

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

June 08, 2015

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2333-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

Acting Administrator Andrew M. Slavitt:

On behalf of the American Academy of Child and Adolescent Psychiatry (AACAP), please accept our comments to the Centers for Medicare and Medicaid Services (CMS) pursuant to the public notice for comment [CMS-2333-P] on implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

AACAP is an 8,800 member-strong, professional medical organization comprised of child and adolescent psychiatrists. These uniquely trained physicians promote healthy development by their evaluation, diagnosis, and treatment of children, adolescents and their families who are affected by disorders of feeling, thinking, learning, and behavior.

AACAP generally supports the Mental Health Parity Proposed Rule for Medicaid and Children's Health Insurance Program (CHIP) and applauds the continued effort by the U.S. Department of Health and Human Services (HHS) to ensure that the goal of equitable access, care, and treatment for mental health services required under the MHPAEA is fully met. Additionally, AACAP fully supports the Department's and other agencies' continued determination under the Act to prohibit applicable public and private health plans from applying separate deductibles, out-of-pocket maximums, or other cumulative financial requirements on mental health and substance abuse disorder benefits. AACAP's suggestions for clarification, synergy of efforts, and improving access and the delivery of care appear below.

Restricting the Network Tiering Based on Prescription Drugs

Among the categories commonly included in Non-Quantitative Treatment Limitations (NTQLs)—a term used to reference non-numerical limitation standards for parity, such as pre-authorizations or medical management, among others—is the permissible classification of multi-tiered prescription drug benefits. Specifically, the proposed rule cites reasonable factors including “cost, efficacy, generic vs. brand.”

In practice, the stratification of prescription drug benefits based upon efficacy is untenable when it involves children's mental health. Nearly all psychotropic medications are prescribed off-label. In fact, HHS' Agency for Healthcare Research and Quality (AHRQ) stated in its Comparative Effectiveness Review Number 43, "Off-Label Use of Atypical Antipsychotics: An Update," that "At least 90 percent of antipsychotics prescribed to children are atypical, rather than conventional antipsychotics. The majority of use is off-label."

While FDA-approved indications differ, off-label use does not necessarily constitute a contraindication of the usage of the product in children. When indicated, practitioners routinely prescribe such medications for off-label use in safe and clinically-effective ways tailored to the specific mental health condition and diagnosis of each child or adolescent. AACAP strongly urges CMS to clarify that any tiering standard based on prescriptions drugs is mindful and inclusive of off-label use, especially for pediatric and adolescent populations. To do otherwise, would allow health plans employing such tiering to effectively negate the promise of parity for children and adolescents in these Medicaid-offered plans.

Include Updated Network Adequacy Standards as an NQTL

AACAP applauds the proposed rule's continuing emphasis to ensure parity applications to other NQTLs, and encourages CMS to include recently introduced Medicaid and CHIP network adequacy standards to its list of NQTLs.

The proposed rule provides for parity among "standards for provider admission to participate in a network, including reimbursement rates" and "standards for accessibly out-of-network providers... if a provider network is unable to provide necessary services." The rule does not specifically address the myriad of network adequacy issues typically found within provider networks. For example, does the network maintain accurate, up-to-date, and easily accessible directories? Is the appeals process fair, timely and transparent? Does the network supply the appropriate range of primary, specialty, and subspecialty providers for both adults and children?

The addition and explicit inclusion of network adequacy to the parity requirements as an NQTL is timely. AACAP notes that in a different pending proposed rule, CMS-2390, the "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability" rule (hereafter referred to as CMS-2390), CMS has set forth new standards for network adequacy.

In the proposed rule on CMS-2390, CMS states:

"Given the large number of pediatric Medicaid enrollees, we believe it is important for states and plans to specifically include pediatric primary, specialty, and dental providers in their network adequacy standards. Network adequacy is often assessed without regard to practice age limitations which can mask critical shortages and increase the need for out-of-network authorizations and coordination."

It is imperative that CMS consider pediatric populations when determining barometers to measure whether provider networks met the three “A”s of delivering high quality mental health care - adequacy, accuracy, and accessibility. In CMS-2390, CMS wisely notes that networks may be stratified without regard to pediatric population, and, by doing so, act to “mask critical shortages” and increase “out-of-network authorizations.”

The existent parity rule’s NQTLs regarding prior authorizations and approvals are also included within the broader network adequacy standard offered by CMS-2390. AACAP contends that if such critical elements are included in both rules that CMS therefore has the authority to offer this broader network adequacy standard in the parity rule.

Ensuring Parity by Maintaining Access: Insufficient Payment Rates Exacerbate CAP Workforce Shortages

Access to mental health services and substance abuse treatment for child and adolescent populations is limited due to a significant shortage of appropriate mental health care providers, particularly child and adolescent psychiatrists. AACAP applauds the inclusion of reimbursement rates as an NQTL among the standards for provider network admission and encourages CMS to actively investigate and advance solutions to address this vexing shortage through enhanced economic incentives and higher reimbursement.

This acute shortage is readily visible. AACAP estimates there are approximately 8,800 practicing child and adolescent psychiatrists (CAPs) nationwide, whereas studies indicate the capacity need is closer to 30,000 CAPs. Unfortunately, subspecialty fellowship slots are not being completely filled, at the same time as the average age of a CAP has risen to 57 years old, resulting in a growing shortage that will only increase in the years to come.

The harmful effects resulting from CAP workforce shortages are evident in that the average initial wait time to see a CAP now stands at over 7.5 weeks—a figure inclusive of all forms of payment including cash and private payer insurance. (This figure does not take into account individuals who did not pursue the scheduling of an appointment due to the extended initial wait time.)

AACAP believes that economic considerations are one of the largest driving factors behind our workforce shortage and that they weigh heavily on the minds of medical students and recent graduates. According to the American Association of Medical Colleges (AAMC), the median medical school student, taking forbearance through his or her education and residency, completes medical school with \$328,000¹ of debt. This figure is compounded by the fact that CAPs require an additional two years of subspecialty fellowship training following a general residency training program in psychiatry.

¹ Association of American Medical Colleges (2014). Medical Student Debt Card. Retrieved from <https://www.aamc.org/download/152968/data/debtfactcard.pdf>

A strong correlation exists between payment and provider acceptance of patients. A study in the journal, *Psychiatric Services*, concluded that “Increased access may be achieved through increased federal support for clinical training in mental health professions and a decrease in the administrative and financial disincentives to participation in these health plans. If current trends in the psychiatric workforce and public and private reimbursement for mental health care are not reversed, the treatment access crisis will only worsen.”² In fact, the broader field of psychiatry’s annual compensation ranked among the bottom of all physicians alongside their primary care colleagues.³

Ensuring Parity Among Health Plans’ Denial and Appeals Processes

Denial of mental health services continues as an issue in the implementation of parity. The MHPAEA and subsequent rules clearly require health plans and insurers to disclose any reasons for denial of claims. Unfortunately, this has not stopped some of these entities from aggressively denying claims.

The popular investigative television series, *60 Minutes*, aired a feature on persistent patterns of denial of mental health claims by a major California health plan. The investigation reported that with one health plan’s physician reviewer “[the denial] rate averaged 92 percent in one six month period in 2011. But that was typical among 11 reviewers contracted... Some of the providers had denial rates of 95 and 100 percent.”⁴

In March of 2015, the New York State Attorney General announced a \$9 million settlement with a major health plan for its failures to comply with state and federal parity laws. Tragically, the New York State Attorney General’s Office reported that this settlement was the fifth settlement with health plans statewide for violations of mental health parity laws.⁵

Given this disturbing trend of parity violations, AACAP encourages CMS to urge state Managed Care Organizations (MCO) Administrators and Medical Directors to closely monitor mental health and substance abuse denial of service claims for patterns of mass denials.

Additionally, there is no clear comparative timeline for the issuance or explanation of these denials of service, and AACAP encourages CMS to adopt a timeline or standard for reasonable responses to denials and appeals. In this regard, CMS should turn to applicable standards found within the Patient Protection and Affordable Care Act.

² Wilk et al., “Access to Psychiatrists in the Public Sector and in Managed Health Plans.”

³ Medscape Physician Compensation Report (2014). Retrieved from <http://www.medscape.com/features/slideshow/compensation/2014/psychiatry#2>

⁴ *60 Minutes* (2014). Denied. Retrieved from <http://www.cbsnews.com/news/mental-illness-health-care-insurance-60-minutes/>

⁵ New York State Office of the Attorney General. (2015). A.G. Schneiderman Announces Settlement with Excellus Health Plan to End Wrongful Denial of Mental Health and Addiction [Press release]. Retrieved from <http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-excellus-health-plan-end-wrongful-denial-mental>

Conclusion

AACAP applauds CMS for the continued strong commitment to delivering the promise of mental health of parity to all. In particular, mental health care and services are essential to the good health of all children and adolescents. AACAP stands ready and willing to assist in efforts to improve access, treatment, and delivery of mental health care. Please direct any questions you may have to AACAP's Director of Government Affairs & Clinical Practice, Ronald Szabat, JD, LLM at 202-587-9666, or by e-mail at rszabat@aacap.org.

Sincerely,

A handwritten signature in black ink that reads "Paramjit Joshi". The signature is written in a cursive style with a horizontal line underneath the name.

Paramjit T. Joshi, MD
President, American Academy of Child & Adolescent Psychiatry