From:	Karen Ferguson
To:	EBSA MHPAEA Request for Comments
Subject:	Comments on Parity Technical Release
Date:	Tuesday, October 17, 2023 4:17:01 PM
Attachments:	AACAP Parity Technical Release 10.17.23.pdf

Good Afternoon,

Please see the attached comments from the American Academy of Child and Adolescent Psychiatry on the Technical Release on mental health parity.

Thank you,
-Karen

Karen Ferguson
Deputy Director of Clinical Practice
American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016
202.587.9670

www.aacap.org

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

WWW.AACAP.ORG

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: Comments on Technical Release 2023-01P

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

The American Academy of Child and Adolescent Psychiatry (AACAP) 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") Technical Release 2023-01P, *Request for Comment on Proposed Relevant Data Requirements for Nonquantitative 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* (MHPAEA) (hereinafter "Technical Release").

The American Academy of Child and Adolescent Psychiatry (AACAP) is the professional home to more than 10,000 child and adolescent psychiatrists, child and adolescent psychiatry fellows, psychiatry residents, and medical students, some of whom also

treat adults and transitional age youth (youth up to age 26). Our mission includes promoting the healthy development of children, adolescents, and families. On behalf of the physicians we represent and the patients they serve, we commend the Departments' efforts to improve access to mental health care and addiction treatment. This letter is in addition to the comments submitted in response to the Department's proposed Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA).

NQTL data collection is critical to ensure that plans and issuers do not impose treatment limitations that place a greater burden on plan members' access to MH/SUD treatment than to medical/surgical (M/S) treatment. Combined with the accompanying proposed requirements related to the MHPAEA, the data collection requirements that are envisioned in the Technical Release would be powerful steps in the right direction to increase access to MH/SUD treatment. We urge the Departments to require that the data points for MH services and SUD services be separately collected, analyzed, and reported, consistent with MHPAEA statutory and regulatory requirements, and differentiated by age, including infants, children, adolescents, transitional age youth, and race and ethnicity (where possible). Data should also be collected for M/S services to facilitate MHPAEA comparisons with particular focus on all pediatric physician subspecialties, as described in Appendix 1. The Departments should also develop uniform definitions and methodologies for the collection of all data points so that valid data are collected and can be compared across plans/issuers.

AACAP, along with the American Academy of Pediatrics and Children's Hospital Association, declared a national children's mental health emergency in October 2021, which persists today. As we mark the two-year anniversary of this declaration, physicians are once again sounding the alarm that young people continue to struggle with soaring rates of depression, anxiety, trauma, loneliness, and suicidality that will have lasting impacts on them, their families, their communities, and all our futures.

A board-eligible child and adolescent psychiatrist is a physician with six years of additional training beyond the four years of medical school education, including two to three years of additional subspecialty clinical training in psychiatry and neuroscience specific to children and adolescents. Child and adolescent psychiatrists gain medical training to understand complex pathophysiology and psychopharmacology and to recognize medical illness which could contribute to a patient's presentation.

Addressing persistent child and adolescent psychiatry workforce issues remains a top priority of AACAP, so much so that AACAP created a special taskforce to develop new ways to recruit physician trainees into the field. While available training slots for child and adolescent psychiatry followship trainees have slowly increased, and fewer training slots went unfilled in 2023 as compared to 2022, generally, fewer individuals are choosing careers in pediatric subspecialties while the existing workforce continues to age. Financial concerns, such as medical school debt, are a significant factor given the lengthier training requirements. Persistent disparities in reimbursement rates between mental health/substance use disorder (MH/SUD) services and medical/surgical (M/S)

treatment services, combined with overly burdensome utilization management practices for behavioral health, also serve as a deterrent for future physicians to choose a career in child and adolescent psychiatry. Such inequities have similarly impacted recruitment of other mental and behavioral health provider types. If implemented well, what has been proposed by the Departments could help to finally realize mental health parity and attract a large, diverse generation of child and adolescent psychiatrists.

Poor access to care due to workforce shortages disproportionately impacts minoritized populations. Systemic discrimination and structural barriers make it difficult for Black, indigenous, and people of color (BIPOC) and for lesbian, gay, bisexual, transgender, and queer and/or questioning (LGBTQ) children and youth to have equal access to high-quality mental health services. Cultural competencies are necessary to meet the needs of these patients and their families. Under-recruitment of physicians representing these communities and a lack of cultural competence among non-minority providers create additional barriers to care.

Children and adolescents differ from adults in their continued biopsychosocial development. Research has demonstrated that the brain continues to develop throughout adolescence and into early adulthood. Early identification and intervention are essential to help children and adolescents who need mental health care to thrive and become productive adults. Patients are harmed when access to the expertise of a child and adolescent psychiatrist is needed but they are cut off by narrow provider networks. Moreover, when this happens, families are faced with additional financial burdens for out of network psychiatric care.

We appreciate the Departments' commitment to ensuring that the data plans/issuers will be required to collect provides an accurate reflection of individuals' access to treatment. Given that the Departments' guidance to plans will likely need to evolve over time to ensure such accuracy, we urge the Departments not to proceed with a "safe harbor" for plans/issuers based on data collection that has yet to be validated as meaningful. Otherwise, the Departments may give "safe harbor" to plans/issuers that impose discriminatory barriers that inhibit access to MH/SUD treatment.

Out-of-Network Utilization

Studies indicate that the percentage of services received out of network (OON) is a key indicator of the availability of in-network services. Due to the higher cost-sharing of OON services, individuals rarely choose to obtain care OON if adequate in-network services are available on a timely basis. The landmark 2019 Milliman report demonstrates that MH/SUD care is more frequently obtained OON compared to M/S care. According to this Milliman report in 2017, 17.2 percent of all behavioral office visits were OON compared to 3.2 percent for primary care providers, and 4.3 percent for medical/surgical providers. The data should be disaggregated by age groups wherever possible, so that utilization by children and adolescents can be distinguished from adults. This is particularly important given that half of lifetime mental health conditions begin by age 14 and our country's ongoing national children's mental health emergency.

Percentage of In-Network Providers Actively Submitting Claims

Research studies indicate that collecting this data is critically important to determining the adequacy of a network. Plans/issuers frequently list providers as in-network even if they are not actively submitting claims. There are a variety of reasons why an in-network provider may not actively submit claims, including low reimbursement or overly burdensome utilization management like prior authorizations, that could disincentivize providers from accepting patients with certain health insurance. We ask that this data be disaggregated by psychiatrists and other mental health providers treating children and adolescents wherever possible.

While we welcome the Departments' reference to child and adolescent psychiatrists and clinical psychologists with an expertise in children and adolescents, all types of pediatric providers should be included. Additionally, it is important to include data on M/S pediatric subspecialists for the purpose of assessing parity. The list of all pediatric physician subspecialists listed by the American Board of Medical Specialties are found in Appendix 1 of this letter, as a starting point. We encourage the Departments to require actual participation data on all sub-types of MH/SUD physicians and other providers for children, adolescents, and adults as well as inpatient and outpatient facilities, including intensive outpatient programs.

Time and Distance Standards

We strongly support the Departments' suggestion that the Departments collect detailed data on the percentage of participants/beneficiaries/enrollees who can access specified provider types in-network within a certain time and distance. We agree with the Departments' view that this data would help with the assessment of a plan/issuer's operational compliance with respect to any NQTLs related to network composition. We also recommend that the Departments collect data on appointment wait times, which are an essential metric to measure network adequacy and the most critical for participants/beneficiaries seeking timely access to care. The Department of Health and Human Services has already put forward strong proposed standards for Medicaid managed care and the Children's Health Insurance Program, which establish maximum appointment wait time standards for routine outpatient mental health and substance use disorder services of 10 business days and require independent secret shopper surveys. These standards align with appointment wait time metrics that have been adopted for Qualified Health Plans. We recommend that any network adequacy standards, such as time/distance, wait times, etc., issued by state or federal governments identify key subspecialties of MH/SUD physicians and other providers, such as child and adolescent and adult psychiatrists, child and adolescent and adult clinical psychologists, master's level social workers, mental health counselors, psychiatric advanced practice nurse practitioners (APNPs), and psychiatric physician assistants (PAs). In addition, all acute and sub-acute inpatient sub-types should have specific network adequacy standards, as well as sub-types of outpatient facility programs, such as intensive outpatient, (IOP), partial hospitalization programs (PHP), ABA, medication assisted therapy (MAT), eating disorder, autism spectrum disorder (ASD), as there is wide variability in practice size and across levels of care.

The Departments should collect data on routine and crisis appointments, including for follow-up and ongoing care. When only initial appointment wait times are measured, plans/issuers can manipulate their practices to have initial "intake" or triage appointments while having long delays in the delivery of ongoing services. Data should be disaggregated by age group to assess wait times and travel distance for children and adolescents.

We also urge the Departments to require any plan/issuer that uses a source or evidentiary standard for its network adequacy standards (whether a state/federal government or an independent entity such as NCQA) to identify and explain how the standards were designed, as written, to comply with MHPAEA. The Departments should require that, for any source, a plan/issuer must provide and define all the factors and evidentiary standards relied upon for each MH/SUD network standard (e.g., time and distance) and complete a comparative analysis for each factor to demonstrate that the standard is comparable and no more stringent, as designed, for MH/SUD than for M/S.

Network Availability and Distribution of Professions

We applaud the Departments for focusing on whether providers are accepting new patients, which is a crucial issue considering the high demand for MH/SUD services during a national children's mental health crisis. A MH/SUD provider with just a few patient appointments available does not add significant capacity to plans/issuers' networks. And child and adolescent psychiatrists are known to frequently close their waist list for new patients, given the overwhelming demand for their expertise. We believe that the Departments should require that any network adequacy standard should consider typical limits on psychiatrists and other MH/SUD providers, who typically have smaller caseloads, less capacity and limited availability for new patients as compared to most M/S physicians and other providers. (For example, a standard that equates 1 full-time PCP to 1 full-time psychiatrists is not comparable, in light of the differences in caseloads and capacity).

Child and adolescent psychiatrists are trained to manage developmental and behavioral disorders at every stage of youth and adolescent development. Many, however, subspecialize in specific clinical areas or with specific patient populations. For example, A child and adolescent psychiatrist that specializes in autism spectrum disorder may not also be an expert in treating eating disorders. This often results in child and adolescent psychiatrists referring patients to colleagues whose expertise better aligns with a patient's treatment needs. Therefore, AACAP urges the Departments to recognize that a robust network of child and adolescent psychiatrists, which includes expertise in a variety of settings and diagnosis, is necessary to adequately evaluate and treat all children and adolescents needing high-quality mental health care.

There is a significant disparity in the geographic distribution of pediatric subspecialists across the country, resulting in many children in underserved rural and urban areas not receiving timely health care. Thus, we also support that plans should measure the actual numbers of licensed MH/SUD professionals by zip code.

Surveys have repeatedly shown that psychiatry continues to rely on telehealth at a far greater rate than any other physician specialty and AACAP remains supportive of broad access to and coverage of telemedicine, including audio-only care. Plans should be discouraged, however, from using narrow telehealth-only networks to satisfy network adequacy requirements.

Network Admissions

In assessing network composition and access to MH/SUD services, we urge the Departments to review the criteria and processes by which plans/issuers determine which providers to admit into networks and/or how plans/issuers define when a network is considered "full" or "closed." Reports from child and adolescent psychiatrists suggest that they are often denied participation in networks by plans that maintain that their network is "full" of available child and adolescent psychiatrists even though patients are unable to find available providers. Measuring and monitoring access to care for all MH/SUD physicians and other providers will reveal how much responsibility plans/issuers bear for the lack of access to MH/SUD services. For example, plans/issuers should provide metrics on how many providers applied to the network, what percentage were rejected and the reasons for the rejection (e.g., network full, provider not qualified, application delays.

Reimbursement Rates

We applaud the Departments' suggested data collection relating to reimbursement rates, which are critical determinants of network adequacy; many studies show the strong correlation between network access and reimbursement rates. We also commend the Departments for putting forward potential requirements that reimbursement rate data be "compared to billed rates." Reimbursement rates that are not reflective of current market reimbursement can profoundly affect the availability of MH/SUD physicians and other providers, as well as inpatient pediatric psychiatric units remining operational, current providers' decision to join a network, and psychiatry residents' decisions whether to enter the field of child and adolescent psychiatry. We strongly recommend the Departments evaluate the ratio of allowed in-network and OON amounts to OON billed market rates for MH/SUD and M/S. The billed rates of OON providers are the most accurate representation of the market rate. We also support developing additional reimbursement rate measures, such as percent of out-of-pocket (OOP) expenses for enrollees using out-of-network providers for MH/SUD versus M/S care.

The Technical Release asks whether there are different or additional CPT codes than those specifically mentioned in the document (99213, 99214, 90834 and 90837) that could assist plans with evaluating their reimbursement structure and track MH/SUD services. There are a considerable number of additional CPT codes that should be tracked and evaluated. As physicians, child and adolescent psychiatrists can use the full range of office visit Evaluation and Management (E/M) codes (99201-99215) with add-on psychotherapy codes (90833, 90836, 90838), in addition to psychiatric diagnostic

evaluation codes, with or without medical services (90791-92). In addition, other non-physician licensed mental health professionals can use standalone psychotherapy codes (90832, 90834, 90837). Family psychotherapy, both with and without the patient present (90846, 90847), and the group therapy code (90853) could also be used to track mental health services.

Psychiatric care management services (99484) and psychiatric collaborative care management (CoCM) codes (99492, 99493, 99494) are used to report these evidence-based services and should also be tracked. In 2023, updated E/M codes for hospitals and other facilities were added to the CPT code set, and there are additional inpatient care (99221-99223) and inpatient consultation codes (99251-99255) that child and adolescent psychiatrists can use to furnish MH/SUD services that should be tracked and analyzed. Health plans are familiar with these CPT codes and the Departments should expand the universe of codes to be tracked and analyzed accordingly to help plans and issuers evaluate their reimbursement rate structures and accurately track MH/SUD services.

With respect to the use of Medicare Fee Schedule and other external benchmarks such as Fair Health, we urge the Departments to utilize significant care to avoid perpetuating historic (and ongoing) disparities between MH/SUD and M/S reimbursement rates that are embedded in these benchmarks. We urge the Departments to recognize that Medicare and other claims databases and benchmarks rely on historical data that embeds legacy disparities in reimbursements between MH/SUD and M/S. Additionally, we strongly believe that caution is warranted with respect to Medicare because it:

- Is not subject to MHPAEA;
- Does not have allowed amounts for certain sub-types of MH/SUD providers (e.g., sub-acute inpatient care and the full range of MH/SUD professional providers);
- Does not cover some MH/SUD services for children and adolescents given that this population does not participate in the program, although a small number of transitional aged youth may participate; and
- Has a structure that undervalues the work of MH/SUD professionals, which CMS recently acknowledged in its recent Physician Fee Schedule proposed rules.

Nonetheless, we recognize that the Departments, multiple state regulators, and research organizations (such as Milliman) have documented significant disparities between Medicare allowed amounts and plans/issuers' allowed amounts for MH/SUD providers versus M/S providers. As described below, the ultimate measure of parity for any reimbursement comparison is the access to services (i.e., adequacy) within MH/SUD networks in comparison with M/S networks. Indeed, reimbursement rate comparisons could show that MH/SUD providers are reimbursed at the same level as M/S providers, yet if MH/SUD network inadequacies persist, plans/issuers should be required to increase rates further for MH/SUD providers to address network inadequacies, as plans/issuers do for M/S.

The Departments have made it clear that when faced with M/S provider shortages, if plans increase reimbursement rates for M/S providers to ensure adequate M/S networks, they must increase rates to address MH/SUD providers shortages as well to ensure adequate behavioral networks. Yet, child and adolescent psychiatrists know there is relatively low out-of-network use for PCPs, and PCPs are routinely paid more than psychiatrists for the same evaluation and management billing codes.

The Department's guidance in the 2020 Self Compliance Tool is also clear:

> "NOTE – Plans and issuers may attempt to address shortages in medical/surgical specialist providers and ensure reasonable patient wait times for appointments by adjusting provider admission standards, **through increasing reimbursement rates, and by developing a process for accelerating enrollment in their networks to improve network adequacy.** To comply with MHPAEA, plans and issuers must take **measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers,** even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan's network…" (Emphasis added).

As with all quantitative data metrics, multiple measures are important to accurately assess the compliance of any NQTL. Consistent with the current regulations and enforcement, as well as the Proposed Rules, reimbursement rates for MH/SUD providers are a key aspect of in-network access to care. We have seen that plans/issuers use reimbursement rate increases to establish and maintain adequate M/S networks, especially in addressing shortages of M/S providers. MHPAEA requires plans to take the same measures for MH/SUD providers to ensure adequate networks.

Service Utilization Data

In assessing network composition and access to MH/SUD services, we urge the Departments to require plans to report on utilization rates for specific MH/SUD services and levels of care. These utilization rates should be compared to estimates of participants/beneficiaries with these conditions, as well as utilization rates for M/S services. Examples of services providers, settings, and levels of care on which we urge the Departments to collect utilization data include:

- Child and adolescent and adult psychiatrists, child and adolescent and adult psychologists, master's level social workers, mental health counselors, psychiatric APNPs, psychiatric PAs;
- Each of the levels (and sub-levels) of care described in The American Society of Addiction Medicine (ASAM) Criteria, the American Association of Community Psychiatrist Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS), and the Academy of Child and Adolescent Psychiatry Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument, (ECSII) as well as the average length of stay/treatment units and denial rates by each of these levels of care;

- Service utilization by MH/SUD diagnoses.

Safe Harbor

We urge the Department not to proceed with a safe harbor for NQTLs related to network composition. We understand the desire to target the Departments' enforcement resources most effectively. However, network adequacy has always been difficult to define and easy to mismeasure. Even when plans have been provided with templates by various state regulators, data is often incomplete, inconsistent and/or contradictory. Thus, a safe harbor has the potential to be harmful if the data collection requirements do not capture a full and complete picture of participants/beneficiaries' access to MH/SUD services. Given the significant work that the Departments need to do to ensure collected data is complete, accurate, and meaningful, a safe harbor should not be considered in the near future. Such a safe harbor should only be considered when the Departments and key consumer stakeholders are confident that the data collected accurately captures actual access to MH/SUD services.

Meaningful Data & Preventing Data Manipulation

To ensure that the proposed requirements relating to outcomes data and actions to address material differences in access are meaningful, we urge the Departments to issue standardized definitions on all data points and on methods for gathering and reporting data. For example, the Departments propose collecting data on the number and percentage of claims denials. Yet, there are many ways that plans can collect, and potentially manipulate, such "claims denials" data. For example, the Departments should make clear that failure to pay a claim in part or in full constitutes a denial and must find ways to capture common practices of undocumented denials that occur verbally through peer-to-peer reviews. Additionally, plans can manipulate denial data by approving each visit or day of treatment (thereby increasing the denominator) while telling the provider verbally that further visits/days will not be approved, which is another common occurrence. Such practices can result in meaningless data that bears little resemblance to what individual patients experience.

Child and Adolescent Psychiatry Reference

Child and adolescent psychiatry is the largest subspecialty of psychiatry and while "child psychiatry" may be used as shorthand at times when referring to child and adolescent psychiatry. AACAP respectfully asks that all references to child and adolescent psychiatry in any final rule and guidance should use the full name of the physician subspecialty: child and adolescent psychiatry.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Alexis Geier-Horan at ahoran@aacap.org.

Sincerely,

Warren Y.K. Ng, MD, MPH
President