January 25, 2022

Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: No Surprises Act Interim Final Rules (CMS-9909-IFC and RIN 1210-AB00)

Dear Administrator Brooks-LaSure:

The undersigned organizations represent a broad array of providers across the spectrum of mental and behavioral health treatment. We write to you to express our concerns about the Interim Final Rules ("IFRs") issued last year under the No Surprises Act. While we share the Administration's goal to facilitate transparency in health care costs, these rules have a disproportionate impact on mental and behavioral health providers and unnecessarily add to their existing administrative burdens. We are particularly concerned about the impact these IFRs will have on access to mental and behavioral health services in communities that have long lacked access to these services.

Accordingly, we ask that you issue a stay on enforcement of these IFRs affecting routine mental and behavioral health services. If the Administration insists on retaining the existing regulations, we ask for an exemption to the current IFRs for mental and behavioral health providers, who were not the problem the No Surprises Act sought to resolve and often lack the resources to fulfill the steep administrative burdens these rules impose.

Given that the No Surprises Act targeted costly services usually available only on an out-of-network basis, we were surprised to see the extent to which these rules apply to mental and behavioral health practitioners, and how quickly compliance is expected of them. Some of the confusion may be attributable to the process by which these rules were promulgated. As you know, IFRs are exempt from the general requirement that proposed rules be published for public notice and comment prior to enforcement.

Citing the January 1, 2022 effective date of the No Surprises Act, federal agencies chose this expedited path, but in so doing missed a key opportunity to seek input from stakeholders on the practicality and burden of these rules, particularly on providers who are not necessarily the object of the Act's policy goals. Because many IFRs are never replaced or updated, we are concerned that our providers will be indefinitely stuck with these burdens without having a pre-enforcement opportunity to weigh in on their impact.

The duty to furnish a "Good Faith Estimate" ("GFE") of costs outlined in Part 2 of the regulations imposes an undue administrative burden on our members. Our providers have a long-standing practice of being transparent about fees with their patients because it is required by their

professional ethics. Requiring clinicians to fill out the GFE form and update it every time there is a minor change in the treatment plan that may or may not have an impact on costs takes away from valuable treatment time – which is in extremely high demand as more and more people are struggling with the mental health impact of the COVID pandemic. Demand is already so high that many patients are finding it difficult to find a provider with enough availability to meet their needs. Further, requiring our members to provide the GFE is contrary to the original intent of the NSA, which was to protect patients and their families from surprise medical bills that threatened their solvency and made them subject to predatory debt collectors.

The rule also fails to capture the practical nuances involved in referring patients to other independent mental health practitioners for treatment, as well as the urgency under which appointments are scheduled. This leaves much ambiguity as to when GFEs must be issued to uninsured/self-pay patients, who must issue them, and when and how such GFEs must be updated to reflect changes in a patient's status, course of treatment, or insurance coverage. We also understand from CMS' recent public events that providers are expected to prepare GFEs even when services are provided at no cost to the patient. While we understand the value of patients having access to clear cost information, we are concerned that the current IFRs only impose a gratuitous regulatory burden that does little to further this goal.

Looking ahead to forthcoming rulemaking on transmission of GFEs to insurers, we have broader concerns about how insurers will use these documents in making coverage determinations. Specifically, we are concerned that insurers will use these GFEs as a mechanism or justification to limit mental health treatment beyond the scope of the GFE, or otherwise view them as an admission that the patient will only require a certain degree of mental health treatment. As you know, mental health exists on a continuum, and patients may move in different directions along that continuum depending on various factors. Especially given the existing barriers that plans may impose to mental health treatment, we hope the Administration shares our view that patients and providers should be empowered to recommend and obtain the services most appropriate for the patient's needs.

Additionally, the Federal Independent Dispute Resolution ("IDR") described in the IFRs raises multiple concerns about upsetting the delicate balance between adequate access to mental health services and appropriate reimbursement for such services. We are concerned that the process outlined in the IFRs cedes undue influence to insurers in setting the terms of negotiations between providers and insurers. We are also concerned about the possibility of insurers abusing the IDR process as part of an overall strategy of further suppressing reimbursement rates for mental and behavioral health services.

Despite the enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA) over a decade ago, the reality of placing coverage of mental health services on equal footing with their medical counterparts has fallen far short of MHPAEA's ambitions. Research consistently reinforces the everyday experiences of our membership: that mental health providers face higher administrative barriers to coverage and lower reimbursement rates for their services (as compared to medical/surgical providers), while patients often find themselves having to choose from narrower networks of mental health providers. Because insurance networks are often not a

hospitable place for mental and behavioral health services, providers often find themselves "out-of-network."

The undersigned organizations welcome an opportunity to collaborate with you on rules that would serve the Act's purposes while minimizing the administrative burden on mental health practitioners. While we share the Administration's view that patients should be informed of treatment costs, we also want to ensure that our providers can spend adequate time with patients who, now more than ever, require access to quality treatment.

Sincerely,

American Psychological Association
American Psychiatric Association
National Association of Social Workers
National Board for Certified Counselors
American Mental Health Counselors Association
American Counseling Association
American Association for Marriage and Family Therapy
California Association of Marriage and Family Therapists
National Association for Behavioral Healthcare
Psychotherapy Action Network
Clinical Social Work Association

Cc: Chiquita Brooks-LaSure, Administrator, Centers for Medicare and Medicaid Services