help and crisis residential that provides a structured environment. The system also includes MH professionals embedded within the emergency/crisis call center to assist law enforcement. For people covered by private insurance or Medicare, this care is paid for from Arizona state funds.

In addition to a comparable MH crisis system, we also need private insurance to pay for the cost of providing this care to their beneficiaries. We recommend that mental health crisis services, including safety planning done in the emergency room, be considered an essential health benefit. We also recommend billing codes be developed for all levels of facility-based care so that lower levels of care can

be billed. Currently only codes for higher levels of care exist, and this has resulted in fewer lower levels of care options being available.

Using texting in a MH crisis is a new area of care delivery. It is an area that is evolving very quickly and needs research. We understand people, including the youth and elderly, are choosing to receive crisis services via text, and if texting is not covered properly and paid for, this service will no longer be available. However, properly valuing these services is difficult. Instead of using a skill level/time-based billing code for crisis text/chat and calls, we recommend plans/issuers be assessed a flat rate to cover 24 hour trained staffing of crisis call/text centers. Demands for these services are rising and it is not sustainable for county and state governments to fund their availability.

Thank you for the opportunity to respond to the proposed rule and this RFI and to provide recommendations on how the Departments can work to bring plans/issuers into immediate compliance with MHPAEA. If you have questions or would like to discuss these comments in more detail, please contact Maureen A. Maguire, Associate Director, at [MMaguire@psych.org](mailto:MMaguire@psych.org).

Sincerely,

A handwritten signature in blue ink that reads "Saul Levin" with "M.D., M.P.A." written in smaller letters to the right.

Saul M. Levin, M.D., M.P.A., FRCP-E, FRCPsych  
CEO and Medical Director  
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