From:	Soule, Rachael
To:	EBSA MHPAEA Request for Comments
Subject:	APASI Comments to Technical Release 2023-01P
Date:	Tuesday, October 17, 2023 4:09:00 PM
Attachments:	APASI_Comments on Technical Release 2023-01P_10172023.pdf

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

Attached please find the American Psychological Association Services, Inc.'s comments to the Technical Release 2023-01P, Request for Comment on Proposed Relevant Data Requirements for Non-Quantitative 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 along with the proposed rule, Requirements Related to the Mental Health Parity and Addiction Equity Act.

We appreciate your consideration,

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American Psychological Association
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American Psychological Association Services, Inc.

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: 0938-AU93
1210-AC11
1545-BQ29
Comments to Requirements Related to the Mental Health Parity and Addiction Equity Act
And Technical Release 2023-01P

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

American Psychological Association Services, Inc. (APA Services) appreciates the opportunity to comment on the Department of Health and Human Services, Employee Benefits Security Administration, and the Internal Revenue Service's (the Departments) Proposed Rule, Requirements Related to the Mental Health Parity and Addiction Equity Act (Proposed Rule).

We also appreciate the opportunity to comment on the Departments' Technical Release 2023-01P, Request for Comment on Proposed Relevant Data Requirements for Non-Quantitative Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group

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Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act (Technical Release)[1].

APA Services is the companion organization of the American Psychological Association, which is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 146,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

APA Services joined the Mental Health Liaison Group letter on the Proposed Rule (MHLG letter)[2] and the Kennedy Forum-led joint letter on the Technical Release (Technical Release Joint Letter)[3]. We agree with the comprehensive comments of both letters.

This letter focuses on areas of particular or additional concern for APA Services. We have combined our comments for both the Proposed Rule and the Technical Release because the same underlying parity concerns (outlined in Section I below) support both comments, and because there is some overlap of issues between the two documents. We are submitting these combined comments to both comment portals.

Overview

The Proposed Rule—with the changes that APA Services and our fellow parity advocates suggest[4]—will be a bold step forward toward true parity, with mental health and substance use patients finally achieving robust access to care.

Our key points are that we:

1. Urge the Departments to eliminate the proposed overbroad exceptions for clinical standards and fraud, waste and abuse exceptions that threaten to engulf the benefits of the Proposed Rule.
2. Applaud the required use of outcomes data and the special rule for network composition but urge the removal of the undefined requirement that differences must be "material" before an insurer must take reasonable action or be deemed non-compliant.
3. Support consideration of specific data elements relevant to network composition, such as whether providers are available to take new patients and wait times.

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[1]Employee Benefits Security Administration. July 25, 2023. Technical Release 2023-01P, Request for Comment on Proposed Relevant Data Requirements for Nonquantitive 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). Retrieved from: Technical Release 2023-01P | U.S. Department of Labor (dol.gov)

[2]Mental Health Liaison Group. October 17, 2023. Requirements Related to the Mental Health Parity and Addiction Equity Act. Available at: https://www.thekennedyforum.org/app/uploads/2023/10/MHLG-Comments-on-MHPAEA-Proposed-Rule-FINAL.pdf

[3] Kennedy Forum Partners. October 17, 2023. Comments on Technical Release 2023-01P. Available at: Kennedy-Forum-Partners-Comments-on-Technical-Release-FINAL.pdf (thekennedyforum.org)

[4] In the two joint comments referenced in footnotes 2 and 3 above.

4. Recommend that plans that use Third Party Administrators (TPAs) be required to contractually obligate the TPAs to assist with providing required information to patients and regulators and recommend that plans have the option to make the TPAs responsible for parity compliance on matters that the TPA controls.
5. Urge the Departments to delay any safe harbor proposal around network composition until they have fully analyzed and validated that the new data requested actually demonstrates fair access to mental health benefits.

I. Our Perspective on Parity Issues

Issues with the Current Approach to Non-Quantitative Treatment Limitations (NQTLs)

In the many years since the first regulations went into effect under the Mental Health Parity and Addiction Equity Act (MHPAEA), the most problematic and persistent parity issues we have encountered have been NQTLs, especially network adequacy and its key driver – reimbursement disparity (persistently lower reimbursement rates for mental health as opposed to medical/surgical services). APA Services has been frustrated that the heavily "process" focused approach to NQTLs makes it difficult to enforce parity even when these limitations were clearly impairing patient access to mental health and substance use disorder services (mental health). With creative lawyering, insurance companies can easily construct arguments for why disparate outcomes are justified by claiming to have applied the same processes, strategies, and evidentiary standards to both MH/SUD and medical/surgical (M/S) services when designing and implementing NQTLS. The ambiguity created by this abstract and subjective approach allowed these insurer arguments to prevail for too long.[5]

Without insurers having clear requirements to systematically collect, analyze or provide data on NQTL impacts on access to care, neither insurers nor regulators would have a comprehensive picture of whether NQTLs were severely limiting access to MH/SUD care, and whether those limitations were worse than for M/S services.[6] For these reasons, we applaud the Proposed Rule's requirements that insurers must collect outcomes data and take reasonable action to address disparities identified by that data. These critical provisions would bring to the parity regulations a focus on the core parity question—whether access to mental health care is being unfairly denied— and set a clear path for fixing those problems.

[5] For ease of reference, we will refer to "insurers" or "insurance companies" to cover both issuers and plans. This is based on our view that most parity issues with plans stem from the policies and practices of the insurance companies that act as their third-party administrators, as detailed in Section I. D below.

[6] We recognize that sub-regulatory guidance from the Departments highlighted the importance of this kind of data, e.g., 2020 MHPAEA Self-Compliance Tool, but the Proposed Rule sets for clear, systematic requirements and consequences and does so in the regulations themselves.

The Mental Health Crisis

We are in the midst of an unprecedented mental health crisis. The fallout from the COVID-19 pandemic and other social stressors (e.g., political and social strife, climate change, global conflicts) has intensified an already significant access problem, revealing profound shortcomings in our behavioral health care system. Today's population is experiencing extraordinarily high levels of stress and anxiety, with a quarter of U.S. adults reporting that they are too stressed to function.[7] Mental health issues are particularly acute among children and adolescents, as evidenced by the disturbing report from the Centers for Disease Control and Prevention that one in three teenage girls have contemplated suicide.[8] As the need for mental health services escalates, mental and behavioral health providers struggle to meet increasing demands. Psychologists have reported that demand for treatment for anxiety and depression remains high, especially among populations of color and young people.[9] Amid this influx, lack of access to mental health care continues to be an enormous concern.

Network Adequacy Problems and Trends

Even prior to the pandemic, many insurance networks had poor access to care.[10] Consumers difficulties accessing care in networks due to inaccurate and unusable provider directories, also known as the "ghost networks", has only worsened. In prior years, psychologists would report that a desperate patient had called five or maybe ten providers in the directory trying to find an appointment. Now we hear reports of desperate patients calling over a hundred therapists in the network.[11]

One of the primary factors driving disparities in access to mental health treatment is the difference in reimbursement rates for mental health services compared to physical health services.[12] As noted by

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[7] American Psychological Association. (October 2022). Stress in America: Concerned with the future, beset by inflation. Retrieved from: https://www.apa.org/news/press/releases/stress/2022/concerned-future-inflation; American Psychological Association. (March 2022). Stress in America: Money, Inflation, War Pile on to Nation Stuck in COVID-19 Survival Mode. Retrieved from: https://www.apa.org/news/press/releases/stress/2022/march-2022-survival-mode.

[8] Centers for Disease Control and Prevention. February 13, 2023. U.S. Teen Girls Experiencing Increased Sadness and Violence. Available at: https://www.cdc.gov/media/releases/2023/p0213-yrbs.html#:~:text=Youth%20mental%20health%20has%20continued,60%25%20from%20a%20decade%20ago.

[9] American Psychological Association. (November 2022). Psychologists struggle to meet demand amid mental health crisis, 2022 COVID-19 Practitioner Impact Survey. Retrieved from: https://www.apa.org/pubs/reports/practitioner/2022-covidpsychologist-workload.

[10] See generally, Stephen Melek, Stoddard Davenport, & T.J. Gray, Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement (Seattle: Milliman – 2019). (Milliman Reports). Retrieved from: https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

[11] See also, The Seattle Times. Oct. 3, 2023. How Insurance Companies fill their networks with 'ghost' therapists. Retrieved from: https://www.seattletimes.com/seattle-news/mental-health/how-insurance-companies-fill-their-networks-with-ghost-therapists/

[12] Technical Release, supra fn. 1.

the Government Accountability Office (GAO), many stakeholders have identified the persistently low reimbursement rates as a primary deterrent for mental health providers' involvement in insurance networks.[13]

During the subsequent post-pandemic surge in demand, insurance companies have reported amassing billions in profits[14] They could have allocated those profits to address the disparately low reimbursement for mental health services to attract and retain mental health professionals for their networks. But this did not happen.

Instead, many psychologists report that, with rare exceptions[15], insurers have not increased their reimbursement for many years, not even keeping up with rising inflation, thus making it difficult to sustain a practice while continuing as an in-network provider. We appreciate the Departments' recognition that low reimbursement for mental health services are a major factor attributing to low network participation by mental health providers.[16]

Insurance companies could also have retained and attracted network psychologists by reducing the administrative burdens of network participation; unfortunately, our members report that these hassles are on the rise. These include:

- Pre-payment audits – often inexplicably continued when the initial audit revealed no problems.
- Clawbacks of payments, even in cases where authorization was received.
- Challenges to the use of certain codes, although psychologists are properly billing them.
- Long wait times for providers seeking admission to the network – some over 9 months.
- Denial of admission, often due to the network being "closed."

[13] U.S. Government Accountability Office. March 2022. Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts, GAO-22-104597. Retrieved from: https://www.gao.gov/assets/gao-22-104597.pdf

[14] Major health insurers have seen a drastic increase in revenues and profits since the beginning of the COVID-19 pandemic. For example, according to the company earnings reports, UnitedHealth Group brought in 80.1 billion in revenue, earning 5 billion in profits; Anthem earned 1.8 billion in profits for the first quarter of 2022, seeing the fourth-highest revenue that quarter, earning $38.1 billion. Fierce HealthCare. May 2022. UnitedHealth was this quarter's most profitable payer-again. Retrieved from: https://www.fiercehealthcare.com/payers/unitedhealth-was-quarters-most-profitable-payer-again. Cigna earned $1.2 billion in profit for the first quarter of 2022, up from $1.16 billion a year before. Revenue in 2022 reached $44 billion, up from $41 billion in the first quarter of 2021. Cordani, E. (2023, February 18). Cigna Posts $1.2B Profit in Q1 Amid Double-Digit Revenue Growth at Evernorth. FierceHealthcare. Retrieved from https://www.fiercehealthcare.com/payers/cigna-posts-12b-profit-q1-amid-double-digit-revenue-growth-evernorth

[15] APA Services has heard of one recent rate increase from a major insurer. As one of our psychologist members noted, however, this insurer had not increased their payment rates in over 20 years, meaning that the increase did not come close to keeping up with inflation over that time.

[16] Technical Release, supra fn. 1 at pg. 17; Harvard Medical School Primary Care Review. (December 2020). Here's Why Mental Healthcare Is So Unaffordable & How COVID-19 Might Help Change This. Retrieved from: https://info.primarycare.hms.harvard.edu/review/mental-health-unaffordable (Noting that "many psychotherapists and psychiatrists receive[] such poor coverage and reimbursement with most health plans that clinicians abstain[] from a payer system that neglected them and their services, setting a precedent for cash pay practices instead."); See also, Milliman Reports, supra fn. 10 (describing behavioral care providers' low reimbursement rates).

- Inability to connect with provider representatives to resolve issues, including hours of hold times and their failure to return calls.

These tactics by insurance companies have created enormous difficulties and wasted providers' time, reducing their ability to serve patients. This is particularly detrimental for psychologists in small practices with little or no administrative support.

The combination of unsustainably low reimbursement, high administrative burdens, and a large demand for services paid out of pocket has fueled a substantial departure from insurance networks by psychologists in recent years, as reported by our members.

The impact of these trends is that insurance network access has gone from poor to very bad. Psychologists who have remained in networks report little or no capacity to take on new patients, with waiting periods, if any, of many months.

Patients suffer from these network adequacy problems by having to pay more for out-of-network (OON) care, if they are fortunate enough to have such coverage, or having to pay completely out of their own pocket. For many patients, this means their access to critically necessary care is delayed, or worse, they simply give up and go without care altogether. This can have life threatening consequences.[17] Even those patients with OON coverage have faced a new problem over the last year. Several major insurers have engaged in "repricing" of OON claims that in some cases has surprised patients with significant, unexpected drops in their OON reimbursement for mental health care. Beyond the immediate impact on patients, we are concerned that these tactics—which in some cases create substantial hassles for the provider—discourage mental health professionals from even taking patients with OON coverage, thereby further reducing access to covered mental health care.[18]

Some insurers claim that network adequacy problems are due to a workforce shortage for mental health professionals. We disagree. From our perspective, there is a large pool of experienced psychologists who could fill networks if paid and treated fairly.

Many of our members would be interested in returning to or joining networks if reimbursement was increased to adjust for high demand and inflation, and harassing tactics by certain insurers stopped. Our members share the health equity concern that care must be accessible to the large swath of Americans who rely on insurance to cover their mental health needs. Mental health providers' lack

[17] While some might argue that psychologists struggling to keep their practices afloat (with fees that for years have not kept up with inflation) should put their patients' needs first, we would point to the billions of dollars in record insurer profits noted in fn. 14 above and suggest that those companies are in a better financial position to put patient needs first.

[18] The situations we have investigated appear to be quite troubling, with patients and providers being told that a third party "repricing" company is merely giving the psychologist a "repricing offer" to accept less pay, and maybe only finding out by reading the fine print at the end of an explanation of benefits statement. But if the psychologist tries to reject the offer, they are bounced back and forth between the insurer and repricing company with no reasonable means to stop these "offers." In some cases, patients have been given misleading information, suggesting incorrectly that under the No Suprises Act they have no obligation to pay the now greater difference between the psychologists' fee and the lower "repriced" amount. While we understand that these companies are also engaging in this tactic with respect to M/S services, the greater prevalence of patients having to rely on OON coverage for mental health means that these patients are disproportionately impacted.

of participation in insurance networks is intrinsically linked to failures in complying with and enforcing mental health parity around reimbursement and administrative hurdles under the old process-heavy approach. We are optimistic, however, that the proposed changes to the rule will push insurers to create the reasonable conditions to bring in the necessary pool of available psychologists and other mental health professionals to meet the needs of those covered by the plan.

When those needs are met by a truly adequate network, patients can access timely mental health care before their conditions deteriorate, and those patients who have OON coverage or can afford to pay-out of pocket do not need to incur costs for care that their in-network insurance should cover.

Benefits for Employers

While some have argued that implementation of the Proposed Rule would hurt employers and plans, in our view the Proposed Rule provides greater clarity and specificity that some employers have claimed they need to guide their compliance. More importantly, it responds to the concern that only 31% of employers were satisfied with their employees' access to in-network mental health and substance use care, according to a Voice of Purchaser survey released earlier this year.[19] Employers recognize that their employees want and need mental health services. That same concern was expressed by several human resources and employee benefits representatives during the Departments' parity stakeholder meeting in September 2022. Employees' untreated mental health problems costs employers *billions* of dollars in lost productivity, increased healthcare expenses, and increased recruitment costs due to turnover, which surpasses any investment in adequate mental health coverage.[20]

In addition, our proposals for Third Party Administrators (TPA) at Section II.D would solve what we believe is one of the major problems with parity compliance for self-insured ERISA plans – that they do not have the expertise or knowledge on key aspects of parity compliance because they rely on the expertise and resources of their TPA to handle matters such as network composition and reimbursement, and medical necessity determinations and guidelines. Our proposal would clarify the respective roles of the plan and the TPA on parity compliance and gives plans the option to make the TPA responsible for parity compliance on those aspects of compliance that are really within the control and expertise of the TPA.

[19] National Alliance of Healthcare Purchaser Coalitions. (April 2023). The Voice of Purchaser Survey on Behavioral Health Support. Retrieved from: https://higherlogicdownload.s3.amazonaws.com/NAHPC/3d988744-80e1-414b-8881-aa2c98621788/UploadedFiles/T514R490RouKpe2lnF9J_VOP%20Public%20Report_Finalized%203.pdf

[20] According to a recent study by the health and wellness publisher HealthCanal, untreated workplace mental illness costs U.S. businesses US $3.7 trillion dollars each year due to lost working time, turnover caused by mental illness, and the expense of treating mental health illness. HealthCanal. Cost of Untreated Workplace Mental Health. Available at: https://healthcanal.com/cost-of-untreated-workplace-mental-health-us/

II. Comments on the Proposed Rule

A. Exceptions

Our primary concern with the Proposed Rule is that proposed exceptions for independent standards and fraud, waste & abuse are overbroad and threaten to severely undermine proposed rule's effectiveness. When announcing the Proposed Rule in July, the Administration listed "close existing loopholes in mental health care" as one of three core principles behind it. The two proposed exceptions would create enormous new loopholes in parity compliance. We agree with the concerns about these exceptions stated at pp. 4-9 of the MHLG Letter. We outline below some additional concerns and perspectives.

We urge the Departments to remove these exceptions and instead fold these considerations into the regular NQTL analysis. If the Departments insist on retaining them, we urge that they be very narrowly defined to address the concerns described below.

Independent Professional Medical or Clinical Standards Exception

We agree with the extensive discussion in the MHLG Letter of the reasons why independent professional medical or clinical standards (independent standards) should not be an exception and should instead be folded into the NQTL analysis.[21] We are concerned about how "independent" standards are defined, and concerned that in critical areas like network composition there may be multiple standards with no clear consensus. In such situations, the selection of one standard out of many by an insurer should be subject to scrutiny, instead of shielded from it.

Proprietary Standards

If the Departments insist on retaining this exception, it should be narrowly circumscribed so that a plan could not rely on non-transparently developed, proprietary guidelines of for-profit companies to take advantage of the proposed exception. A narrower definition should ensure that guidelines meet the three core criteria explained at p. 7 of the MHLG Letter, that they be: fully transparent and accessible; developed through a consensus process that protects against conflicts of interest; and externally validated.

Nonprofit clinical criteria are subject to rigorous peer review, validation studies in real-world clinical settings, and are reviewed in professional and scholarly journals. For example, The American Psychological Association, like many other non-profit professional associations, painstakingly develops its clinical practice guidelines through a highly transparent process, with strong protections

[21] MHLG Letter at pp. 4-8.

against conflict of interest, in accordance with the National Academy of Medicine's *Clinical Practice Guidelines We Can Trust*.[22]

We are concerned about health plans' ability to leverage proprietary guidelines as a justification for applying the exception because of our experience with psychologist members who do testing and assessment. Those psychologists are often frustrated by insurers who rely on propriety guidelines to limit testing to a certain number of hours or to certain conditions. They believe that these opaque limits are contrary to their professional judgement about what testing is medically necessary and appropriate, and that psychological testing is being constrained more than medical testing.

Often, these psychologists are the national experts in the field, yet have no idea what expertise or research are relied upon to justify seemingly arbitrary and unnecessarily narrow limits. Testing and assessments are critical to determining accurate diagnosis and ensuring that a patient is on an appropriate and effective treatment path, yet the proprietary nature of the plans' guidelines make it impossible for these experts to successfully appeal or otherwise challenge these decisions.

Allowing the application of non-transparent, proprietary, for-profit guidelines through this exception would further plans' ability to deny care based on guidelines that have been developed in secrecy by for-profit companies that have a clear financial incentive to develop restrictive guidelines. Some insurers will want to employ these opaque guidelines as a way to reduce mental health costs, regardless of whether those reductions are based on objective science. This would be contrary to the broad trend toward greater transparency in health care, as exemplified by the Cures Act, the No Surprises Act, etc.

Application of the exception where multiple standards exist

We are aware that in some critical areas, no single, widely accepted "gold standard" or consensus standard exists. For example, an insurer might argue that by using one of many divergent independent standards for network adequacy (from state laws, accreditation bodies, or other organizations),[23] it would be exempt from the data requirements and other parity scrutiny for the network composition NQTL for that category. We are aware of widely divergent network adequacy standards used by state regulators and accreditation organizations. In our view, none of the standards we have seen adequately cover all the critical components to determine real access to care; some standards are likely

[22] Institute of Medicine. (2011a). *Clinical practice guidelines we can trust*. National Academies Press. https://doi.org/10.17226/13058.

[23] We note that we are not certain whether some or any network adequacy standards fall within the intended definition of "independent medical or clinical standards" because they focus more on the system by which care is delivered as opposed to the clinical standards for delivering care. But this uncertainty is part of the problem with the proposed exception.

outdated[24], while most were developed without parity considerations or the current understanding of problems with access to mental health care.

Where multiple independent standards exist and there is no consensus on the best or appropriate standard, it is critical that insurers collect data on how the application of a particular standard used affects access to care and conduct stringency and design/application tests as part of the NQTL analysis. That data and analysis will determine whether the independent standard relied upon actually promotes full and equitable access to mental health care, as opposed to the insurer's reliance on a conveniently restrictive standard.[25]

A final concern about this exception is that it is unclear from the plain language of the Proposed Rule and the preamble discussion whether this exception would apply to only the part of the NQTL to which the independent standards are applied, or to the entire breadth of the NQTL. The latter interpretation would be highly problematic and contrary to the Departments' stated intent that these exceptions be narrowly defined. (The same scope concern applies to the fraud, waste and abuse exception discussed next.)

Based on these concerns, we urge that this exception be removed as a standalone exception, and that independent standards simply be subsumed as part of the regular NQTL analysis.

Fraud Waste & Abuse Exception

We recognize the importance of reducing health care fraud, waste, and abuse, yet we have grave concerns that plans will use the fraud, waste, and abuse exception to justify burdensome and improper audit and other practices with less parity scrutiny.

We've already observed the trend in the last few years that plans are implying fraud in what we consider to be routine utilization reviews involving perfectly appropriate billing by psychologists. In particular, we have seen some plans send letters from Special Investigations Units (which are the companies' fraud & abuse departments) to inappropriately suppress the use of the higher psychotherapy code (CPT code 90837, for 60 minutes of psychotherapy). When we investigated, we determined that psychologists are appropriately billing the code as defined by the CPT manual. We believe that the plans may have just used this fraud and abuse as a scare tactic, hoping that psychologists and other mental health professionals would just cave to unreasonable demands. We fear that this exception will empower plans to cloak other routine efforts to constrain mental health care under a fraud rubric to evade parity scrutiny.

Processes and strategies pertaining to the detection of fraud, waste and abuse should be part of the plan's policies subject to NQTL analysis, not an exception for plans to use to avoid compliance

[24] This is evidenced by the fact the state regulators have complained about difficulties applying existing network adequacy standards to situations where they know that access to care is very poor, and our observation of serious network problems with insurers with that are accredited by independent accrediting bodies, with network adequacy standards, although those do not yet have a parity lens.

requirements. Should the Departments insist on keeping this exception we urge that it be clearly and narrowly defined. In addition to the requirement that fraud, waste and abuse policies be "narrowly designed to minimize the negative impact on access to appropriate mental health and substance use disorder benefits," we suggest adding the requirement that plans state whether other methods less likely to constrain access to mental health care were considered, and why such methods would not be as effective. This additional step might provide some further protection against exploitation of the proposed exception, but we would greatly prefer to have this removed as a standalone exception.

B. Required use of outcomes data and consequences where that data shows disparities

APA Services has long pushed for requiring outcomes data, recognizing that making plans track key metrics is absolutely essential, showing insurers and regulators the actual impact of NQTLs on mental health access. We applaud the Departments for giving these clear data requirements real teeth by requiring insurers to take reasonable action to address "material" differences in access identified by that data, and finding insurers in violation if the outcomes data regarding network composition identifies material disparities.

The collection of data using standardized definitions and methodologies is critical to assessing an NQTL's impact on access to mental health and M/S care. A core weakness of the existing regulations is that an NQTL's impact on access to mental health treatment as compared to M/S treatment is rarely appropriately measured and analyzed. Instead, insurers rely on process-related justifications and arguments to inappropriately justify disparate access to treatment. More importantly, the existing regulations do not require insurers to address disparities if data that is collected shows differences in access between mental health and M/S.

Adding these critical provisions to the regulations would return the focus to the core intent of MHPAEA—whether access to mental health care is being unfairly limited—and require insurers take action when the data shows disparities in access. For network composition issues, the insurer would also be deemed non-complaint if the data shows access disparities. Together these will be major steps forward in solving the key parity issues.

But the strength of both provisions is undercut by the undefined qualifier that the difference in access must be "material". We urge the Departments to eliminate, or at a minimum very narrowly define, the qualifying term "material," which has no basis in the statute. As stated, this ambiguous term creates too much uncertainty around when insurers will have to take reasonable action or be found in non-compliance.

From our many years working on parity implementation and enforcement (as well as extensive efforts with stakeholders on all sides to develop parity accreditation standards), we are aware that central parity issues like network composition and reimbursement are extremely complex and can be measured in numerous ways that indicate divergent results. Additionally, some data doesn't work in all contexts. For example, OON utilization is a great indicator of network adequacy, but for HMO plans and other plans with no OON benefits, the insurers have no OON utilization data to analyze.

For these reasons, it is critical to require multiple data points. This gives insurers and regulators the fullest picture possible on key parity issues.

We are very pleased that one of the specific metrics listed in the Proposed Rule is whether providers are accepting new patients (Section (c)(4)(iv)(A)(2)). This is a critical data point given how busy those mental health providers staying in networks are, as evidenced by the reports from psychologists that they are too busy seeing current patients in the network to take on any new patients. Other network data (except perhaps for wait times) may make a network look full of mental health providers actively submitting claims, but if few are available to take new patients, the network is of little help to patients seeking care for the first time.

It is also our understanding that very few of our members have wide open availability. Therefore, we recommend that the required data include a "limited availability" category for those mental health providers who may have only a few slots open because such providers do not add significant capacity insurers' networks.[26]

C. Special Rule for Network Composition

We strongly support this provision because, as stated above, we believe that network adequacy is the biggest parity problem. We also fully support listing network composition as a separate NQTL.

We have suggestions in the technical release about additional data points on network composition. Having worked on these issues for over two decades, we know that network adequacy is easy to mismeasure.

D. Third Party Administrators

In APA Service's experience, the key NQTL problems we see with self-insured ERISA plans (as outlined in Section I) have their origin not with those plans, but with the third-party administrator (TPA) the plan has hired to offer and manage its network, to set medical necessity and utilization criteria, to manage claims, etc. In other words, the problem comes to us as an across-the-board policy of insurance company A, instead of being a policy unique to the XYZ Manufacturing Plan. This creates a huge enforcement and compliance barrier and inefficiency, since the Department of Labor does not have direct enforcement authority over the TPAs that are responsible for so much of a plan's parity compliance.

Thus, we favor efforts to have TPAs more involved in, and responsible for, parity compliance. We fully support the proposal at p. 15 of the MHLG letter to require plan sponsors to insert MHPAEA compliance provisions into their contracts with TPAs. This concept borrows from HHS' "business associate agreement" approach in HIPAA, whereby privacy and security protections have been

[26]This concept was developed by a Massachusetts task force studying provider directory issues, see Massachusetts Division of Insurance, Report of the Provider Directory Task Force to respond to Section 4 of Chapter 124 of the Acts of 2019, (2020), available at: https://www.mass.gov/doc/provider-directory-task-force-report-2020/download

extended to billing, accounting, IT, and other entities that were beyond the purview of the original HIPAA statute. The MHLG proposal recommends that a plan sponsor that contracts with a TPA should be required to include specific obligations in the contract whereby the TPAs must assist the plans in fulfilling their MHPAEA obligations for the benefit of participants/beneficiaries and regulators. (For ease of reference, we refer to the proposed agreement as a Third-Party Administrator Agreement or TPAA.)

We suggest that the Departments expand the TPAA concept. First, the Departments should provide more specificity as to how the TPA would assist the plan in fulfilling plans' obligations to participants/beneficiaries and regulators. In particular, while we agree with the analysis at pp. 14-15 of the MHLG letter that TPAs should not be allowed to withhold required medical necessity or compliance information or data from plans, participants, and regulators on the basis that it is of "proprietary" or "commercial" value, this should be specified in the TPAA to eliminate any uncertainty and reinforce these requirements with both TPAs and plans.

Second, the Departments 2022 parity enforcement report to Congress noted that some plans claimed confusion on responsibility between them and the TPA as a reason for non-compliance. Some plans claimed that they thought that the TPA was taking care of the required comparative analysis.[27] Thus, we recommend that the TPAA should specify the scope of TPA's responsibilities for assisting the plan with parity compliance, beyond the information provisions noted above.

Finally, we recommend that the final rule should make clear that plans have the *option* of making the TPA responsible for any portion of parity compliance that the TPA has control over, such as network composition. We believe that reminding plans of this option could put market forces to work in a beneficial way. Many plans that lack expertise in parity compliance would gladly shift parity compliance responsibilities to a TPA that does have that expertise. TPAs would be incentivized to take on that responsibility, and handle it well, for a competitive advantage over other TPAs.

E. Provider Directories

The NPRM seeks stakeholders' feedback on provider directories. We attach our June 27, 2023, letter to the Senate Finance Committee, which is considering these issues. The letter represents our latest thinking. While we recognize that it is beyond the Departments' authority to order insurers or issuers to provide the information that we recommend listing in their provider directories, we think that it might be helpful for the Departments to be aware of our suggestions.[28]

If Congress required provider directories to establish accurate, up-to-date provider directories that include key data elements, this would increase transparency, allowing free market forces to drive consumers and employers to select insurers that provide the best access. Requiring this information in provider directories would incentivize insurers to identify and address network deficiencies to

[27] MHPAEA Comparative Analysis Report to Congress. July 2023. Available at: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf.

[28] We note that the Committee was focused on provider directory issues for government insurance plans, especially Medicare Advantage plans. But we believe that the same directory issues apply to the networks covered by this rule.

better attract customers. The key data would be granular information on how available providers are (as described at the end of Section II.B above), and details about the provider to help patients/consumers find mental health providers who meet their needs.[29] This data would also let insurers and regulators assess whether a network provides the broad array of specialties and capabilities to fully serve the population covered by the network.

We recognize that a key difference between the information included in our provider directory proposal, and what would be gathered for parity compliance, is that the power of the former would be making it publicly available in a way that could harness marketplace competition. We would be open to discussing with the Departments ways to incentivize insurers to voluntarily make such information available.

Medicaid parity rules

We are pleased that HHS recently issued proposed parity rules for Medicaid and CHIP. We will comment on those rules but want to stress in these comments the importance of making those parity rules be as strong as the Proposed Rule here, with the additions we and other mental health groups support. We should not tolerate a two-tiered system in which lower-income, underserved and diverse populations served by public health programs have weaker parity protections than those in group and individual health plans covered by the current Proposed Rule.

III. Comments on the Technical Release

As stated in Section II, we fully support the Department's proposals to require use of outcomes data. We appreciate the extensive effort in the Technical Release to begin mapping out what data should be collected.

Network Data

There are two key network data elements that we think are important based on our, and our members', experiences with access problems in mental health:

1) **Availability to see new patients**. We explained the importance of this metric in Section II.B above, as well as our suggestion for giving this data greater granularity by including data on partial availability, e.g., a provider has only a few slots available.

[29] Relevant provider details would include:
- Populations served, such as adults, teens, children, couples, families, LGBTQ+, autism spectrum disorders, etc.
- Specialty or subspecialty
- Treatment modalities offered, e.g., cognitive behavioral therapy
- Optional demographic information the provider may want to offer in the interest of health equity/underserved populations such as race, age, ethnicity, LGBTQ+, religion, etc.
- Languages spoken
- Provider technology capabilities for facilitating patient communications via telehealth
- Hours of operation, including weekend or evening availability

2) **Wait times**. Many members have reported substantial, unprecedented increases in their wait times during the current mental health crisis. Long wait times are a clear indication that a network needs more providers.

Both metrics should be separately tracked for high-demand specialties such as mental health providers specializing in children and adolescents and eating disorders.

We have heard insurers argue that these metrics are hard to track, but we expect that both could be tracked through secret shopper surveys.

Insurer tactics that have caused providers to leave networks. As noted in Section I above, certain tactics, like unjustified continued pre-payment audits, have a high impact on network composition because they are likely to cause mental health providers to leave networks. Accordingly, we recommend that the Departments request specific data about these tactics and give them heightened scrutiny.

Network Admissions. In assessing network composition and access to mental health services, we urge the Departments to review the criteria and processes by which insurers determine which providers to admit into networks and/or how plans/issuers define when a network is considered "full" or "closed." Our members report that they are often denied participation on networks due to the networks being "closed" or "full," even though patients are unable to find appropriate providers in that network.

Some of our members also report having to wait as long as nine months to be added. Thus, the time to onboard MH providers seeking to join networks should also be examined.

Non-traditional networks/closed systems. We note that for closed systems (like Kaiser Permanente) where most care is provided by employees of the plan and therefore under its control, it is important to look at additional variables like the return time, i.e., the time before a patient is able to return for the next appointment. Variables like this are less important in traditional networks where the mental health provider has control over scheduling once they have accepted a patient.

A. <u>Reimbursement Data</u>

We appreciate that the Departments recognize that reimbursement disparities are a key factor in network composition problems. As noted in Section I above, low reimbursement is the primary reason our psychologist members give for having left, or chosen not to join, networks.

Reimbursement data should be evaluated from multiple perspectives, including those listed below, to effectively assess parity compliance:

Rates actually paid vs. scheduled rates. For network reimbursement, we stress the importance of evaluating actual paid rates vs. scheduled rates. We understand that medical providers are significantly more likely than mental health providers to be able to negotiate above scheduled rates. In any event, paid rates reflect what the plan is actually doing to fill its network, while scheduled rates may just be the starting point for negotiations for some providers.

Geographic considerations. We believe that geographic considerations are important when examining reimbursement data, based on very sizeable differences in reimbursement we have seen over the years between different parts of the country. This may be due to the impact on rates of certain dominant insurers in some states, that are often BCBS companies. We also recommend considering the difference between metropolitan and non-metropolitan areas, given the higher cost of living and concentration of mental health professionals typically found in the former.

Range of CPT codes examined. At the top of p. 18 there is the suggestion that relevant data should include allowed amounts for four specific CPT codes (99213, 99214, 90834 and 90837) for specific types of providers. We support the specific provider analysis, but we believe that examining only the four codes suggested is too narrow for several reasons. First, this narrow set would cover only two CPT codes (90834 and 90837) for the vast majority of mental health providers who are not psychiatrists (as only MDs are generally permitted to bill E&M codes). While these two codes are the most commonly billed codes for most mental health providers, others should also be included, especially 90791 for the initial evaluation. In addition, one major insurer has sharply restricted the use of code 90837 to the point that many psychologists do not even attempt to use it. For that insurer, this approach would effectively mean evaluating only one psychotherapy code. We are also concerned that only two codes would be examined for M/S providers.

Weighting multiple codes by utilization. This may seem obvious, but we note that any analysis of reimbursement under multiple codes should be weighted by how much each code is utilized.

Pressure to restrict use of certain codes or services. Insurers often reduce reimbursement by pressuring mental health providers to use lower-level codes (among the graduated series of psychotherapy codes) or constraining use of services such as psychological testing. In particular, many insurers have pressured mental health professionals to use the 45-minute psychotherapy code instead of the 60-minutes code (90834 vs. 90837) when the professionals are properly following the CPT code guidelines for that code, or placed other constraints on the higher code, such as asserting that it is only permitted for a certain narrow set of diagnoses or treatment modalities. We do not believe these insurers are putting the same pressure or constraints on medical physicians who are billing the analogously graduated evaluation and management codes (such as codes 99213 and 99214 cited above) that have higher costs.[30]

Inflation adjustments. As noted in Section I, many psychologists complain of flat reimbursement rates that have not been adjusted for inflation over many years. Thus, we believe that it would be important to consider whether there is a disparity in that M/S provider reimbursement has been adjusted for inflation.

[30] We note that we do not believe that looking at "comparable services" is a good approach for analyzing parity problems *generally* and agree with statement on this point at p. 3 of MHLG letter to that effect. This is one narrow area, however, in which this approach may provide useful data.

B. **Safe Harbor**

As noted above, network adequacy is difficult to accurately assess, and insurers have demonstrated their ability over the last decades to make networks look robust on paper when in fact they are far from that. We hope that new network composition data reporting requirements will make that much more difficult, but we remain cautious. We also expect that it will take the Departments some time to get a real sense of whether the new data it will be receiving on network composition validly demonstrates access, and whether it is subject to manipulation by insurers submitting it.

Thus, we recommend that Departments delay any development of a safe harbor until they, and stakeholders, are confident about what data accurately reflects a robust network offering all the important types of access. While we are generally open to incentives and rewards for good insurer behavior, this is an area that we believe requires caution and patience.

Conclusion

Thank you for your efforts to make the landmark MHPAEA law more effective and meaningful. We believe that the final rule will be a major step toward achieving true parity—if the Departments adopt the changes that we recommend here and that we and other parity advocates recommend in the MHLG Letter and the Technical Release Joint Letter.

We look forward to discussing this further with the Departments as they move forward to finalize the parity regulations (and the data requirement covered by the Technical Release) based on the input they receive. If you have questions or if we could be of other assistance, please contact Alan Nessman, Senior Special Counsel, Legal & State Advocacy, at ANessman@apa.org.

Jared L. Skillings, PhD, ABPP
Chief of Professional Practice
American Psychological Association Services, Inc.

Katherine B. McGuire, MSc
Chief Advocacy Officer
American Psychological Association Services, Inc.

Attachment: Letter to Senate Finance Committee re: provider directories

AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

June 27, 2023

The Honorable Ron Wyden
Chair
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American Psychological Association Services, Inc. (APA Services), we are writing to share comments and recommendations for consideration as part of your committee's May 3rd hearing, "Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks". APA Services is the companion organization of the American Psychological Association, which is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 146,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

We applaud your leadership in convening this hearing. APA Services has worked on provider directory (PD) issues affecting access to behavioral health services for over two decades. We suggest the following key solutions for behavioral health:

- Require networks to display current information on behavioral health provider's availability to accept new patients, including a category of "limited availability";
- Require sufficient minimum data elements to enable patients to find the provider they need;
- Establish a scoring or rating system for the accuracy of directories and availability of services based on annual reviews by Centers for Medicare and Medicaid Services (CMS), and include financial penalties and rewards;
- Require plans to cover out-of-network care with no more cost-sharing than in-network care if patients are unable to find an in-network behavioral health provider;
- Bar networks from removing behavioral health providers who are not currently available to take new patients from their panels;
- Simplify and standardize the process for all behavioral health professionals to report changes to their location, availability, plan participation, and areas of specialization; and
- Create a standardized national directory of health care providers, as is under consideration by the CMS, including both professionals participating in government and private insurance plans as well as those not in networks.

Current problems created by inaccurate Provider Directories

Inaccurate provider directories can be a barrier to accessing health care services generally, but are an especially acute problem for those in need of mental and behavioral health services. While this has been the case for several years, our nation's mental health is currently in a state of crisis. Data collected by APA show a population experiencing extraordinarily high levels of stress and anxiety, with a quarter of U.S. adults reporting that they are too stressed to function.[1] Almost three out of four Americans are feeling overwhelmed by the number of crises facing the world right now.[2] Unsurprisingly, psychologists report that, after an initial surge during the pandemic, demand for treatment for anxiety and depression remains high, especially among populations of color and young people.[3] Practitioners are seeing increased workloads and longer waitlists, which have contributed to higher levels of burnout within the profession.[4]

We believe it is essential for the committee to recognize that "ghost networks" are a manifestation of the broader societal failure to appropriately value mental health treatment. As noted by the Government Accountability Office (GAO) in its report to the committee last year, stakeholders including consumers, health plans, providers, an insurance regulator, and state health agencies cited low reimbursement rates as a factor contributing to a lack of willingness among mental health providers to join a network or accept insurance.[5] We note that when adjusted for inflation, Medicare's reimbursement rate for a 45-minute psychotherapy session is 19% lower than it was 15 years ago. Our members report that payor reimbursement rates have not gone up to meet the COVID-related dramatic increase in demand for behavioral health care. Nor have the heavy administrative burdens on behavioral health providers improved despite federal and state reform efforts to do so, and in some cases these burdens have gotten worse.[6] Consequently, psychologists have continued to leave insurance networks, particularly those managed by commercial insurers, in favor of seeing patients who pay out of pocket. Low participation rates in insurance plans constrain access to in-network behavioral health care for patients who must rely on public or private insurance in order to afford treatment.[7]

Many of our members would be interested in joining or returning to networks if reimbursements were increased to adjust for high demand and inflation, and harassing tactics by certain insurers stopped. Our

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[1] American Psychological Association. (October 2022). Stress in America: Concerned with the future, beset by inflation. Retrieved from: https://www.apa.org/news/press/releases/stress/2022/concerned-future-inflation.

[2] American Psychological Association. (March 2022). Stress in America: Money, Inflation, War Pile On to Nation Stuck in COVID-19 Survival Mode. Retrieved from: https://www.apa.org/news/press/releases/stress/2022/march-2022-survival-mode.

[3] American Psychological Association. (November 2022). Psychologists struggle to meet demand amid mental health crisis, 2022 COVID-19 Practitioner Impact Survey. Retrieved from: https://www.apa.org/pubs/reports/practitioner/2022-covid-psychologist-workload.

[4] Ibid.

[5] Government Accountability Office. (2022). *Mental Health Care: Access challenges for covered consumers and relevant federal efforts* (GAO-22-104597). Retrieved from https://www.gao.gov/products/gao-22-104597.

[6] *See generally,* a 2022 Annual Regulatory Burden Report published by the Medical Group Management Association indicated that 89% of respondents reported that the overall regulatory burden has increased over the past 12 months. The respondents in this report were from over 500 medical group practices who have significantly more staff and resources to implement regulatory requirements than do practitioners in the behavioral health space. MGMA Annual Regulatory Burden Report (Oct. 11, 2022) available at: https://www.mgma.com/practice-resources/government-programs/mgma-annual-regulatory-burden-report-2022

[7] See generally, Stephen Melek, Stoddard Davenport, & T.J. Gray, Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement citing strong evidence of reimbursement disparity. *See* also, Nicole M. Benson & Zirui Song, *Prices and Cost Sharing for Psychotherapy in Network Versus out of Network in the United States*, 39 Health Affs. 1210, 1215 (2020). We emphasize that APA wants to improve conditions so psychologists will participate in networks; we share the view of many of our members that it's vital to serve the millions of Americans who must rely on their health insurance to cover their mental health care.

members share the health equity concern that care must be accessible to the large swath of Americans who rely on government or commercial insurance to cover their mental health needs.

In addition, opaque provider directories that create the false appearance of being adequate provide a rationale for insurers to tell psychologists who *do* want to join their network that they cannot because the network is full. The false picture of network adequacy may also be a factor in networks taking several months to credential psychologists who want to join, when these networks should be bringing on additional providers as fast as possible.

Solutions

Establishing accurate, up-to-date provider directories that include key data elements will increase transparency, allowing free market forces to drive consumers and agencies to select plans that provide the best access, and incentivizing plans to identify and address network deficiencies.

Within this context, we offer comments and recommendations in three areas: Transparency and Reliability; Incentives and Protections; and, Standardization and Support.

Transparency and Reliability

- **Require networks to display current information on behavioral health provider's availability to accept new patients, including a category of "limited availability".** Given the high demand for psychologists' services, very few of our members report having wide open availability to take new patients. Most of our members who have some capacity to take new patients typically have only a few slots available; these slots are likely to fill up fast once they announce that they are available to take new patients. A "limited availability" category signals to consumers that a psychologist may have only a few time slots available, which may fill up fast. It also gives networks and government agencies managing Medicare Advantage and managed Medicaid plans a better sense of network capacity. By contrast, a binary "available/not available" data point may incorrectly suggest that a provider has wide open availability.

  We note that a Provider Directory Task Force, convened by the Massachusetts Department of Insurance in 2019, recommended that health plans identify whether a provider (a) is closed to new patients, (b) has limited availability to accept new patients, or (c) is open to accept new patients (which may still require a wait time). The Task Force considered provider availability standards based on wait times to make provider availability information more meaningful.[8]

- **Require sufficient minimum data elements to enable patients to find the care they need.** Directories should include sufficient data to enable consumers to find behavioral health providers who meet their unique needs, and to help plans ensure they have an appropriate mix of provider skills and specialties in their network. For example, a parent seeking a specialist in adolescent eating disorders should not have to waste time contacting network providers who do not treat adolescents or that specific disorder. Any consumer faced with a choice of networks should be able to see which of them include providers with the expertise they need.
  This information should include:
  - Populations served, such as adults, teens, children, couples, families, LGBTQ+, autism spectrum disorders, etc.
  - Specialty or subspecialty
  - Treatment modalities offered, e.g., cognitive behavioral therapy

[8] Massachusetts Division of Insurance, Report of the Provider Directory Task Force to respond to Section 4 of Chapter 124 of the Acts of 2019, (2020), available at: https://www.mass.gov/doc/provider-directory-task-force-report-2020/download

- Optional demographic information the provider may want to offer in the interest of health equity/underserved populations such as race, age, ethnicity, LGBTQ+, religion, etc.
- Languages spoken
- Provider technology capabilities for facilitating patient communications via telehealth
- Hours of operation, including weekend or evening availability

Incentives and Protections

- **Establish a scoring or rating system for both accuracy of directories and availability of providers, based on the granular information described above.** For example, a star rating system could give more stars to a directory that regulators determined was more accurate, based on secret shopper surveys and other methods. And provider availability could be based on wait times, with the highest stars or grades given to the networks with the lowest wait times. A good scoring system will allow consumers, patients, and federal and state agencies that manage Medicare Advantage and managed Medicaid programs to get a quick snapshot of how different provider directories are doing in these critical areas. Such a scoring system would also put free market forces to work, rewarding networks that have the best accuracy and availability, and incentivizing other networks to improve.

- **Require plans to cover out-of-network care with no more cost-sharing than in-network care if patients are unable to find an in-network behavioral health provider.**

- **Bar networks from removing behavioral health providers who are not currently available to take new patients from their panels.**

  While some have suggested that networks should remove mental health providers who are not currently taking or seeing patients, our discussions with psychologists in the trenches leads us to the opposite view. Psychologists often stay in networks in case their existing patients change insurance, which happens frequently, so they can continue to provide lower cost care to their patients. Psychologists may be unable to rejoin a plan's network when the patient returns to that insurance because the health plan claims to have a full network or has a slow administrative process for readmitting providers. Because of these factors, the fear of getting kicked off networks will discourage accurate and timely availability reporting by BHPs.

  If the provider directory is transparent about how available providers are to take new patients, the picture of network capacity will not be clouded by any providers who are remaining in the network primarily to be able to continue care with existing patients who shift networks. If patients have a choice between different networks (e.g., between different Medicare Advantage plans), it will be helpful for them to be able to search the directories to see if their current behavioral health provider is in the network to continue care.

  We would be happy to talk to the Committee about appropriate incentives to encourage providers to timely report changes in their availability or other directory information.

Standardization and Support

- **Create a standardized national directory of health care providers, as is under consideration by CMS**

  We urge the Senate Finance Committee to ensure that CMS has the legal authority to establish such a directory. Such a directory would create "one stop shopping" for behavioral health providers to update their network availability, and help patients compare health plans, find in-network providers, and identify providers who meet their specific needs and preferences. Currently, patients choosing a provider must navigate a series of fragmented systems maintained by various entities to gather and compare provider information. By contrast, a national provider directory would improve consumer experience, better-inform patients' choice, and make it easier to find available care.

  APA Services' detailed thoughts on how a national provider directory would work best for behavioral health are in our recent comments in response to CMS' proposal for such a directory. [9] As we stated in our comments, a national directory of health care providers should include all behavioral health providers, including those who are not in any network. Behavioral health services are much more likely than general medical services to be delivered by an out-of-network provider. [10] Accordingly, we recommend that the directory be open to the many psychologists who are not within any payer network, so that they can be reached by consumers stuck with inadequate networks under their existing coverage.

  It is also critical to create a single portal that would enable behavioral health professionals to update their information regardless of whether or not they use certified electronic health records (EHR) systems that could automatically connect to the directory. Congress excluded most behavioral health providers from incentives for the adoption and use of EHR under the HITECH Act, and as a result, a large percentage of behavioral health providers do not use such systems.

- **Simplify and standardize the process for all behavioral health professionals to report changes to their location, availability, plan participation, and areas of specialization.**

  Until a national provider directory is created, it will be important to require networks to have a simplified and standardized process for reporting changes in their availability and other changes to their directory information. Those behavioral health providers who have stayed in networks are frequently in multiple networks. Having to report changes across multiple different network platforms with varied requirements will make it much more difficult for those providers, particularly those in small practices with limited administrative support, to update their network status. We would be happy to work with the Committee on how to implement this requirement.

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[9] *See*, American Psychological Association Services, Inc., Letter in response to Request for Information; National Provider Directory for Healthcare Providers & Services, 87 FR 61018, ((File No. CMS-0058-NC), (December 6, 2022).

[10] See generally, Stephen Melek, Stoddard Davenport, & T.J. Gray, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* (Seattle: Milliman – 2019), hereinafter, "Milliman Reports", (describing behavioral care providers' low reimbursement rates) available at: https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

Thank you for your consideration of this critically important barrier to establishing effective access to behavioral health services. APA Services would greatly appreciate the opportunity to work closely with your committee and its members to develop policies in this area. If we can be of any assistance, please contact Alan Nessman, JD, Senior Special Counsel, at anessman@apa.org.

Sincerely,

Jared L. Skillings, PhD, ABPP
Chief of Professional Practice

Katherine B. McGuire, MSc
Chief Advocacy Officer