



November 15, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue S.W.
Washington, D.C., 20201

Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals (File No. CMS-9900-NC)

Dear Administrator Brooks-LaSure,

On behalf of the American Psychological Association (APA)¹, we respectfully submit the following response to the September 16, 2022, [Request for Information](#) concerning the No Surprises Act's requirements for furnishing "Good Faith Estimates" (GFEs) to payers² for patients who intend to use their insurance. We share the very serious concerns expressed by the mental and behavioral health provider community that includes, but is not limited to, psychiatrists and social workers.

Given the No Surprises Act's clear focus on high-dollar, surprise bills from services like air ambulance and emergency services, behavioral health providers should be entirely exempted from the NSA requirements as they are rarely, if ever, the cause of these surprise bills. Our members' rates are not surprising to patients because psychologists have an ethical obligation to agree with patients on billing early in the therapeutic relationship.

Relative to much of the health care world, the cost of behavioral healthcare services is quite modest. Most psychologists work in independent practices; these are nearly all small businesses with fewer than 10 employees. The Medicare rates for the most common psychological services - 45 and 60 minutes of psychotherapy – are just over \$100 and \$150 respectively.³ Commercial insurance rates are frequently even lower.⁴ These rates are not exorbitant in today's economy; in

¹ APA is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 133,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

² Payers defined throughout as including health insurers, health plans, and health carriers.

³ Medicare rates provide an industry recognized benchmark. Most primary care doctors' and specialists' rates exceed this benchmark whereas insurers reimburse in-network behavioral health care providers at much lower rates relative to even Medicare-allowed amounts. See generally, Stephen Melek, Stoddard Davenport, & T.J. Gray, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* (Seattle: Milliman – 2019), hereinafter, "Milliman Reports", (describing behavioral care providers' low reimbursement rates) available at:

https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

⁴ We recognize that Medicare rates are not subject to the NSA, but those rates are commonly followed by commercial insurers and other entities that are subject to the NSA in setting their rates.



fact, they are exceedingly low relative to comparable medical services. As such, mandating that psychologists and other behavioral health providers endure the significant administrative burden of the GFE/Advance Explanation of Benefits (AEOB) process during a mental health crisis is unreasonable.

We are concerned that this burden will discourage even more psychologists from taking patients with insurance, which is a health equity concern. Many of our members report that despite their desire to serve patients who must rely on their insurance, they have left insurance networks because of unfairly low reimbursement and unjustifiably high administrative burdens. All psychologists and behavioral health providers should be exempted from GFE/AEOB requirements as soon as possible.

Future rulemaking can and should focus on systematizing the important goals of transparent billing for patients, while ensuring these regulations fit an accurate understanding of how the billing and operations function within behavioral health practices. Nonetheless, we understand that CMS cannot modify the statute, and we appreciate this opportunity to offer our perspective on burdens and issues with the GFE/AEOB process as it is today. We also want to confirm that after receiving responses to this RFI, CMS still intends to follow a standard “notice-and-comment” rulemaking process so that all stakeholders will have a full opportunity to react to the agency’s specific proposal for the complex GFE and AEOB process.

Our January letter⁵, written alongside eleven other mental and behavioral health provider associations, stated our initial concerns about the GFE/AEOB system. This response expands upon those concerns, while also responding to specific inquiries in the RFI that are most relevant to our members. We appreciate that cost transparency empowers patients to make informed healthcare decisions, but we urge that CMS create standards for this GFE process that do not impose undue administrative burdens on providers or foster payers’ arbitrary limitations on covering care.

Accordingly, we ask that when CMS develops the proposal for the GFE/AEOB process, CMS:

1. Create a small practice or infeasibility exception from any interoperability and technology standard established for the exchange of GFE/AEOB information.
2. Develop a centralized web-based portal where standardized GFE information can be submitted to and accepted by all payers. Providers and facilities with the capacity⁶ to use a web-based portal can employ this centralized system when submitting GFEs to payers.
3. Prohibit payers from using GFE information to deny coverage for care.

Please refer to Section II below for further details on each of these overarching recommendations.

I. Background Information for CMS’ Consideration in Creating GFE/AEOB Standards

⁵ Letter to HHS Secretary Xavier Becerra, et. al. (January 25, 2022), <https://www.apaservices.org/advocacy/no-surprises-act-letter.pdf>.

⁶ A small practice or infeasibility exception from using this electronic GFE portal should be applied as further explained herein, in Section II. Overarching Recommendations.

a. Tech and support infrastructure:

A large proportion of behavioral health professionals (as compared to medical/surgical providers) are in small and independent practices that do not have interoperable Electronic Health Record (EHR) systems and will not likely have them at least for the near future. The financial costs of implementing and maintaining EHR systems have been a primary barrier to their adoption across all providers.⁷ To incentivize the adoption of these systems, certain medical providers/facilities were allotted incentive funding for having and using an EHR system under the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act).

Behavioral health practitioners were excluded from federal assistance provided under the HITECH Act⁸, which is why many behavioral health practitioners have not invested in sophisticated EHR systems.⁹ Because of the stigma around mental health that still permeates today, mental health records are typically regarded as more sensitive with certain mental health records receiving additional protections under the law. For that reason, traditionally these records were kept separate from other health information and not prioritized when implementing processes to facilitate the secure exchange of health information between different health entities. Also, behavioral health practitioners have not been required to use such systems as payers still frequently require telephone calls or fax machines as the most common method to exchange necessary information for existing administrative processes like claims submissions and prior authorizations.

The technical infrastructure necessary to facilitate the real-time exchange of health information between most behavioral health practitioners, other providers, and payers is currently very fragmented. A fractured infrastructure is further evidenced by entrenched, unsystematic processes that require the exchange of specific information and still prevail despite state and federal regulators' attempts to reduce burdens on providers and streamline these processes.¹⁰ One reason existing processes for exchanging information between providers and payers – like prior authorizations or claim submissions – are so burdensome is that different payers have different standards and processes for how and what information needs to be transmitted for these administrative transactions. Providers are then responsible for knowing and tailoring workflows for different payers, each employing different communication channels for their specific process.

⁷ Kruse CS, Kothman K, Anerobi K, Abanaka L. Adoption factors of the electronic health record: a systematic review, *JMIR Med Inform.* (June 2016) available at: <https://medinform.jmir.org/2016/2/e19/>

⁸ The HITECH Act of 2009 (P.L. 111-5) excludes psychologists and most other non-physician providers from receiving funding to adopt electronic health record technology. *See also*, Bipartisan Policy Center, *Integrating Clinical and Mental Health: Challenges and Opportunities* (January 2019) (Report noting the lag in adoption of electronic health record systems for mental health providers). <https://bipartisanpolicy.org/wp-content/uploads/2019/01/Integrating-Clinical-and-Mental-Health-Challenges-and-Opportunities.pdf>

⁹ Study finding that large increase in EHR adoption can be attributed specifically to HITECH. Julia Adler-Milstein and Ashish K. JHA, HealthAffairs, HITECH Act Drove large Gains in Hospital Electronic Health Record Adoption, (August 2017), available at <https://doi.org/10.1377/hlthaff.2016.1651>

¹⁰ In 2018, the American Medical Association, the American Hospital Association, and several other major industry groups signed a consensus statement affirming their commitment to improving prior authorization processes. In 2021, a bipartisan prior authorization reform bill was introduced to Congress. Still, these processes have not improved.



Notably, many payers are still requiring that providers use antiquated and time-intensive communication channels such as faxing or telephone calls for existing administrative processes.¹¹

Many rules that influence administrative processes, including much of the NSA rulemaking to date, assumes that providers often have administrative staff to aid in the implementation of new systems or processes, when in fact many—particularly those that operate in rural and underserved areas, or outside of established health systems—do not. This is especially true for small or rural practitioners that do not have the resources to invest in hiring support staff.

For behavioral health providers that do have the resources to hire support staff, many lack the necessary knowledge concerning clinical, coding, and financial matters needed for assisting with complex technological and administrative undertakings. In addition, our members' small practices generally do not have resources for the outside support of IT, compliance, or legal consultants. Regulations that may be a moderate or heavy lift for large health care entities can be debilitating for small health practices that lack adequate internal support staff and external consultants. Those practitioners without assistance are left to learn the details of these confusing and often contradictory systems and processes in their own, non-reimbursable time.

This is particularly troubling for psychologists who are already suffering from low reimbursement rates. Low reimbursement rates from payers to psychologists, and generally most behavioral health providers, are a major contributing factor for the infrastructure problems noted above and are still prevalent despite federal parity laws.¹² Generally, behavioral health providers are reimbursed less than their colleagues who provide comparable medical services. Many of our members report that their already low reimbursement rates from insurance companies have not increased in 10-15 years, nor have they received any increase in reimbursement relative to higher costs of living.¹³

Our members have also expressed concern about the time expense and financial impact of operationalizing new administrative processes along with implementing EHR systems or upgrading current technologies. Notably, the dominant concern is that the use of new systems and/or processes would reduce the amount of time practitioners can allocate to seeing patients -- ultimately reducing the number of patients practitioners can see per day.

b. Increased demands on behavioral health providers:

¹¹ The number of health entities who file with the National Association of insurance commissioners was 1,127 in 2021. National Association of Insurance Commissioners, U.S. Health Insurance Industry Analysis Report, (2021) available at: <https://content.naic.org/sites/default/files/2021-Annual-Health-Insurance-Industry-Analysis-Report.pdf>

¹² See Milliman Report, *supra* note 3; see also, WaJane M. Zhu, Yuehan Zhang & Daniel Polsky, Networks in ACA Marketplaces Are Narrower for Mental Health Care Than for Primary Care, 36 HEALTH AFFS. 1624, 1627 (2017) (Study reporting disproportionately low rates of network participation among behavioral health care providers compared to primary care physicians).

¹³ Despite the passage of MHPAEA over a decade ago, a recent report from the Department of Labor indicates that, despite recent enhanced enforcement efforts, “[h]ealth plans and insurance companies are falling short of providing parity in mental health and substance-use disorder benefits.” U.S. Department of Labor (January 2022), 2022 MHPAEA Report to Congress, <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf>; See also, *supra* footnote 3 the Milliman report citing strong evidence of reimbursement disparity.



Despite this limited infrastructure and support, most of our members face a significantly increased demand for providing mental health services to more patients.¹⁴ As the demand for care from these practitioners has increased¹⁵, so too have administrative and regulatory demands on their practices increased.¹⁶ For example, the GFE requirements currently in effect—providing GFEs to patients who are uninsured or self-pay — are already requiring providers to establish new and often manual workflows and communication channels to exchange this information. Operationalizing this process is complex and highly burdensome for providers who do not have ancillary staff to support compliance.¹⁷

In addition to the regulations implemented under the No Surprises Act, last year many practitioners faced increased regulatory responsibilities due to the Cures Act’s information blocking provisions. These administrative and regulatory burdens have created barriers to practitioners’ ability to provide the care demanded; instead, they must divert scarce resources away from providing needed care to creating additional workflows and ensuring compliance with additional policies. This is detrimental to providing timely access to care for patients. Reducing regulatory burdens, as opposed to creating more onerous regulations, would allow practitioners to reallocate more resources toward patient care.

Additionally, we are concerned that burdensome GFE/AOEB rules may drive more behavioral health practitioners away from seeing patients using out-of-network insurance benefits to avoid interacting with payers who have a history of bad practices. We have already witnessed a large exodus of our members from insurance networks.¹⁸ Discouraging our members from even seeing

¹⁴See, e.g., Centers for Disease Control (Sept. 2022), Mental Health Treatment Among Adults Aged 18–44: United States, 2019–2021, https://www.cdc.gov/nchs/products/databriefs/db444.htm#Key_finding. A research report conducted by the National Center for Health Workforce Analysis, which looked at supply and demand projections for clinical, counseling, and school psychologists from 2016 through 2030, notes an increased demand for psychologists in health care and an estimated shortage of psychologists when considering unmet need due to barriers in receiving care, <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/psychologists-2018.pdf>

¹⁵American Psychological Association. “Worsening mental health crisis pressures psychologist workforce: 2021 COVID-19 practitioner survey.” Oct. 19, 2021. Available from: bit.ly/3wKfgIs. Currently, 157 million individuals live in a health professional shortage area for mental health professionals. Health Resources & Services Administration, Health Workforce Shortage Areas (Updated Nov. 6, 2022), <https://data.hrsa.gov/topics/health-workforce/shortage-areas>

¹⁶See generally, a 2022 Annual Regulatory Burden Report published by the Medical Group Management Association indicated that 89% of respondents reported that the overall regulatory burden has increased over the past 12 months. The respondents in this report were from over 500 medical group practices who have significantly more staff and resources to implement regulatory requirements than do practitioners in the behavioral health space. MGMA Annual Regulatory Burden Report (Oct. 11, 2022) available at: <https://www.mgma.com/practice-resources/government-programs/mgma-annual-regulatory-burden-report-2022>.

¹⁷*Id.* (Noting that medical practices ranked prior authorization requirements as the top burden for their practices, with requirements stemming from the No Surprises Act ranking as second most burdensome.)

¹⁸We have numerous reports from our leaders and members of this exodus. It is fueled by the dramatic increase in demand for mental health services during the pandemic, combined with low insurance reimbursement and high administrative hassles imposed by payers. The recent departures make the prior shortage of behavioral health providers worse. See Jane M. Zhu, Yuehan Zhang & Daniel Polsky, Networks in ACA Marketplaces Are Narrower



patients out of network will further the health equity issue for the large portion of the population that relies on their insurance to cover behavioral health care. Even worse, additional regulatory burdens may push many practitioners to leave the profession.

c. Impact on patients:

While we see the potential benefit to patients having a better picture of how much of their behavioral healthcare will be covered by their insurers, we also have significant concerns about payers trying to limit care based on these cost estimates. GFEs are often a prediction, usually based on incomplete information, as to what care is likely to be needed in the future. It is not a final determination or admission that a patient will not require more intensive services in the future. Assigning an estimate—and, in that estimate, including a diagnosis code—before seeing a patient could pose multiple problems unique to mental and behavioral health providers. Patients asking for a GFE to contemplate costs prior to receiving a service may be given a quick estimate before they have been fully examined by a provider. When a patient is then assessed more completely and a more accurate estimate of costs is provided, such estimates may be different, which could be grounds for insurers to deny additional *necessary* coverage identified in a new estimate when compared to the initial estimate.

II. Overarching Recommendations

Based on the factors above and specific issues discussed below, APA makes the following recommendations for the GFE/AEOB process:

- **A small practice or infeasibility exception from any interoperability standards be created.**

It is our understanding that the interoperability standards suggested in the RFI (FHIR APIs) would not apply to practitioners that do not have interoperable EHR systems for the reasons discussed above.¹⁹ As noted above, most small and rural behavioral health practices have not needed to, and do not have the resources to, invest in interoperable technology; many still rely on paper-based recordkeeping methods. For these practitioners, implementing any type of technology standard would be cost-prohibitive. Thus, alternative means for submitting GFEs to insurers are necessary. To the extent that interoperability standards would be applied (to psychologists without interoperable systems), we ask that the Agencies exempt psychologists (under either a small practice exception or an infeasibility exception) from any such requirement, including any requirement that their systems interact via a proposed API.

for Mental Health Care Than for Primary Care, 36 HEALTH AFFS. 1624, 1627 (2017) (Study reporting disproportionately low rates of network participation among behavioral health care providers compared to primary care physicians); See also, Milliman Report, *supra* note 3.

¹⁹ Being that the current barriers to implementing health information technology include costs of purchasing and installing the technology along with training, Regulators should consider policy options that permit funding to go to behavioral health providers to adopt sophisticated EHR systems.



1. **Small practice exception.** We recommend a small practice exception to any interoperability requirements, similar to the small employer exemption available under the Mental Health Parity and Addiction Equity Act (MHPAEA) for employers with less than 50 employees.

Alternatively, CMS could create different metrics for this exemption considering the practice's size/resources in terms of factors like total claims submitted; number of licensed practitioners; ratio of practitioners to administrative support staff; and whether and to what degree the practice serves patients located in a mental health professional shortage area.

Or,

2. **Infeasibility exception.** As an alternative to a small practice exception, we recommend an infeasibility exception, like the exception in the Cures Act regulations regarding information blocking for practices where it would be infeasible to upgrade to a certified EHR system²⁰ due to the cost of such a system and the burden on the practice of changing to a new system. Similarly, we recommend that those practitioners without certified EHR technology or without any EHR systems would be exempt from any particular mode of exchanging good faith estimate data when practical challenges limit a provider's ability to comply with the requisite technological capabilities necessary to exchange the GFE per specific technological standards.
 - A significant portion of our membership, especially senior practitioners with little administrative support, are unlikely to be able to submit GFEs even through a unified, user-friendly web-based portal. These practitioners will need an accommodation from technological standards that allow for a lower tech means of submitting GFEs, such as fax or U.S. mail.
- **Single provider portal for all payers:** CMS should design and develop a secure, cloud-based web portal for electronic submission, storage and retrieval to facilitate the exchange of all GFE and AEOB data.
 - Our members are already burdened by engaging with multiple payer systems with whom they are in-network.
 - Requiring clinicians to consistently engage with an even larger pool of payers – including many additional payers for whom they are out-of-network – for this GFE process would be extremely burdensome, particularly if payers use different systems and formats for this process.
 - Creating a standardized portal for all entities would minimize the burden of learning multiple new GFE systems adopted by multiple insurance programs.
 - If CMS cannot or will not develop a single portal, then payers should be required to use identical portals that include uniform GFE forms across all payers. Payers are in a much better position to design and deploy enterprise-level technology

²⁰ To be "certified" EHR technology must meet certain technological capability, functionality, and security requirements to efficiently capture and share information with other systems as required by the Office of the National Coordinator (ONC).



solutions, such as implementing a standardized portal, than individual providers who need to focus on providing necessary care.

- The Small practice exception or Infeasibility exception as described above can also be applied to any technology standard proposed for providers, facilities, insurers, health plans, and carriers who do not have the technological means of facilitating such a process. For example, rural practitioners may not have reliable internet making even a web-based portal difficult to use.
- **Prevent payers from using GFE information sent by behavioral health providers to limit patient care.**
 - Our concern is that payers will attempt to use the GFE process to argue that care should be limited by what a provider may have indicated as their prediction of likely future care, which was based only on information available at the time the GFE was prepared. That is not the purpose of the provider's GFE and the information contained within GFEs should not be used against the patient. Although the rules promulgating the No Surprises Act are less than a year old, already we are hearing that insurers are using the Act's balance billing/IDR provisions to justify massive reimbursement cuts for emergency care providers.

III. Other Policy Considerations

- **Require insurers, plans, and carriers to send the AEOB to the respective provider who sent the GFE.** Providing clinicians with a copy of the patient's AEOB will empower clinicians in two important ways. First, it will help them plan in advance if a patient who is unable to pay out of pocket will be expecting little or no insurance support for future care. Second, it will empower both the clinician and patient to better detect whether the insurer is providing benefits promised to the patient and complying with their obligations under federal parity law.
- **Providers should be able to rely on a patient's insurance card and representation on their own coverage.** Particularly where a psychologist is in a small or independent practice without the aid of electronic verification systems, such clinicians have no other way to verify coverage but to ask the patient for an insurance card and assume that their coverage remains effective. Insurers are in the best position to confirm coverage when they receive a GFE. If the patient is not an enrollee in the plan, the burden should be on the insurer to forward to the patient the GFE prepared and sent by the provider.
- **Making information understandable to patients.** We agree that AEOB information should be in plain language, accessible to average and underserved patient populations. AEOBs could give patients a helpful picture of their likely share of future health costs – especially if written in much more accessible language than the EOBs that most payers currently use. For behavioral health providers, any requirement to provide GFE-related information to patients in certain languages should be limited to translation into the language that that patient uses in speaking with their behavioral health professional.



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IV. Economic Impact

APA appreciates the recognition that these rules impose administrative burdens on practitioners. APA reminds the Administration that these burdens are not just measured in dollars and cents, but also by the minutes and hours spent on preparing these estimates. Given the ambiguities around the existing GFE rules, the degree of this burden varies wildly, with some of our psychologists reporting approximately 30 minutes per patient to prepare GFEs, and others reporting several hours per week.

Regardless of its exact impact, however, many practitioners—particularly those in small or independent practices—are in no position to build an in-house solution to transmit GFE data to payers, nor are they able to purchase a third-party app given the costs of these systems. Providers are already struggling with unnecessary denial of claims, prior authorizations burdens, the difficulties of contracting with insurance companies, continued issues with billing and collection methodology, and finally, the NSA's current requirements to furnish GFEs to self-pay and uninsured patients.

These extremely onerous and time-consuming processes, while implemented with good intent, are undermining access to care. For that reason, we believe it is important for CMS to move very carefully and deliberately in implementing provisions in the Public Health Service Act (section 2799B-6(2)(A)) that would require providers to provide GFEs to insurers for patients choosing to use their insurance to cover their care, based on the lack of infrastructure in place to transmit the necessary information between entities. CMS should take its time when creating standards for this new process to ensure that the standards are well thought-out and calculated to avoid encumbering already overwhelmed practitioners. This will also ensure that all covered entities can focus their energies on standardizing and refining existing processes and systems for providing GFEs to uninsured (or self-pay) patients. This will make implementing additional obligations for the GFE/AEOB process less onerous for all those involved and allow for the judicious development of a standard industry process to support the exchange of information that will ensure timely and accurate estimates can be provided to all patients.

Thank you for your consideration of our response. APA appreciates the Administration's willingness to initiate this discussion and welcomes an opportunity to help the Administration achieve its goals of transparency in health care costs. If you have any questions or require any further resources, please contact Andrew Strickland, J.D. at astrickland@apa.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Katherine B. McGuire', with a stylized flourish at the end.

Katherine B. McGuire
Chief Advocacy Officer
American Psychological Association Services, Inc.



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Jared L. Skillings, PhD, ABPP
Chief of Professional Practice
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