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APA's Response to Technical Release 23-01

Submitted via email to mhpaea.rfc.ebsa@dol.gov

The American Psychiatric Association (APA), the national medical society representing over 38,000 psychiatric physicians and their patients, appreciates the opportunity to provide comments in response to the Departments' [Technical Release 23-01](#) soliciting feedback on the type, form, and manner for the data that plans and issuers would be required to include in their comparative analyses for NQTLs related to network composition; how to define certain thresholds for required data; and a potential enforcement safe harbor with respect to NQTLs related to network composition for a specified period of time. We strongly support the Departments' proposed NQTL data collection requirements relating to network composition. We urge the Departments to require the data for mental health and substance use disorders (MH/SUD) be collected, evaluated, and reported separately. We also urge the Departments to require that all data be collected, analyzed and reported by age group, and race/ethnicity. The Departments should also develop uniform definitions and methodologies for collecting the data. We urge the Departments to delay the adoption of any safe harbor until the data is validated and, if adopted, the safe harbor be time limited.

APA's responses to the Departments' questions, most relevant to our members and the patients they care for, are as follows:

A. Out-of-Network Utilization

The most meaningful measure of whether people are able to access MH/SUD care and how that compares to access for medical/surgical (M/S) care is the number of out of network claims. The Milliman study looked at out of network claims made for MH/SUD care as compared to M/S care and found the people were more likely to obtain MH/SUD services out of network compared to M/S services.¹ We recommend that the most recently available data be analyzed and that it include items and services such as partial hospitalization, residential treatment, and intensive outpatient care and that these items be broken down into subsets, such as, the treatment of eating disorders, child and adolescent care, and geriatric care. The out of network utilization data should be provided by percentage of claims and number of claims. Treatment received from MH/SUD providers where no claim for benefits is made typically occurs when a patient pays cash for care and there is no reliable way to identify the number and percentage of claims where this is taking place. Further, out of network claims data does not reveal people who received no treatment, due

¹ [Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement \(milliman.com\)](https://www.milliman.com)

to reasons such as unavailability or cost. The evaluation of out of network utilization data should account for urban versus rural areas. Measuring the number of single case agreements granted per class over the total number of claims submitted could provide insight into out-of-network utilization for plans or issuers that generally do not provide out-of-network benefits for non-emergency care. APA is familiar with the data models listed in the Appendix and believes they offer helpful steps for identifying and analyzing data related to out of network utilization.

B. Percentage of In-Network Providers Actively Submitting Claims

Many NQTLs influence the percentage of in network providers actively submitting claims, including administrative burden, utilization review and claw back audits. Our members most frequently identify administrative burdens as the reason for leaving networks. These unpaid administrative burdens include: long wait times on phone; difficulty connecting with a human when there is a problem/question; ongoing problems with down coding and no response to phone calls; audits requesting large number of documents, going back years and with no transparency about the purpose or procedure of the audit; having to hire more staff or work at night to deal with all the paperwork and pre-authorizations; requiring the use of a fax machine; claiming the requested documents were not received by the deadline, even though the clinician has a proof of receipt; refusing to recognize a single case agreement for a complex patient and then denying all the claims and requiring a large number of patient files before paying any claims. We urge the Departments to consider these practices when evaluating a plan/issuers' compliance with MHPAEA.

We support the Departments requiring plans/issuers to collect and evaluate data on the total number of active in network providers per participant/beneficiary/enrollee, another measure of access, in addition to the number of providers actively submitting claims. We also support monitoring for trends in the percentage of in network providers actively submitting claims, the place of service, and the availability of telehealth benefits.

The Model Data Request Form, referenced in the appendix, is a good starting place for the Departments to consider when specifying the data on the percentage of in network providers actively submitting claims.

C. Time and Distance Standards

While time and distance standards and provider to enrollee ratios provide some insight into plans/issuers' compliance with network composition and access requirements, they do not measure whether the providers actually have appointments available to care for patients and none of these measures capture the many cases where people need and seek care but do not receive it. Further these measures rely on information from health plan network directories, despite evidence that this information is often not accurate.

We recommend data on wait times for appointments be collected, analyzed, and reported on, and that time, distance and wait times data be broken down so that it reflects a person's ability to access the right level of care. For example, data should look at the range of MH/SUD professionals, including, for example, child/adult psychiatrists, addiction care, child/adult psychologists, master level social workers and counselors and also at the range of facilities, such as outpatient facility programs, including for example

IOP, PHP, ABA, OTP, etc. Data should also be collected for routine and crisis appointments and follow-ups and ongoing care.

We urge the Departments to require plans/issuers that rely on standards promulgated by state, federal or independent organizations (such as URAC) to demonstrate in their comparative analyses how this reliance complies with MHPAEA.²

D. Reimbursement Rates

Plans' reimbursement rates for psychiatric care have not been raised for decades. Meanwhile, unreimbursed time spent on administrative tasks has risen exponentially. When psychiatric doctors attempt to negotiate contract provisions, including their rates, plans respond "take it or leave it."

In addition to codes 99213, 99214, 90834, 90837 we recommend the Departments collect data related to 99212, 99215, 90833, 90836 and 90838.

We recommend that all MH/SUD providers and subspecialties be considered for comparative analysis on reimbursement rates, including psychiatrists and all subspecialties, such as addiction, and psychologists, social workers, marriage and family therapists, addiction counselors. For non-physicians, we recommend that the M/S comparator have comparable educational experience. Psychiatrists, including those who provide addiction medicine, should be compared to M/S specialists, not primary care physicians, who are not specialists.

The National Medicare Fee schedule is a good starting point for evaluating rate disparity and was used in the Milliman study on rate disparity. However, historically this fee schedule has been too low to retain or attract new psychiatrists. We regularly hear from our members that they do not participate in Medicare because the rates are too low. Further, Medicare has not been subject to parity laws and consequently these rates are inherently discriminatory.

The plans claim that they do take geographic areas into account when they set rates, and the Departments should as well. In areas where there is a shortage of psychiatrists, we often do not see that shortage impacting rates, as we do for other specialists, and this defies economics.

FUTURE POTENTIAL FEDERAL ENFORCEMENT SAFE HARBOR FOR NQTLs RELATED TO NETWORK COMPOSITION –

It is premature for the federal government to be considering a "safe harbor" from enforcement for NQTLs related to network composition. The discriminatory practices, prohibited by the 2008 passage of MHPAEA, such as frequent and more arduous prior authorization practices, extremely limited provider networks, more interference in medical decision making, and improper denials of claims, continue to persist. In its 2022 and 2023 MHPAEA Reports to Congress, DOL found numerous parity violations potentially affecting millions of beneficiaries and few comparative analyses reviewed by the Departments complied with the law. Studies continue to show that people are not able to access care for their MH/SUD conditions. We urge the Departments to focus their resources and attention on addressing the widespread lack of health

² Equitable Access to Care for Mental Health and Substance Use Disorders: Standards, Measures and Enforcement of Network Adequacy, September 2023, [Equitable-Access-to-Care-091223.pdf \(pathforwardcoalition.org\)](https://www.pathforwardcoalition.org/wp-content/uploads/2023/09/Equitable-Access-to-Care-091223.pdf)

plan/issuer compliance, including sanctioning non-compliance with MHPAEA. A time limited safe harbor could be appropriate in the future once data points and methodologies have been established and tested.