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September 2, 2021

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Submitted Electronically
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9909-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Requirement Related to Surprise Billing, Part I -- CMS-99-9-IFC

Dear Administrator Brooks-LaSure:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,400 psychiatric physicians who treat mental health and substance use disorders (MH/SUD), would like to take the opportunity to comment on the Interim Final Rule (Part 1) on the Requirements Related to Surprise Billing. APA supports protecting patients from surprise billings that arise from out-of-network charges for emergency room visits and medical care the patient reasonably could have expected to be in-network, a problem that has worsened in the past decade as health plans/issuers have narrowed networks of clinicians.¹ While APA supports the patient protections the No Surprise Act (NSA) puts in place to ensure access to care at a reasonable cost, we are writing to express concerns about the potential unintended consequences these protections could have on inpatient MH/SUD care. Patients suffering from MH/SUD, especially those who need inpatient care, already face barriers to accessing care. These access problems were supposed to be eradicated by the protections provided under the Mental Health Parity and Addiction Equity Act (MHPAEA). However, the promises of MHPAEA remain unfulfilled, and we are concerned that the NSA could result in a loss of even more psychiatric beds at a time when demand for psychiatric inpatient services is rising and there is a growing shortage of psychiatrists. We encourage you to include in the final rule the following recommendations to mitigate these impacts:

¹ Peterson-KFF, An Examination of Surprise Medical Bills and Proposals to Protect Consumers From Them, February 10, 2020, <https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/>

- Require insurers to maintain adequate networks of MH/SUD clinicians with reimbursement parity in accordance with MHPAEA
- Require insurers to reduce the approval process to join a network panel to no more than 30 days

The COVID-19 pandemic has further exacerbated mental health conditions, including substance use disorders. Earlier this year, the Centers for Disease Control and Prevention reported a record-breaking 81,230 drug overdoses during the previous 12-month period ending in May 2020. This represents an eighteen percent increase in drug overdose deaths over the previous 12-month period. Last month, the Kaiser Family Foundation reported that during the pandemic, about four in ten adults in the United States have reported experiencing anxiety or depression -- an increase from one in ten individuals during the previous year. Suicide is the 10th leading cause of death. In 2019, 12 million Americans had serious thoughts of suicide and 1.379 million Americans attempted suicide. Despite progress in the distribution of COVID-19 vaccines and the inoculation of increasing number of individuals, social isolation and the economic repercussions caused by the pandemic will continue to compound the mental health challenges for individuals across the country.

Many communities across the United States lack a comprehensive continuum of care that includes treatment services shown to improve outcomes for diverse populations. Reduced access is reflected in emergency department overcrowding, waiting lists for acute care, and patients not being admitted or being discharged too early. In addition, a persistent shortage of psychiatrists and other mental health professionals contributes to the access problem, particularly in rural areas. According to the Health Resources and Services Administration² by 2030 the supply of adult psychiatrists is expected to decrease by 20% and the demand for their services is expected to increase by 3% and possibly more, given recent trends as a result of the pandemic. Simply replacing psychiatrists with other healthcare professionals such as nurse practitioners or physician assistants cannot provide the expertise and level of care provided by a psychiatric doctor, particularly for patients suffering serious mental illness. Psychiatric residency training programs continue to fill year after year. We must increase the number of graduate medical education psychiatric residency training slots to begin to meet the demand for quality psychiatric care.

Providing psychiatric inpatient care to patients with acute psychiatric symptoms proves challenging given the workforce needs, the shrinking number of hospital beds and the limited availability of community services which has only worsened during the COVID pandemic. Reimbursement for psychiatric inpatient services typically covers only half of the total cost of care.³ As hospitals' operating margins decline, services that do not come close to covering their allocated cost are prime targets for replacement by more profitable services. Consequently, the number of acute psychiatric inpatient beds has decreased steadily

² HRSA, (n.d.) Behavioral Health Workforce Projections: 2017-2030, Retrieved August 2021, from <https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/bh-workforce-projections-fact-sheet.pdf>

³ Applebaum, P, The 'Quiet' Crisis In Mental Health Services: Adequate Reimbursement To Providers Of Mental Health Services Is The Key To Sustaining A Viable Care System, pages 114-5, Health Affairs, September/October 2003, <https://www.healthaffairs.org/doi/10.1377/hlthaff.22.5.110>

over the past decade.⁴ If reimbursement rates for psychiatric hospitalizations do not cover the cost of delivered care, this treatment option may cease to be available, and less appropriate settings, such as correctional facilities, may become the alternative “treatment setting” for individuals with severe mental illness. In addition, the impact of the NSA could force some smaller psychiatric practices and hospitals that provide emergency and inpatient care to patients suffering from MH/SUD out of business as they struggle to absorb unreimbursed costs.

To address the problem of inadequate MH/SUD networks, MHPAEA must be enforced so that plans are held accountable for providing robust networks of clinicians and facilities to care for patients suffering from MH/SUD. Numerous studies have shown that lower reimbursement rates paid, and excessive administrative burdens are a major contributor to lower network participation rates by psychiatrists and other medical specialists.⁵ As a result, accessing these services in-network is often challenging. Low reimbursement rates to behavioral health clinicians have serious ramifications: They depress the availability of psychiatric inpatient beds and treatment capacity at other essential levels of care at a time when the system grapples with the opioid addiction crisis and is stretched beyond its limitations. A Massachusetts Attorney General study attributes the drastic decline in psychiatric hospital beds to a negative 39% operating margin for psychiatric inpatient services and hospital psychiatric outpatient operating margins of negative 58%.⁶ In a competitive market where mental health services are in high demand, results like these cannot be based upon a fair or reasonable application of any pricing

⁴ “As of 2014, the year for which the most recent data on specialty mental health providers are available, there were over 170,000 residents in inpatient and other 24-hour residential treatment beds on any given night, an average of over 53.6 patients per 100,000 population. Although 170,000 residents in 24-hour treatment beds every day may seem a large number, it reflects a 64 percent decrease in psychiatric residents from 1970. When data are adjusted for the growth in the population of the United States since 1970, the decline in beds is an even greater 77.4 percent.” National Association of State Mental Health Program Directors, Trend In Psychiatric Inpatient Capacity, United States And Each State, 1970 To 2014, August 2017, page 4.

https://www.nasmhpd.org/sites/default/files/TACPaper.2.Psychiatric-Inpatient-Capacity_508C.pdf

⁵ Mental Health Association of Maryland, Access to Psychiatrists in 2014 Qualified Health Plans, January 26, 2015 <https://www.mhamd.org/wp-content/uploads/2014/01/2014-QHP-Psychiatric-Network-Adequacy-Report.pdf>; National Alliance on Mental Illness, A Long Road Ahead, Achieving True Parity in Mental Health and Substance Use Care, April 215, <http://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf>; Mental Health Association in New Jersey, Inc., Managed Care Network Adequacy Report, July 2013, <https://files.ctctcdn.com/6046ddd7001/22439124-309f-46db-a15d-cbe378949fe3.pdf>; Psych News, APA Study Reveals Network Inadequacy in DC Exchange Plans, June 2016, <http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.6a8>; National Alliance on Mental Illness, Out-of-Network, Out-of-Pocket, Out-of-Options, The Unfulfilled Promise of Parity, November 2016, <https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The>; Jill Akiyama, Robert Kohut, Courtney Lee, and Chima Ohadugha, Network Adequacy for Mental Health Patients, How North Carolina Measures Up, December 1, 2015, http://www.ncpsychiatry.org/assets/docs/network_adequacy_and_mental_health_report_dec_2015.pdf

⁶ Massachusetts Attorney General Report, Examination of Health Care Cost Trends and Cost Drivers, June 30, 2015, pages 14-5, <https://archives.lib.state.ma.us/handle/2452/265343>

methodology or model. Some large chains of freestanding psychiatric hospitals in large population centers can absorb such financial pressures. But these market dynamics threaten the viability of small psychiatric hospitals or hospitals in rural areas which operate on a tight budget and are often the only providers of MH/SUD services for large geographic areas. Should these facilities be put under more financial stress, some could be forced out of business and many patients will go without care, worsening the already poor access to MH/SUD care.

In addition to low rates, the length of time it takes to be credentialed into health plan/issuer networks keeps many psychiatrists who are willing to join networks from doing so in a timely manner. Our members are reporting that the credentialing process can take upwards of 3 to 6 months for plans to process the paperwork and admit them. Psychiatrists that are willing to be in-network and who provide care for patients in a hospital setting, may need to join 20 to 30 networks to be in network for all the patients that they provide emergency care for. This adds more time to the credentialing process. Thus, we submit that under currently prevailing conditions, the NSA will exacerbate the already serious problem of lack of access to MH/SUD care, particularly for the most seriously mentally ill.

Finally, we think it noteworthy that the NSA does not permit a patient to waive the NSA protections in instances where there is not an in-network clinician for (post stabilization) emergency care. We commend the Departments for recognizing the need to protect patients from surprise bills when the patient needs emergency care and has no option of choosing an in-network clinician, because the plan is not providing a robust network. This situation highlights a reality for privately insured patients who need MH/SUD services – both in an emergency and non-emergency settings: There is often no one in-network that has availability to care for them. Simply put, plans/issuers are advertising coverage of MH/SUD care that does not exist: There is not a robust network of mental health clinicians with availability to care for MH/SUD patients (even if a number of names of clinicians are listed). As a result, MH/SUD patients have no real choice – they can either go without care or pay out of pocket for out-of-network care. APA is concerned that the NSA puts the onus on the psychiatric physicians to fix the network deficiencies, instead of holding the plan accountable for selling a product – health care coverage for MH/SUD care, that they claim to offer, but that, -- in reality, does not exist. As currently described, it rewards insurers who maintain limited networks of MH/SUD clinicians and delay credentialing eligible clinicians and penalizes the clinicians who bear the burden of providing care at reduced rates.

We applaud the Departments' efforts to protect patients who need emergency MH/SUD treatment from surprise billing. However, the solution is vigorous enforcement of and health plans' compliance with MHPAEA. Adherence to MHPAEA will address inadequate MH/SUD networks resulting from poor reimbursement rates and administrative burdens and eliminate the discriminatory impact this has on patients suffering from MH/SUD.

Thank you for your consideration. If you have any questions, please contact Maureen Maguire, (MMaguire@psych.org), Associate Director, Policy.

Sincerely,

A handwritten signature in blue ink that reads "Saul Levin" with "M.D., M.P.A." written in smaller letters to the right. There is a horizontal line under the name "Levin".

Saul M. Levin, M.D., M.P.A., FRCP-E, FRCPsych
CEO and Medical Director