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CHILD & ADOLESCENT  
PSYCHIATRY

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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;

The American Academy of Child and Adolescent Psychiatry  
(AACAP) appreciates 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 (hereinafter "Proposed  
Rule").

The American Academy of Child and Adolescent Psychiatry  
(AACAP) is the professional home to more than 10,000 child and  
adolescent psychiatrists, child and adolescent psychiatry fellows,

psychiatry residents, and medical students. Our mission includes promoting the healthy development of children, adolescents, and families.

On behalf of the physicians we represent and the patients they serve, we commend the Departments' efforts to improve access to mental health care and addiction treatment. This letter is in addition to the comments submitted in response to the Department's Technical Release 2023-01P, *Request for Comment on Proposed Relevant Data Requirements for Nonquantitative Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act*.

AACAP, along with the American Academy of Pediatrics and Children's Hospital Association, declared a national children's mental health emergency in October 2021, which persists today. As we mark the two-year anniversary of this declaration, physicians are once again sounding the alarm that young people continue to struggle with soaring rates of depression, anxiety, trauma, loneliness, and suicidality that will have lasting impacts on them, their families, their communities, and all our futures.

Children and adolescents differ from adults in their continued biopsychosocial development. Research has demonstrated that the brain continues to develop throughout adolescence and into early adulthood. It is imperative that the Proposed Rule recognizes both the unique needs of pediatric patients and the continuum of care that supports their varying treatment needs.

## **Purpose Section**

AACAP is grateful for the Departments' persistence in ensuring the intent of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Treatment Act (MHPAEA) of 2008, that health plan participants have the same level of access to their mental health and substance use (MH/SUD) treatment benefits as they do to their medical/surgical (M/S) benefits, is realized. The addition of a Purpose clause to the existing regulations reasserts this fundamental goal.

## **Meaning of Terms**

AACAP also appreciates the attention given to terminology in the proposed rule. Tying the definition of "mental health benefits" and "substance use disorder benefits" to generally recognized independent standards of current medical practice reduces ambiguity regarding these terms and contradictions in terminology that may exist in standards of care developed outside of medical professional standards development, as well as in some state law and regulations related to benefit coverage requirements. The proposed rule specifically highlights the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and the World Health Organization's International Classification of Diseases as examples of generally recognized independent standards of current medical practice. AACAP encourages the Departments to add the *DC: 0-5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* to its list of independent

standards of clinical practice, a diagnostic manual for children in infancy and through age five. Additionally, we believe that autism spectrum disorder is a mental health disorder, and that the rule should reference pediatric clinical practice guidelines developed by national medical professional associations including the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics.

### **Non-Quantitative Treatment Limits**

Health plans' disparate application of non-quantitative treatment limitations (NQTLs) on MH/SUD benefits results in unnecessary delays in patient care that, particularly for children, can have life-long consequences. AACAP supports the proposed additional requirements for NQTLs that ensure that plans do not apply NQTLs to mental health or substance use disorder benefits in any classification, as written or as designed, any more stringently than how NQTLs are applied to medical/surgical benefits in similar classifications. We believe the Proposed Rule could be strengthened, however, by defining the term "meaningful," as it relates to the scope of benefits in every classification.

AACAP also supports the amendments to the non-exhaustive list of NQTLs, including the improved "standards related to network composition" NQTL and the specific reference to prior authorization requirements as an example of a medical management technique that limits benefits based on medical necessity reviews. AACAP asks the Departments to add "scope of services" to the non-exhaustive list of NQTLs as plans often impose treatment limitations for certain services within benefit classifications. These limitations undermine provider-patient treatment plans, including transitions of care between different levels of service intensity.

The NQTLs on mental health and substance use disorders disproportionately impact children and adolescents who are most disadvantaged. Different populations most impacted include those in child welfare care, justice involved settings, low income, rural and racial and ethnic minoritized youth. Increasing barriers to care such as NQTLs impact these children and adolescents who are already underserved, adding to the inequities and disparities.

### **Required Use of Outcomes Data**

Historically, it has been more difficult to assess the impact that NQTLs have on patient access to care than the impact that quantitative treatment limitations have on access. AACAP agrees with the Departments that plans should collect and assess outcome data related to the application of an NQTL to gauge whether the plan is applying NQTLs disparately on MH/SUD benefits versus M/S benefits. AACAP would urge the Departments to strengthen this proposed provision by requiring plans to act whenever the data shows any difference in action. AACAP is concerned that plans will interpret "material" differently which will make this requirement difficult to enforce. Greater transparency with the outcomes data will help ensure greater accountability among all entities.

## **Special Rule for NQTLs Related to Network Composition**

AACAP is particularly grateful for the Departments attention to access disparities related to provider network composition as addressing persistent child and adolescent psychiatry workforce issues remains a top priority of AACAP. While available training slots for child and adolescent psychiatry fellowship trainees have slowly increased, and fewer training slots went unfilled in 2023 as compared to 2022, fewer individuals are choosing careers in pediatric subspecialties while the existing workforce continues to age. Financial concerns, such as medical school debt load, are a significant factor given the lengthy training requirements for child and adolescent psychiatry. Persistent disparities in reimbursement rates between MH/SUD and M/S treatment services, combined with overly burdensome utilization management practices for behavioral health have long served as a deterrent for future physicians from choosing a career path in child and adolescent psychiatry. Lower reimbursement rates disincentivize clinical program development and expansion at a time when greater investments need to be made in these programs to ensure successful mental health/substance use disorder services. Such inequities have similarly impacted recruitment into other mental and behavioral health provider types. If implemented well, what has been proposed by the Departments could help to finally realize mental health parity and attract a large, diverse generation of child and adolescent psychiatrists. AACAP submitted additional and extensive comments on this issue in response to the Departments' *Technical Release on Network Composition*.

## **Eliminating Exceptions Related to Fraud, Waste and Abuse**

We urge the Departments to remove the proposed exceptions from complying with parity requirements based on "independent medical clinical standards" to prevent fraud, waste, and abuse. As proposed, even narrowly applied, this could deeply harm the otherwise overwhelmingly positive attempt in the Proposed Rule to eliminate NQTL parity violations and serve as a vehicle for plans and issuers to avoid finally placing MH/SUD benefits on level footing with M/S benefits. Health plans and issuers should have no way to claim exceptions to MH/SUD benefits, when medically necessary, for the pediatric and transitional aged youth patient population who may require early intervention for MH/SUD symptoms, but not have an official MH/SUD diagnosis. We are deeply concerned with this exception being overused and misapplied.

## **Independent Professional Medical or Clinical Standards Exception**

Health plan medical decision-making should adhere to generally accepted mental health and substance use disorder standards of care as developed by the relevant national non-profit clinical specialty associations. AACAP understands that while the intent of the parity requirement exceptions for NQTLs that apply "generally recognized independent professional medical or clinical standards" is to promote plans' adherence to independently and scientifically developed standards, the Proposed Rule does not adequately define such standards. AACAP proposes that the Proposed Rule point to evidence-based, nationally recognized level of care placement criteria consistent with

generally accepted mental health and substance use disorder care standards that determine the level of treatment services needed for a patient based on clinically derived, and empirically tested, service intensity standards of care developed by the relevant non-profit clinical specialty associations. Examples of such standards include the American Academy of Child and Adolescent Psychiatry Child and Adolescent Service Intensity Instrument and the Early Childhood Service Intensity Instrument; the American Association of Community Psychiatrists' Level of Care Utilization System and Child and Adolescent Utilization System; and the American Society of Addiction Medicine ASAM Criteria. Additionally, AACAP proposes that plans be required to document in their NQTL analyses how their clinical standards deviate from the aforementioned clinical specialty-developed standards and be required to make available to any regulator and enrollee any criteria/guideline they use.

### **Effect of Final Determination of Noncompliance**

AACAP supports the provision that gives the Departments the authority to direct a plan to not apply a NQTL if the Departments have determined that the plan is not complying with the NQTL requirements. AACAP would also urge the Departments to change “may” to “shall” to indicate that the plan will not be permitted to apply a non-compliant NQTL. We further ask that Departments to clarify that if a plan cannot demonstrate that an NQTL is compliant, it cannot apply the NQTL.

### **Additional Requests for Information**

#### **Provider Directory Requirements**

AACAP asks that provider directories specify which providers treat children and adolescents. Additionally, AACAP asks the Departments to require that provider directories indicate which providers are accepting new patients; any relevant areas of expertise, e.g., child and adolescent psychiatrist that specialize in attention deficit disorder or specialize in the treatment of transition-aged youth; and providers that offer telehealth, including telehealth-only providers.

#### **Telehealth to Improve Access**

Surveys have repeatedly shown that psychiatry continues to rely on telehealth at a far greater rate than any other physician specialty and AACAP remains supportive of broad access to and coverage of telemedicine, including audio-only care. Plans should be discouraged, however, from using narrow telehealth-only networks to satisfy network adequacy requirements.

Telehealth access across all services for children and adolescents is important, including in MH/SUD programs, primary care settings, and school-based programs. These settings are important to providing improved access to care.

## **Crisis Services**

AACAP urges the Departments to clarify that if a plan covers physical health emergency/crisis services, it must cover comparable MH/SUD disorder emergency/crisis services. These services need to have the training and competency to provide these important services in a developmentally appropriate, culturally humble, linguistically aligned and family-centered approach. Providing crisis services to children, adolescents and families requires additional training and attunement to the biopsychosocial and family-based frameworks.

## **Medicaid and CHIP Parity**

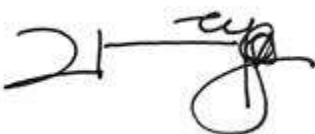
In addition to what is included in the Proposed Rule for private insurance, we urge the Administration to take necessary steps to ensure MHPAEA applies to all Medicaid and CHIP plans. AACAP intends to submit separate formal comments to the Centers for Medicaid and CHIP Services' recent request on how to assess Medicaid and CHIP's compliance with parity and will ask for swift action to help all plans comply with MHPAEA.

Amidst a national children's mental health crisis, the Departments must ensure that the largest payor of behavioral health in the country is complying with parity, and that MH/SUD benefits are being offered as required under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. This is especially important given the fact that millions of parents, children, and adolescents are being disenrolled from Medicaid and CHIP, despite remaining eligible, due to the ending of the continuous coverage protection afforded to enrollees during the COVID-19 Public Health Emergency and the resulting churn between public and private health coverage.

Finally, AACAP respectfully asks that, while "child psychiatry" may be used as shorthand at times, when referring to child and adolescent psychiatry, all references to child and adolescent psychiatry in any final rule and guidance should use the full name of the physician subspecialty: child and adolescent psychiatry.

AACAP is grateful for the opportunity to comment on this important rule. Please contact Alexis Geier Horan at [ahoran@aacap.org](mailto:ahoran@aacap.org) should you have any questions about AACAP's recommendations. We look forward to working with you to improve children's access to mental health and substance use disorder care.

Sincerely,

A handwritten signature in black ink, appearing to read "W. Ng", with a stylized flourish at the end.

Warren Y.K. Ng, MD, MPH  
President