

# AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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May 28, 2009

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4137-NC  
P.O. Box 8017  
Baltimore, MD 21244-8010.

To Whom It May Concern:

On behalf of the American Academy of Child and Adolescent Psychiatry (AACAP), I am submitting comments to the Centers for Medicare and Medicaid Services (CMS) with regarding the public notice for comment [CMS-4140-NC] on implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

The AACAP is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 8,000 members strong, the AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP's members actively research, evaluate, diagnose, and treat psychiatric disorders and pride themselves on giving direction to and responding quickly to new developments in addressing the health care needs of children and their families.

Despite living in the wealthiest nation in the world, many of our children in need of help lack access to appropriate mental health care. While almost one in five children in the United States suffers from a diagnosable mental disorder, only 20 to 25 percent of these children receive treatment. This is a troubling fact considering treatment of many mental disorders has been deemed highly effective and, left untreated, mental illnesses are devastating to our nation's youth and their families. The MHPAEA was intended to ensure equitable access and coverage of mental health services for all Americans. With the appropriate regulations in place to implement the Act, treatment will be available for many children and adolescents who need it.

The Institute of Medicine in their 2009 report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, recommended the federal government make preventing

mental, emotional and behavioral disorders and promoting mental health in young people a national priority. While it is understood that insurers have a fiscal responsibility to manage care, a concern exists that in anticipation of facing higher expenditures for reimbursement, insurers and managed care organizations will look to limit other areas of care. Below are AACAP's responses and recommendations to your questions.

#### *Financial Requirements and Treatment Limitations in Health Plans*

AACAP is concerned about care being sacrificed in other areas, such as current medical benefits to meet the parity requirements yet not increase costs. Plans sometimes limit treatment options based solely on cost. These limitations are arbitrary and must be stopped. Evidence of efficacy, not fear of anticipated cost, should determine available treatment options. At the same time, if a level of care or prescribed treatment modality exists and is reimbursed for a physical illness, then the analogous level of care or treatment modality utilized for the treatment of mental illnesses must be provided as a covered benefit at the same level of reimbursement. In addition, some mental health carve-outs have limited networks and apply stricter limits on providing care, and these carve-outs should be required to adhere to any parity requirement to which the parent plan is mandated.

With regards to equal copayment for mental and physical health treatment, AACAP recommends closing any potential loop hole where mental health professionals are considered specialists in providing the same services as a primary care provider. For example, a copayment for medical management should be the same as it is for other medical management procedures done by a primary care physician.

#### *Additional Clarification of Provisions*

It is unclear whether or not there are separate out of pocket deductibles for medical and mental health. Separate but equal out of pocket maximums should be considered discriminatory toward persons with mental illnesses and prohibited.

#### *Medical Necessity Determinations*

AACAP recommends an external group or body to standardize the definition of medical necessity for MH/SA. At the least, health plans must follow professional organization guidelines. All medical necessity information should be published in such a way that it is available to providers or consumers and all appeals procedures should be clear. In medical necessity determinations, physician reviewers must be a licensed physician of the same specialty, working within the same state, and familiar with the resources available in the community. When the health plan is unable to secure access to the appropriate level of care, it must authorize either a higher level of care or services with an out of network provider. Network limitations, such as day treatment programs or residential treatment centers that are too far away from the parents home creates insurmountable barriers for the families.

#### *Reasons for Denial*

National accreditation organizations, such as URAC, provide a reasonable basis for the process of communicating reasons for denial. Despite these national standards, physician providers experience rigid and aggressive utilization review sometimes related to particular reviewers. This can selectively limit access to mental health and substance abuse services. Reviews must be

done by physicians subject to the oversight of state physician licensing agencies, physicians certified in the specialty area related to the treatment under review, and familiar with the service network in the patient's area. There needs to be prompt and accessible appeals that can be initiated by the provider of services as well as by the patient.

Often, after attempts to catch the treating physician, the reviewer declines the request due to lack of information. Reviewers must be required to make an appointment time (via phone) to discuss the review with the treating physician. In any instance where a denial is given, the name, discipline and phone number for the reviewer must be noted on the denial. Providing physicians subject to unprofessional treatment by physician reviewers should be able to report this behavior to state licensing agencies.

Some health plans use standards for utilization review that are established through broad professional input and make them easily available to providers and patients. This should be required of all health plans.

#### *Scope of Out of Network Coverage*

Historically, many insurance provider networks have insufficient numbers of child and adolescent psychiatrists, hence there is a de facto discrimination when plan networks are not maintained on the MH/SA side and provide "phantom networks" (names of providers not participating). Insurers must maintain and demonstrate adequacy of mental health panel networks on a quarterly basis. For panels that do not meet adequacy requirements based on size of covered population and utilization data, the health plan must identify appropriate providers and services as is currently done for medical panels. Panels must include an adequate number of providers that are trained and licensed to treat children and adolescents. Panels should also be mandated to include clinicians with appropriate cultural and linguistic ability based on the population served. Training and credentialing of mental health providers must be equivalent to that for medical providers. Specifically, self-report of specialization with mental health treatment or treatment of children is not sufficient.

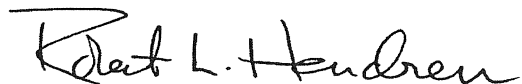
Inadequate networks leave plan participants without sufficient mental health treatment providers and the need to go out of network not by choice. There is also little public information as to when plan participants can seek out of network professionals as well as too much variability between plans regarding coverage and reimbursement when plan participants seek care outside of network. More information must be required to assist the plan participants.

#### *Cost Exemption*

As providers and advocates for consumers, we are concerned that the perceived increased cost would leave the plans to respond by limiting access to specific services, such as home-based wraparound services or residential treatment, or excluding vulnerable populations of children or adolescents by with specific mental health diagnoses (e.g., autism, Attention-Deficit/Hyperactivity Disorder). Practically, there are real concerns that these and other strategies will be used to limit costs despite the fact that adequate safeguards already exist within the new legislation to protect payers. Insurers should also be required to collect and publish annual data on expenditures for the implementation of mental health parity with data subdivided by level of care, facility type, service provided, diagnosis, and geographic area.

These recommendations are intended to preserve the spirit and intent of the new legislation with full consideration of the necessity to manage the costs of both medical and mental health care. Mental health is essential to the health and well being of *all* children and adolescents, and the integration of mental health and physical health services is vital to improve the lives of millions of Americans.

Sincerely,

A handwritten signature in black ink that reads "Robert L. Hendren". The signature is written in a cursive style with a prominent horizontal line above the first few letters.

Robert L. Hendren, D.O.  
President