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I am submitting comments on behalf of the American Psychological Association, which represents more than 121,000 members and associates engaged in the practice, research, and teaching of psychology. We welcome the opportunity to provide input on the "Proposed Updates to 2020 MHPAEA Self-Compliance Tool." We specifically draw your attention to the changes posted on pp's 22, 23, 37, 38 and 39.

PAGE 22: We agree with the addition of the NOTE on page 22, which emphasizes that a plan must demonstrate comparable processes in determining reimbursement rates for in-network providers for both the MH/SUD and medical / surgical benefits. We believe this should not be limited, however, to only in-network providers. There are many reports of patients' disproportionate use of out-of-network (OON) providers for MH/SUD services compared to medical / surgical services, therefore, the need for transparency in the process of setting OON rates is necessary. We recommend including "out-of-network" to this note.

PAGE 23: We appreciate the inclusion of "Warning Signs" that may warrant further review. Our concern is with the wording in the first example: "Inequitable reimbursement rates established via a comparison to Medicare: A plan or issuer generally pays at or around Medicare reimbursement rates for MH/SUD benefits, while paying *much more* than Medicare reimbursement rates for medical/surgical benefits." (Emphasis added)

While we agree that using Medicare rates as a benchmark is an appropriate point of comparison, the term "much more" makes it unclear as to what would trigger this need to review. This is a vague and overly subjective standard, and we recommend removing the word "much." The payer or plan should provide analysis for why there is ANY disparity (beyond insignificant differences of say a percentage point).

PAGES 37 and 38: ILLUSTRATION 6 raises very serious concerns and we would like to know why this was chosen. The example indicates the plan applied prior authorization requirements to physical therapy claims based on inadequate documentation of medical necessity and applied such requirements to psychological testing on the basis of recent **Medicare fraud schemes** and consistent with the Medicare Improper Payment Reports, which found psychological testing claims **often were in error** because of inadequate documentation from psychologists. (Emphasis added)

Although psychological testing may be done by non-psychologists, this example implies to the average reader a high level of fraud schemes and improper payments to, and inadequate documentation by, psychologists. This is highly disparaging to the profession of psychology and is unnecessary to the example; it would be sufficient for this example to say that the plan also found insufficient documentation of medical necessity for psychological testing. But it would be much better to simply say "mental health service X" to avoid disparaging any profession or type of mental health service.

PAGE 39: We appreciate that on reimbursement parity, the Compliance Guide takes the approach that APA has urged for many years – doing the benchmark comparison of whether a plan is paying roughly the same percentage of Medicare rates for commonly billed MH/SA and med/surg CPT codes.

We have two comments on the psychologist row in Appendix II which provides a template for that comparison:

1. For psychologists (and LCSWs) the two CPT codes listed are 90832, which is the 30-minute psychotherapy code and 90791 (for the initial evaluation of a mental health patient). The problem is that while 90832 is likely the most commonly billed psychotherapy code in Medicare (because older patients typically do not have the stamina for long therapy session), in commercial insurance plans the most commonly billed psychotherapy codes are 90837 (for 60 minutes of psychotherapy) and 90834 (for 45 minutes). 90832 is rarely billed in commercial insurance plans.

   Without the addition of 90837 and 90834, the chart will be relatively meaningless for commercial plans. For example, a commercial plan might pay roughly 110% of Medicare rates for most med/surg codes and for the rarely used 90832, but only 70% of Medicare rates for the commonly used 90837 and 90834 codes. But this disparity would not show up on the chart as currently composed. Thus, we urge that both 90837 and 34 be included in Appendix II for psychologists (and probably for LCSWs as well).

2. The "comments" column for codes 90832 and 90791 says "Based on 1 hour Based on ½ hour." This is confusing because the "based on 1 hour" reference appears to apply to 90832, which is a half hour or 30-minute code. Since the therapy codes are by definition time-based, it seems confusing to us, and probably unnecessary, to have time references that don't align with the code's actual time designations.

Thank you for considering our comments.

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