

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

W W W . A A C A P . O R G

November 15, 2021

The Honorable Ron Wyden
Chairman
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The American Academy of Child and Adolescent Psychiatry (AACAP) is the professional home to 10,000 child and adolescent psychiatrists, residents and medical students, some of whom also treat adults and transitional age youth (age 18 years and above). Our mission includes promoting the healthy development of children, adolescents, and families. The mental health struggles of America's children and adolescents since the COVID-19 Public Health Emergency (PHE) have increased dramatically and are well-documented. In addition to the disruption our children and adolescents have experienced due to the PHE, more than 140,000 children under the age of 18 have lost a parent, close relative, or caregiver to COVID-19, according to recently released data from the National Institutes of Health.¹ Children who are racially and ethnically diverse have been disproportionately affected. These developments, coupled with a lack of psychiatric hospital beds for children and adolescents, represent a failure in the continuum of care for our most vulnerable citizens.

In October, AACAP, along with the American Academy of Pediatrics, and the Children's Hospital Association declared a [children's mental health state of emergency](#) in response to the unprecedented mental health needs for children and adolescents coupled with limited access to high-quality mental health care. Our organizations enumerated several policy recommendations that all require additional resources and include sustainable funding for school-based mental health services, suicide prevention programs, and addressing longstanding workforce issues, among others. We deeply appreciate the opportunity to offer input on how

¹ [More than 140,000 U.S. children lost a primary or secondary caregiver due to the COVID-19 pandemic | National Institutes of Health \(NIH\)](#)

the Committee can ensure parity between behavioral health and physical health care, while improving access to mental health care for children and adolescents.

Strengthening the Child and Adolescent Psychiatry Workforce

Long before the COVID-19 PHE became a reality, workforce shortages of pediatric mental health providers were significant. This is especially true for child and adolescent psychiatrists, whose educational requirements as subspecialists are extensive and costly. The student debt for training can serve as a disincentive for medical students to go into child and adolescent psychiatry in the first place, given lower expected reimbursements compared to other specialists over their careers.² AACAP's workforce maps paint a dire picture of the child and adolescent psychiatry shortages across the United States.³

AACAP recommends student loan payment relief as one solution to incentivizing medical students to become child and adolescent psychiatrists. The Pediatric Specialty Loan Repayment Program (PSLRP), recently authorized, would be a viable way to both provide financial relief to medical students who choose this path while simultaneously addressing severe workforce shortages in rural and underserved areas around the county. Once funded, the PSLRP will provide loan repayment for pediatric subspecialists and child mental health professionals who care for children in underserved areas. The program will address critical shortages of these highly trained professionals by lessening financial disincentives for pursuing pediatric subspecialty training. Congress must robustly fund and enact this long-standing AACAP priority.

Loan repayment relief is one piece of the puzzle, the other being adequate reimbursements in Medicaid and the Children's Health Insurance Program (CHIP). Reimbursement rates are lower for mental and behavioral health services than they are for primary care and should increase to attract larger numbers of medical students wishing to pursue a career in child and adolescent psychiatry, as demonstrated by the Milliman Research Report cited above. More adequate reimbursement across all payers would help address concerns around network adequacy that lead to less in-network access, longer wait times, and higher expenses for patients, and the parents of patients, who are often forced to go out of their insurance networks to find care, at a greater out-of-pocket expense. **AACAP therefore recommends increased investments in loan repayment for pediatric subspecialists via the PSLRP, and adequate reimbursements for mental and behavioral health services in federally regulated health plans.**

During the COVID-19 pandemic, physicians have seen more patients die and suffer from severe disease burden, experienced extended time away from family while dealing with additional stress, and an increased risk of contracting COVID-19. Physicians need and deserve our support.

² [Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement \(milliman.com\)](https://www.milliman.com/research/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-provider-reimbursement)

³ AACAP Workforce Maps by State: [Workforce Maps by State \(aacap.org\)](https://www.aacap.org/Workforce-Maps-by-State)

While it has passed the U.S. Senate, **it is important to see the *Dr. Lorna Breen Health Care Provider Protection Act, S. 610*, becomes law.**

The severe national shortage of child and adolescent psychiatrists combined with the national children's mental health emergency has only exacerbated the demand for child and adolescent psychiatric services leading to burnout and likely worsening mental health across the profession. Any effort to protect and support physician wellness is critical as the psychiatric care system is buckling from a lack of health professionals, partly due to burnout, willing to help treat sicker psychiatric patients.⁴

While outside of the jurisdiction of the U.S. Senate Finance Committee, physicians face barriers to accessing mental health care themselves due to state licensure applications in many states asking about any past impairment, rather than only current impairment, a violation of the *Americans with Disabilities Act*.⁵ As the Federation of State Medical Boards (FSMB) correctly points out, state medical boards must not be an impediment for physicians to receive mental health care and too few state medical boards have made progress in implementing the FSMB recommendations on improving physician wellness.

With physicians serving as the backbone of the COVID-19 pandemic response, they deserve the same access to mental health care they offer to patients. Pre-COVID-19 pandemic, physicians already had a higher rate of anxiety and depression than the general population. Further, no inpatient psychiatric bed should go unused during a children's mental health emergency due to a lack of available highly trained staff. Emergency department (ED) visits for suicide ideation are at an all-time high, as is ED boarding of children and adolescents with no appropriate available placement for a lower level of care.

In addition, International Medical Graduates (IMGs) are an important part of our mental health care teams, particularly in rural and underserved areas, and Congress must support lawfully present IMGs. Recent data shows that 30.9 percent of child and adolescent psychiatrists are IMGs.⁶ AACAP supports the *Healthcare Workforce Resilience Act, S. 1024*, which would direct immigration authorities to recapture 15,000 unused employment-based visas from prior years and make them available to non-citizen international medical graduates (IMGs) and expedite the approval process of these applications. There will be no greater need of quality, evidence-based mental health care from psychiatrists in the months and years ahead, and one-third of all practicing child and adolescent psychiatrists, and their families, should not live in limbo, fearing the loss of their legal status.

⁴ Miller, Andy. Understaffed State Psychiatric Facilities Leaves Mental Health Patients in Limbo. Kaiser Health News. Oct. 26, 2011. See: <https://khn.org/news/article/understaffed-state-psychiatric-facilities-leave-mental-health-patients-in-limbo/>.

⁵ Van der Burgh, Anna, et al. May 18, 2021. Consistency Between State Medical License Applications and Recommendations Regarding Physician Mental Health. Letter. Journal. Am. Med. Ass.

⁶ Active Physicians Who are International Medical Graduates by Specialty, 2019. Association of American Medical Colleges, available at: <https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-who-are-international-medical-graduates-imgs-specialty-2019>.

Ensuring Mental Health Parity

The field of mental health care will not attract qualified, highly trained providers, reduce stigma, nor ever accommodate the growing demand for such services through a full continuum of care until it is on equal footing with physical health and surgical care. Fundamentally, the stated Congressional goals of the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (Federal Parity Act) which is that insurance coverage for mental health and addiction treatment should be no more restrictive than insurance coverage for other medical care, must be realized to tackle mental health access issues.

AACAP believes the Federal Parity Act must be extended to Medicare, Medicaid, including managed care plans, and TRICARE. In addition, the ability for health plans administered by state and local governments to opt-out of the Federal Parity Act,⁷ leaving millions of employees and their families without the mental health coverage they expect, is concerning. **The U.S. Department of Labor maintains a list of plans which have opted-out of Federal Parity Act protections,⁸ a practice which must end.**

The U.S. Department of Labor, which regulates Federal Parity Act compliance for Employee Retirement Income Security Act (ERISA) plans must be granted the civil monetary penalty authority currently included in the House Rules Committee-release *Build Back Better Act* to help curb Federal Parity Act violations. The *Parity Enforcement Act*, HR 1364, would similarly grant such penalty authority.

The lack of Federal Parity Act protections in Medicare has translated to undervaluing mental health care, leading to lower reimbursement rates and a lack of coverage for needed services in commercial plans, as demonstrated by the challenges states are facing in implementing by July 2022 the *National Suicide Hotline Designation Act of 2020*, and the related 988 hotline and crisis intervention services.

When a majority of those with a mental illness go undiagnosed, untreated, or undertreated, it becomes critical that underserved patients and their family members do not face stigma or discrimination based on a mental illness. Stigma brings shame and stress, especially in certain cultures, reduces the likelihood that a patient will access needed health care, while increasing the likelihood that they will delay or refuse help, or drop out of treatment altogether. Untreated mental health disorders lead to higher rates of juvenile incarcerations, school dropout, family trauma, substance use, and unemployment. In addition, adolescents and young adults with untreated mental illness are far more likely to experience poverty, social isolation, and poorer health outcomes later in life. Failing to place mental health and substance use disorder treatment on equal footing with other health care exacerbates existing stigma and reduces access to evidence-based mental health care.

⁷ Abelson, R., [Teachers, Police, Other Public Workers Left Out of Mental Health Coverage](#), New York Times. Aug 21, 2021.

⁸ See: [HIPAA Opt-Out Elections for Self-Funded Non-Federal Governmental Plans \(cms.gov\)](#).

The 2019 *Wit v. United Behavioral Health* (UBH) groundbreaking decision has created a new opportunity to achieve parity between mental health and physical health services. The court found UBH used flawed medical necessity criteria and was ordered to reprocess almost 67,000 previously denied claims for mental health and substance use treatment, including residential care, on behalf of 50,000 claimants from 2011-2017 (half of whom were children and adolescents) in four states: Connecticut, Illinois, Rhode Island, and Texas. The *Wit* decision represented the first time a health plan was found to deny care by relying on improper clinical guidelines to make claim decisions. UBH was also found to place their financial interests over patient access to generally accepted standard of care for mental health and substance use disorders.

U.S. District Court for the Northern District of California found that UBH's standards of care applicable to service intensity and patient placement selection for mental health care were flawed. UBH was ordered to adopt nonprofit physician specialty recommendations and service-intensity instruments, such as AACAP's [CASII and ECSII](#), and apply those to their practices. ECSII, developed by AACAP, is a service intensity instrument for children aged 0-5. The CALOCUS-CASII is a result of the merger between the Child and Adolescent Service Intensity Instrument (CASII) and the Child and Adolescent Level of Care Utilization System (CALOCUS) developed by AACAP and the American Association of Community Psychiatrists, who jointly oversee all training and licensing. This tool can be used to determine the appropriate level of service intensity for children and adolescents 6-18 years-of-age and their families.⁹

AACAP supports state efforts such as California's 2020 law, SB 855,¹⁰ modeled after the *Wit* decision which requires the adoption of nonprofit clinical specialty society service intensity and level of care instruments, such as those developed by AACAP, by all state regulated health plans when making coverage decisions. Similar state laws passed this year in Illinois¹¹ and Oregon,¹² requiring through legislation the use of medical necessity standards that align with established standards of care for mental health and substance use disorders were also supported by AACAP.

In the stunning *Wit* decision, UBH was deemed to repeatedly cover treatment of only acute symptoms, rather than the underlying conditions, among other things. This decision raised numerous unanswered questions about the practices of other payers of behavioral health care, and if the pervasive nature of UBH denying patient's access to standard of care is replicated elsewhere. **While advancing new state laws resulting from the *Wit* decision are important, federal action is needed to help ensure all federally regulated health plans adopt the roadmap for appropriately covering the standards of care for mental health and substance**

⁹ AACAP Clinical Practice Products:

https://staff.aacap.org/AACAP/Member_Resources/Practice_Information/Clinical_Practice_Products.aspx.

¹⁰ https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855

¹¹ <https://www.ilga.gov/legislation/BillStatus.asp?DocNum=2595&GAID=16&DocTypeID=HB&LegId=131415&SessionID=110&GA=102>

¹² <https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB3046>

use disorders, including tailoring medical necessity criteria to the unique needs of children and adolescents, set forth in the *Wit* decision.

Long-term Support for Telepsychiatry

As was true prior to the COVID-19 pandemic, most youth who need mental health services do not receive the needed care. For reasons mentioned above, AACAP has long sought for new approaches to help expand access to child and adolescent mental health care, such as telepsychiatry, and views telepsychiatry as a key therapeutic intervention to expanding models of care, particularly for underserved patient populations. Telepsychiatry extends the psychiatrist's reach across large geographic areas to youth in different community settings, including primary care offices, schools, daycare facilities, detention centers, and homes.¹³ AACAP also believes the pandemic and subsequent shift to telehealth has made it clear telehealth is here to stay for providers from major medical centers, community health centers, and in private practice alike.

Psychiatrists relied on telehealth throughout the COVID-19 pandemic more than any other physician specialty and continue to rely on it at a higher rate, according to several recent surveys^{14,15} conducted at different points of the COVID-19 pandemic. One study found that 85 percent of all psychiatrists conducted telepsychiatry (via videoconference and telephone) since the start of the COVID-19 pandemic to diagnose and treat patients.¹⁶ In these surveys, psychiatrists have reported lower no-show rates, improved patient satisfaction, and improved access to care through telepsychiatry during the COVID-19 pandemic. **It is imperative, given the national children's mental health emergency, that regulatory flexibilities provided at the start of the COVID-19 pandemic remain in place following the end of the public health emergency (PHE) to allow for a continuity of care to a diverse patient population, particularly patients seeking mental health care.**

Increased availability of telehealth, through the removal of geographic and site of service restrictions and wider insurance coverage of telehealth, both video and audio-only, has helped AACAP members treat established patients and reach many new patients in need of mental health care. Telehealth can save patients time and money as patient travel is not typically necessary. Although, as many COVID-19 pandemic telehealth flexibilities and state enacted

¹³ J Am Acad Child Adolesc Psychiatry 2017; *Clinical Update, Telepsychiatry with Children and Adolescents*. 56(10):875–893. [https://www.jaacap.org/article/S0890-8567\(17\)30333-7/pdf](https://www.jaacap.org/article/S0890-8567(17)30333-7/pdf).

¹⁴American Medical Association, 2020 Physician Benchmark Survey, Sept. 2021, [Physician Practice Benchmark Survey | American Medical Association \(ama-assn.org\)](https://www.ama-assn.org/practice-benchmark-survey).

¹⁵American Psychiatric Association, Psychiatrists Use of Telepsychiatry During COVID-19 Public Health Emergency, July 2021, <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Telepsychiatry/APA-Telehealth-Survey-2020.pdf>.

¹⁶American Medical Association, 2020 Physician Benchmark Survey, Sept. 2021, [Physician Practice Benchmark Survey | American Medical Association \(ama-assn.org\)](https://www.ama-assn.org/practice-benchmark-survey).

public health emergencies have expired,¹⁷ AACAP members have reported the need for patients to drive across state lines to comply with state regulatory requirements.

AACAP is grateful to Congress for permanently waiving origination and geographic restrictions for patients needing mental health care in the *Consolidated Appropriations Act of 2020*. We are similarly grateful to Centers for Medicare and Medicaid Services (CMS) for allowing physicians to use their clinical expertise to determine the frequency in which patients covered by Medicare must be seen in person, as finalized in the recently released Medicare Physician Fee Schedule Final Rule for 2022, rather than requiring an arbitrary in-person visit within six months of the first telehealth visit. The Final Rule also includes policies that will continue to lower barriers to access for mental health and substance use services through audio-only visits when patients choose this modality, and the reason for the patient's choice is thoroughly documented in the medical record. **Private insurance plans must follow suit and agree to modernize their payment policies to reflect these significant improvements to accessing mental health and substance use treatment.**

Payment parity for telepsychiatry is needed to sustain such services, and the maldistribution of video capable devices and reliable and affordable broadband access for patients remains a concern. The FCC's Telehealth Program, appropriated by Congress as part of the *Coronavirus Aid, Relief, and Economic Security (CARES) Act* and the *Consolidated Appropriations Act (CAA) of 2021*, was helpful to hospitals, health centers, and their employees to stand up telehealth programs when funding was made available at two points during the COVID-19 pandemic. However, additional support should be directed to help expand telehealth services, both for providers and patients, specific to mental health care with a preference for child and adolescent patient populations.

The federal PHE resulted in the Drug Enforcement Administration (DEA) granting an important flexibility to allow child and adolescent psychiatrists to conduct telepsychiatry successfully. The DEA announced an exception to the Ryan Haight Act¹⁸ for telehealth which allowed, for the first time, DEA-registered prescribers to prescribe controlled substances without first conducting an in-person evaluation so long as the following conditions were met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and
- The practitioner is acting in accordance with applicable Federal and State law.

¹⁷Center for Connected Health Policy, Telehealth in the Time of COVID-19, <https://www.cchpca.org/covid-19-actions/>.

¹⁸ Drug Enforcement Administration, DEA Policy: COVID-19 Prescribing Guidance, <https://www.deadiversion.usdoj.gov/coronavirus.html>.

Despite the *SUPPORT for Patients and Communities Act* becoming law in 2020, which statutorily required the DEA to issue a special registration process allowing providers to legally prescribe a controlled substance via telehealth, the DEA has failed to establish such special registration and is therefore not complying with federal law. **While the DEA PHE flexibility has been essential for psychiatrists to widely adopt telepsychiatry, the missed deadline for the DEA to establish a special registration for DEA-registered providers should not stand in the way of the provision of telepsychiatry following the end of the federal PHE.**

Improving Access for Children and Young People

Collaborative care arrangements, in which child and adolescent psychiatrists consult with and educate pediatricians on treatment options for behavioral and mental issues that present during patient visits are an effective approach to identifying and treating children and youth who may need mental and behavioral health services. Congress should consider solutions for increasing the uptake of collaborative care arrangements, including those in pediatric practices. These programs must be funded adequately and include resources for start-up costs. Collaborative care arrangements in the pediatric setting have proven beneficial in the early identification of children who need treatment for behavioral and mental health conditions because children are seen by pediatricians on a regular basis. A pediatrician's office therefore serves as a natural entry point of access to mental and behavioral health care. **Enactment of [Collaborate in an Orderly and Cohesive Manner Act, HR 5218](#), which would help meet initial costs for collaborative care arrangements and establish technical assistance centers, would be a step in the right direction and we call on Congress to act and advance this bill into law.**

Child Psychiatry Access Programs (CPAPs) are another way to increase access to mental and behavioral health care. CPAPs have been implemented in most states across the country, and are funded through Health Resources and Services Administration grants, state, or institutional funding, or a combination of both, yet a small number of states have not implemented these programs, including some states with large rural and underserved areas that could most benefit.¹⁹ Pediatricians can contact the CPAP in their state to consult with a child and adolescent psychiatrist about treatment options for the children and adolescents they see in their practices who may need mental and behavioral health care. Research has shown that the use of CPAPs significantly improves outcomes for the patients who receive integrated medical and behavioral health care through this model compared to treatment as usual.²⁰ **AACAP strongly supports sustainable federal funding for these highly effective models of integrated care and recommends that CPAP programs be implemented in every state.**

CPAPs and collaborative care models in pediatric settings meet children and adolescents where they are—in the pediatrician's office—and therefore help eliminate barriers to mental and behavioral health care.

¹⁹ [Map — NNCPAP National Network of Child Psychiatry Access Programs](#)

²⁰ [Integrated Medical-Behavioral Care Compared with Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis - PubMed \(nih.gov\)](#)

School-based mental health services are another way to increase access to needed services. Accessing mental health supports in schools, where students spend much of their day, while providing evidence-based recommendations for educators and school staff is key to a sustainable system of supports for students with behavioral health needs and their families.

Congress has recognized the importance of school-based mental health services and has provided funding for several school-based models of care, including Project AWARE (Advancing Wellness and Resiliency in Education) State Education Agency Grants. This program helps build or expand state and local governments' coordination to increase awareness of mental health issues among school-aged youth. It also provides training for school personnel and other adults who interact with students to detect and respond to mental health issues and connect those who may have behavioral health issues – including serious emotional disturbance (SED) or serious mental illness (SMI) – and their families to community-based mental health services. Investments in mental health care for students are effective means of providing services in a manner that is less disruptive to students, but currently only 17 states have Project AWARE grants. **This funding should be buttressed through passage of additional legislative proposals such as the [Mental Health Services for Students Act of 2021, S 1841/HR 721](#).**

School districts and school personnel are eager to offer comprehensive school-based health services, particularly mental health care given the growing need for students. As such, states and school districts, particularly smaller districts, must have the technical guidance and personnel assistance needed to take advantage of Medicaid funding for school-based health services, not just for services to students with an Individual Education Plan (IEP).²¹ Medicaid funding is critical for school-based health services, yet a recent study found half of all states faced barriers to using Medicaid funding for school-based health services.²² Given that students and their families are more likely to gain access to prevention and early intervention measures in schools than elsewhere in their community and are more likely to continue mental health care through school-based services, which must include consultation or liaison services with child and adolescent psychiatrists, the availability of such services is critically important. Helping school districts take advantage of Medicaid funding for school-based health services is a fundamental piece to improving health equity particularly given the increased need of mental health services as a result of the national children's mental health crisis.

The U.S. Department of Education recently released a report entitled "Supporting Child and Student Social, Emotional, Behavioral and Mental Health Needs During the COVID-19 era"²³

²¹ Community Catalyst, State Efforts to Implement the Free Care Policy Reversal, Oct. 2021, <https://docs.google.com/document/d/1u0j1so-se8ohhyl7AcHaaXIGX5I3s0PN2cuIDejXZQw/edit>.

²² Wilkinson, A., et al., Child Trends, Early Intervention and Medicaid's Important Role in School-based Health Services. Dec. 14, 2020, <https://www.childtrends.org/publications/early-evidence-medicareid-role-school-based-health-services>.

²³ U.S. Department of Education, Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs, Oct. 19, 2021, <https://www2.ed.gov/documents/students/supporting-child-student-social-emotional-behavioral-mental-health.pdf>.

which appropriately focuses on and explores the challenges students are facing as a result of the PHE and provides recommendations to address current mental health needs, such as prioritizing wellness for every student, educator, and provider. AACAP supports the recommendations in this report and believes that it would serve as an effective roadmap when considering how to fully address the well-being of children and students.

Once again, AACAP appreciates the opportunity to provide input as the Senate Finance Committee considers how Congress can best address barriers to mental health services. Should you have questions, please don't hesitate to reach out to Alexis Horan at ahoran@aacap.org.

Sincerely,

A handwritten signature in black ink that reads "Gabrielle A. Carlson". The signature is written in a cursive style and is enclosed within a large, sweeping, handwritten flourish that extends to the right and then loops back under the name.

Gabrielle A. Carlson, MD
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