

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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August 7, 2017

John R. Graham

Acting Assistant Secretary for Planning and Evaluation

Department of Health and Human Services

Hubert Humphrey Building

200 Independence Avenue, SW

Washington, DC 20201

Re: Strategies for Improving Parity for Mental Health and Substance Use
Disorder Coverage

Dear Mr. Graham:

The American Academy of Child and Adolescent Psychiatry (AACAP) greatly appreciates the opportunity to respond to this request for public comments on improving parity for mental health and substance use disorder coverage. We applaud the recent public meeting for stakeholders mandated by the 21st Century Cures legislation, and we would like to expand on the remarks AACAP provided at that event. AACAP is the professional home to 9,200 child and adolescent psychiatrists. Our mission is to promote the healthy development of children, adolescents, and families, and we therefore have a strong interest in this topic. Early and prompt mental health intervention is essential to the healthy development of a child or adolescent, yet significant obstacles exist. While this is a complex topic with multiple variables at play, we would like to share some ideas for more closely aligning the concept of mental health parity with what AACAP members currently face as they provide their critically important services to the children and adolescents they see.

Prior Authorization

While we acknowledge utilization management practices to evaluate proper treatment and make better use of healthcare expenditures, child and adolescent psychiatrists frequently face significant obstacles to providing quality care to the children and adolescents they treat due to overly burdensome prior authorization rules. Our members routinely run into difficulty prescribing necessary medications or find that a step therapy protocol has been abruptly implemented that results in an interruption in medication adherence for their patients. This can be particularly harmful in cases where children or adolescents have been stabilized on a medication regime that allows them to function at their best, but due to shifting prior authorization requirements, their regime is disrupted. Such disruptions can result in unnecessary patient harm and increase stress on families. But these disruptions also increase the burden on the prescribing psychiatrist,

when his or her time should more properly be used to provide direct patient care. Interruptions of this sort constitute clear mental health parity violations.

AACAP suggests that utilization management programs be flexible and include the ability to override step therapy requirements or formulary changes in cases when a patient is stable and requires a refill for the same medication they've been taking. Moreover, once a prior authorization is obtained for a specific treatment, the approval should be valid for the entire course of the prescribed treatment. We believe that medical decision-making should rest with clinicians, and not with insurance companies or utilization review entities. To do otherwise undermines the spirit and intent of mental health parity rules and regulations.

Another area that presents enormous challenges for some of our members is the prior authorization process when an inpatient stay would be the best choice for a patient. Severe limits on the number of days permitted, and even the availability of a bed in an appropriate setting, constitute parity violations. There are times when an inpatient stay for the clinically correct length of time can make all the difference in the future of a child or adolescent, and decrease the severity and likelihood of relapse.

We would like to take the opportunity to express support for a tremendous resource that addresses the need for more balanced application of utilization management policies. AACAP was involved in the development of, and fully supports, the American Medical Association's *Prior Authorization and Utilization Management Reform Principles*¹ published earlier this year, and believe they would be valuable to anyone concerned about more efficient delivery of healthcare.

Workforce Shortages

AACAP has developed Workforce Maps,² available on AACAP's website, illustrating the magnitude of the national CAP shortage. Nationally, 13% of youth 8-15 years of age have a mental illness, yet 79% of children 6-17 years of age who have a mental illness, do not receive treatment. This shortage is significant given the individual and societal impact of children and adolescents failing to receive needed services. An adequate supply of mental health professionals available to meet current needs is the backbone of mental health parity and should be a national priority.

This crisis points to the urgent need to develop and utilize new treatment approaches such as collaborative mental health models, and have health plans fully support and fund them on par with medical and surgical interventions. AACAP recognizes the benefit of integrating behavioral health care into pediatric care, and in 2015 launched an initiative called the *Pediatric Integrated Care Resource Center* (PIC-RC). My AACAP Presidential Initiative has supported this endeavor which has resulted in a website resource entitled *IntegratedCareforKids.org*³. This living resource represents the collective wisdom of medical, behavioral, and mental health experts, and supports and

¹ American Medical Association. <https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf>

² American Academy of Child and Adolescent Psychiatry. https://www.aacap.org/aacap/resources_for_primary_care/Workforce_Issues.aspx

³ American Academy of Child and Adolescent Psychiatry. <http://integratedcareforkids.org/>

encourages collaborative partnerships with pediatric medical homes. Summaries of several innovative programs and projects taking place around the country are available at the website, highlighting the value of the consultative model and care teams, among other innovative approaches. The programs also demonstrate the significant interest among the states to develop team-based approaches that can improve health outcomes, while being mindful of workforce issues and limited funding.

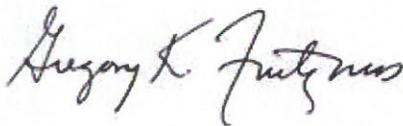
AACAP fully supports the continued development of integrated care delivery models in federal healthcare programs that would help address the unmet mental health needs of our nation's youth. The Psychiatric Collaborative Care Management codes that have been adopted by Medicare are a good start, but much remains to be done to develop their equivalent for use in child and adolescent psychiatry, and in the Medicaid and in the Children's Health Insurance Program (CHIP), however, we are pleased to see an increase in interest in these models at the federal level. Health plans need to follow suit and support these initiatives with appropriate funding and payment.

Federal Law

AACAP is very appreciative of the current laws addressing mental health parity such as The Mental Health Parity and Addiction Equity Act of 2008 (Parity Act) that ensures that deductibles and co-payments for mental health and addiction services do not exceed those of medical or surgical services. We are also heartened by the passage of the 21st Century Cures Act of 2016 that will create clear guidance and standards for determining payer and provider compliance with the Parity Act, ensuring more uniform compliance with existing law. AACAP also supports the recently introduced CHIP Mental Health Parity Act (H.R. 3192) that would require CHIP programs to cover mental health and substance use disorder services for some of our most vulnerable children and youth.

There is more work ahead to put the ideals discussed here into practice, but AACAP greatly appreciates the agency's renewed focus on mental health parity. Thank you for your serious consideration of our comments. Please don't hesitate to contact Karen Ferguson, Deputy Director of Clinical Practice at kferguson@aacap.org should you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Gregory K. Fritz".

Gregory K. Fritz, MD
President