MARYLAND PSYCHIATRIC SOCIETY

October 12, 2023

Lisa M. Gomez
Assistant Secretary
Employee Benefits Security Administration
Room N–5653
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
***Attention:* 1210–AC11**

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

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

The Maryland Psychiatric Society (MPS) is a state medical organization whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, the MPS works to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strives through public education to dispel the stigma and discrimination of those who have a mental illness. As a district branch of the American Psychiatric Association covering the state of Maryland, MPS represents over 775 psychiatrists and physicians currently in psychiatric training.

The MPS appreciates the opportunity to comment on Requirements Related to the Mental Health Parity and Addiction Equity Act: Proposed Rule. We applaud the Administration's efforts to improve and strengthen mental health parity requirements and ensure that people with private health insurance can access benefits for mental health and substance use disorders (MH/SUD) under their insurance plans. Despite the Mental Health Parity and

Addiction Equity Act (MHPAEA) being the law for more than 15 years and a top enforcement priority for the Departments, true MH/SUD parity remains elusive. The Departments' most recent Report to Congress, issued in July 2023, states that "nearly all plans or issuers audited for MHPAEA compliance could not demonstrate compliance with the law's obligations in response to an initial request for NQTL comparative analyses." Studies continue to show that people cannot access benefits for care of MH/SUD. We remain concerned that insurance plans and insurers are still not compliant with the federal parity law and as a result people who would benefit from our care cannot access it. We applaud the Departments' proposed rule and their efforts to help bring insurers into compliance with MHPAEA immediately.

We are concerned that the proposed exceptions to the requirement for NQTLs will undermine the intent and purpose of MHPAEA and recommend that these exceptions be eliminated, or alternatively, further defined and narrowed. The proposed rule provides an exception to the requirements for NQTLs, if the plan/issuer "applies a nonquantitative treatment limitation that impartially applies independent professional medical or clinical standards or applies standards to detect or prevent and prove fraud, waste, and abuse." Neither of these exceptions are found in MHPAEA's statutory language or its amendments. Further, we have serious concerns that these exceptions will inadvertently undermine the strength of the regulations. We recommend the Departments provide more clarity to the terms "professional standards", "fraud, waste and abuse", and what it means for these standards to be "impartially" applied.

We recommend the Departments provide more clarity around what would be considered "discriminatory factors and evidentiary standards." The prohibition against plan/issuers relying on discriminatory factors and evidentiary standards when designing and applying NQTLs is a concept that is inherent in MHPAEA. We recommend that the Departments clarify that relying on Medicare fee schedules, while a good place to start in assessing reimbursement rates, have not been subject to MPHAEA and historically have been too low to attract and retain psychiatrists[1], needs to account for the fact that they are inherently discriminatory in their comparative analyses.

We recommend adding "scope of services" to the updated and non-exhaustive list of NQTLs. Access to MH/SUD is illusory if people cannot access the right level and range of care that they need for their conditions, including access to a continuum of clinical services in numerous settings, such as private offices, community mental health centers, specialty clinics, and hospitals as well as in the workplace, schools, and correctional facilities. Psychiatric care should be fully integrated with the rest of medicine in primary care settings and in hospitals.

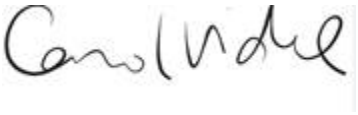
We recommend that the Departments provide standardized definitions of the data points and methodologies for collecting data related to NQTLs' impact on accessing MH/SUD and that the Departments provide more clarity on the definitions of "material differences" in access to MH/SUD benefits and plan/issuers' "reasonable action" to address these differences. According to the Milliman study, where discriminatory disparities are found in fee schedules, a plan/issuer "should increase its payment levels to behavioral healthcare providers. That increase in payment could also lead to an increase in the desire of behavioral health providers to join the health plan's provider network."[1] We agree. However, raising rates is only a partial solution. Plans/issuers must also address the high levels of administrative burden and the legacy issues that discourage medical students and early career psychiatrists from joining networks by actively providing information about the benefits of

and process involved in joining networks, streamlining their credentialling processes, and making meaningful outreach efforts to recruit clinicians to their network panels.

We support the special network composition and agree that data such as in-network and out-of-network utilization rates (including data related to provider claim submissions), network adequacy metrics (including time and distance data, and data on providers accepting new patients), and provider reimbursement rates (including as compared to billed charges) can provide insight into whether beneficiaries are able to access MH/SUD benefits. Collecting and analyzing this data must be a required part of a compliant comparative analysis and when this data demonstrates a "material differences" in access, it is a strong indicator that the plan/issuer violates MHPAEA.

Thank you for considering our comments.

Respectfully submitted,



Carol Vidal MD, PhD, President
Maryland Psychiatric Society, Inc.

[1] https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf

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