American Academy of Addiction Psychiatry
Translating Science. Transforming Lives.

Board of Directors

Larissa Mooney, MD
President
Kevin Sevarino, MD, PhD
Immediate Past President
Shelly F. Greenfield, MD, MPH
Chair, Past Presidents Council
John Mariani, MD
President Elect
Tim Fong, MD
Vice President
Rebecca Payne, MD
Treasurer
Kevin Gray, MD
Secretary
Carol Weiss, MD
Member at Large
Kathryn Cates-Wessel
Chief Executive Officer
Karen Drexler, MD
Medical Director
Alena Balasanova, MD
AMA Liaison
Adina Bowe, MD
Chair, Diversity, Equity, and Inclusivity Committee
Michael Hoefer, MD
Chair, Education Committee
Thomas Kosten, MD
Editor-in-Chief, The American Journal on Addictions
Frances Levin, MD
Grant Liaison
David Lott, MD
APA Liaison, Assembly
David Marcovitz, MD
Chair, Early Career Committee
Sanchit Maruti, MD
Director, Addictions and Their Treatment Course
Inbal Gafni, MD
Chair, International Committee
Thomas Penders, MD
Chair, CPD Committee
Ismene Petrakis, MD
Chair, Area Directors
John A. Renner, Jr, MD
APA Liaison, Council on Addictions
Richard N. Rosenthal, MD
Chair, Public Policy
Lewei (Allison) Lin, MD, MSc
Chair, Research Committee
Corneliu Stanciu, MD
Editor, AAAP Newsletter
Jose Vito, MD
Chair, Membership Committee
Nitigna Desai, MD
Chair, Scientific Program Committee
Laurence Westreich, MD
Chair, Law and Addiction
Will Rutland, MD
Trainee Representative
Ebony Caldwell, MD, MPH
Trainee Representative

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
Requirements Related to the Mental Health Parity and Addiction Equity Act**

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

On behalf of the American Academy of Addiction Psychiatry (AAAP), thank you for 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").

AAAP is a professional organization representing specialists in addiction psychiatry and other healthcare professionals who treat patients with substance use disorders (SUDs). AAAP's primary mission is to educate healthcare professionals in the prevention and treatment of SUDs and co-occurring psychiatric disorders. AAAP is focused on working with the Administration, Congress, and experts in the field of addiction treatment to develop and implement science-based policies and programs to accomplish our shared goal of expanding SUD treatment, ending the opioid misuse and overdose epidemic, addressing co-occurring mental health conditions, and providing effective treatments for our patients and their families. From that perspective, we offer the following comments in response to the Proposed Rule.

Overview

AAAP applauds the Proposed Rule's overarching goal of increasing access to mental health and substance use disorder (MH/SUD) treatment. When the Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted 15 years ago, Congress intended to prohibit discriminatory barriers to MH/SUD care. However, as practitioners, we are acutely aware of how plans/issuers have avoided compliance with the parity law and its regulations by continuing to impose greater limitations on MH/SUD treatment than on medical/surgical benefits. Strong regulations such as this Proposed Rule are required to address continuing inequities and ensure patients receive the treatment they are entitled to under the law.

400 Massasoit Ave., Suite 307, East Providence, RI 02914 | www.aaap.org | Phone: 401-524-3076 | Fax: 401-272-0922

We offer the following comments from our perspective as experts in the treatment of individuals with substance use disorders and mental health conditions and based on our significant real-life experience with the barriers associated with discriminatory insurance practices.

Independent Professional Medical or Clinical Standards" Exception to NQTL Requirements – (c)(4)(i)(E), (c)(4)(ii)(B), (c)(4)(iv)(D), and (c)(4)(v)(A) and "Fraud, Waste, and Abuse" Exception to NQTL Requirements – (c)(4)(i)(E), (c)(4)(ii)(B), and (c)(4)(v)(B) and "

We are very concerned that the Proposed Rule will not achieve its goal of increasing patient access to MH/SUD treatment if the "independent professional medical or clinical standards" and "fraud, waste and abuse" exceptions are included in the Final Rule. To be clear, we support requiring that plans/issuers follow independent professional medical/clinical standards (generally accepted standards of care) and fraud, waste and abuse must be addressed.

However, our experience since the enactment of MHPAEA has shown us that such exceptions must be tightly controlled in order to prevent them from being used as a work-around to evade the law. While we appreciate the Departments' description of these exceptions as "narrow," we know from our experience as clinicians that plans/issuers will adopt and implement significant benefit exclusions and administrative barriers based on either exception. **We urge the Departments to remove the exceptions, which we believe are deeply flawed and will be exploited by plans/issuers to limit access to medically necessary MH/SUD treatment services.**

Purpose – (a)(1)

In response to the Departments' request for comments on the addition of a purpose section to the regulations, we strongly support such an inclusion. We agree that the fundamental purpose of MHPAEA and its implementing regulations, "is to ensure that participants and beneficiaries covered under a plan or health insurance coverage that offers mental health or substance use disorder benefits are not subject to more restrictive lifetime or annual dollar limits, financial requirements, or treatment limitations with respect to covered mental health and substance use disorder benefits than the predominant dollar limits, financial requirements, or treatment limitations that are applied to substantially all medical/surgical benefits covered by the plan or coverage." **We support the inclusion of such a purpose section in the Final Rule.**

Prohibition on Discriminatory Factors and Evidentiary Standards (c)(4)(ii)(B)

We strongly support prohibiting plans/issuers from relying on any factor or evidentiary standard if it discriminates against MH/SUD benefits. We appreciate the example in the Proposed Rule stating that a plan or issuer would not be permitted to calculate reimbursement rates based on historical data using a time period when the plan or coverage was not subject to MHPAEA or was in violation of MHPAEA.

While this example would seem self-evident, the consequences of not having such a standard have been significant. For example, plans regularly justify their low and discriminatory reimbursement rates by referencing the Medicare Fee Schedule – a rate that is not subject to MHPAEA.

Recent studies have found that MH and SUD clinicians do not participate in Medicare because of low reimbursement and other challenges. Centers for Medicare and Medicaid Services (CMS) data indicates that approximately 43% of the clinicians who opt out of Medicare are behavioral health clinicians. Given the frequency with which the Medicare Fee Schedule is used to justify discriminatory MH/SUD reimbursement rates, **we urge the Departments to specify that utilizing the Medicare PFS to justify reimbursement rates is not permissible.**

The resulting clinician shortage due to low reimbursement and other factors is particularly severe for youth. Centers for Disease Control and Prevention (CDC) data indicates that at least 1,800 teens died between July 2019 and December 2021 from taking fentanyl, a 182% increase. But treatment options for youth are particularly limited with a JAMA study finding that only a quarter of treatment facilities offer Medication Assisted Treatment to this population. On August 30th, Politico reported about the increasing toll fentanyl is taking on America's youth; in the article a mother of loss describes losing her son to a fatal overdose. She

stated that he was “begging for treatment,” but could not be seen by an addiction psychiatrist for 3 months.

Our nation will never have an adequate number of qualified addiction treatment specialists if we do not address these reimbursement disparities. As a consequence of low reimbursement combined with significant medical education debt, medical students and trainees are choosing other more lucrative specialties than addiction psychiatry. Last year, only 29 of 52 recruiting addiction psychiatry programs filled their slots. The 2019 Milliman report cited in the Proposed Rule gets to the heart of this issue of poor reimbursement. Milliman found that primary care reimbursement for the same service performed by addiction psychiatrists was 23.8% higher than for behavioral health visits. **It is imperative that plans be required to reimburse MH/SUD clinicians on par with medical/surgical clinicians and be prohibited from using discriminatory historical data to justify low reimbursement rates.**

Special Rule for NQTLs Related to Network Composition – (c)(4)(iv)(C)

In our experience, inadequate clinician networks are one of the most significant barriers to individuals accessing needed MH/SUD care. For example, one of our members just recently had a patient who had nearly fatally overdosed twice within the last week. The patient wanted to receive MAT, but he could not find a prescriber. This situation is untenable.

Thus, we strongly support the new proposed rules relating to “network composition,” which would address access issues. The special rule relating to network composition NQTLs is particularly powerful because a plan/issuer would fail to meet the requirements of (c)(4)(i) and (c)(4)(ii) “if the relevant data show material differences in access to in-network mental health and substance use disorder benefits as compared to in-network medical/surgical benefits in a classification.” **This strong requirement should be included in the Final Rule.**

Clinician Directory Requirements

In response to the request for feedback on how to improve clinician directories through rulemaking, **we urge the Departments to require periodic independent third-party testing of clinician directories to assess the accuracy of information and that a sufficient percentage of clinicians are accepting new patients.** HHS has already put forward strong proposed standards for Medicaid managed care and the Children’s Health Insurance Program (CMS-2439-P), which establish maximum appointment wait time standards for routine outpatient MH/SUD services of 10 business days and require such independent secret shopper surveys. This proposed rule should be a model for the Departments in individual and group plans. Additionally, plans/issuers should be required to identify clinicians who are available via telehealth. Finally, the Departments should ensure that participants/beneficiaries who cannot access in-network services on a timely basis can access out-of-network services, with their out-of-pocket costs no greater than the amounts that they would have paid for the same services received from an in-network clinician.

Conclusion

Thank you again for the opportunity to provide comments and we want to reiterate our support for the intent of the Proposed Rule and increasing access to non-discriminatory mental health and substance use disorder treatment. Please do not hesitate to contact us if we can serve as a resource to you.

Sincerely,

Larissa Mooney, MD
President
American Academy of Addiction Psychiatry