American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

AAP Headquarters
345 Park Blvd
Itasca, IL 60143
Phone: 630/626-6000
Fax: 847/434-8000
www.aap.org

Reply to
AAP Washington Office
601 13th St NW, Suite 400N
Washington, DC 20005
Phone: 202/347-8600
E-mail: kids1st@aap.org

October 16, 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: RIN 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:

On behalf of the 67,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists of the American Academy of Pediatrics (AAP) who are committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults, we appreciate this opportunity to provide comments on the US Department of Health and Human Services, Employee Benefits Security Administration, and the Internal Revenue Service's (the Administration) proposed rule, *Requirements Related to the Mental Health Parity and Addiction Equity Act*.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (MHPAEA) prevents insurers from imposing more stringent benefit limitations on mental health and substance use disorder (MH/SUD) treatment compared to benefits for medical/surgical (M/S) care. Since its passage, there has been a persistent need to improve oversight and compliance with the requirements of MHPAEA. This rule is an important step in supporting MHPAEA's underlying goal to increase access to MH/SUD treatment and prevent insurers from imposing treatment limitations that overly burden young patients seeking MH/SUD care.

Mental health concerns are on the rise for youth across the nation. In October 2021, AAP, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a national emergency in child and adolescent mental health. Since then, important work has been done to address the mental and behavioral health needs of the nation's youth, but it is not enough. Suicide is the second leading cause of death for youth ages 10-18 in the

United States.[i] In 2021, 42% of high school students reported feeling persistently sad or hopeless, and 29% reported experiencing poor mental health.[ii] Additionally, 20.1% of youth ages 12 - 17 had a major depressive episode in the past year, compared to only 15.7% of youth in 2019.[iii] Now more than ever, families and children from infancy through adolescence need access to mental health screening, diagnostics, and a full array of evidence-based therapeutic services, including trauma-informed care, to appropriately address their mental and behavioral health needs. The US falls woefully short of meeting these needs.[iv] Nearly half of youth suffering with mental health disorders do not receive treatment from mental health professionals.[v] The proposed rule is essential to addressing this need by supporting access to pediatric mental and behavioral health care.

As the Administration considers policies and procedures to improve access to MH/SUD care under MHPAEA, we urge you to remember an essential core principle: **children are not little adults**; they require services and care specifically suited to their unique developmental needs. The system must be prepared to address their unique needs across the continuum of mental health care services. AAP strongly supports many provisions in the proposed rule, which requires private insurers to provide meaningful coverage for MH/SUD care across the scope of needed services, address nonquantitative treatment limits (NQTLs) that are disproportionately applied to MH/SUD benefits, examine their provider networks, and adjust provider reimbursements to align with M/S care.

Our comments below highlight our general support for key policy changes that are included in the proposed rule. We also provide recommendations for additional actions to strengthen the proposed rule for children.

Burdensome NQTLs

Often, insurers inconsistently apply NQTLs to MH/SUD benefits compared to M/S benefits. Burdensome NQTLs, such as prior authorization and stepwise therapy, can delay and prevent patients from receiving necessary care. The rule requires insurers to apply NQTLs in a manner that is no more restrictive than NQTLs applied to M/S benefits, and that insurers cannot rely on factors or evidentiary standards that are inherently discriminatory towards MH/SUD benefits when designing an NQTL. The Administration is correct to hold insurers accountable for disproportionately applying these onerous limits to MH/SUD care over M/S care.

Members of the AAP have reported significant barriers in patients' access to MH/SUD care due to insurers' treatment limits. Due to insurance delays and denials, children can miss out on scarce appointment slots and have to return to the patient queue to wait for the provider's next availability. This issue is exacerbated by same day billing restrictions that prevent patients from receiving both medical and MH/SUD care on the same day. Patients also face limits on how many appointments the insurer will cover with a mental health professional, regardless of the child's specific care needs. Additionally, stepwise therapy and prior authorization are overwhelmingly common NQTLs for MH/SUD medications, even when they are not common for comparable M/S treatment. This has been an increasingly prevalent concern for providers treating ADHD as there have been widespread stimulant shortages. Prescribing physicians sometimes need to prescribe an alternative stimulant to the original medication if the original is not in stock in any local pharmacies, and having to prove step therapy or wait for prior authorizations hinders access to effective ADHD therapy. Insurers must minimize the use of these NQTLs and be prepared to provide greater flexibility in the case of medication shortages.

NQTLs like primary authorization are not only common for MH/SUD medications, but also when treatment needs escalate. For example, one pediatrician works with a trauma clinic where the staff has substantial experience treating youth with current or recent suicidal ideation in an outpatient setting. One patient's suicidality and self-harm behaviors worsened, and the medical team was able to quickly determine she would be best supported by adding day treatment stabilization services to her ongoing outpatient therapy. While engaging in the prior authorization process with the patient's insurer, the therapist rearranged her schedule to

see the patient twice per week and provide additional support. However, before the medical team was able to get approval for day treatment, the patient's condition worsened and required hospitalization for a suicide attempt. By the time the patient was discharged from the hospital, the insurer had authorized the day treatment program, and the patient was able to complete a multi-week course without further incident. If the patient had been able to enter day treatment without the delay caused by the prior authorization process, their suicide attempt would have been much less likely and hospitalization avoided. Without stronger MHPAEA enforcement, the current system effectively punishes providers who care for high-risk patients in the least restrictive settings possible. When doctors identify patients that need a higher level of MH/SUD care, insurers must not present critical barriers to patients receiving that care. The updated standards for designing and applying NQTLs to MH/SUD benefits are a vital improvement to implement MHPAEA properly and ensure youth have access to MH/SUD care without unnecessary delays.

The proposed rule also states that if an insurer covers some types of MH/SUD care, such as for prescription drugs or in-network, outpatient care, then insurers must provide benefits for MH/SUD care in all care classifications. Most importantly, the Administration is requiring insurers to offer "meaningful" coverage for MH/SUD benefits in each of the classifications. By reducing the unnecessary barriers caused by restrictive NQTLs and requiring insurers to offer substantial coverage for MH/SUD benefits in parity with M/S benefits, the rule will functionally improve access to MH/SUD treatment.

NQTL Exceptions – Standards of Care and Fraud, Waste, and Abuse

We are concerned that the proposed exception for NQTLs that follow "independent medical or clinical standards (consistent with generally accepted standards of care)" will be mis- and over-used by insurers to avoid compliance with the spirit of the rule. We do believe that health plan medical decision-making should adhere to generally accepted MH/SUD standards of care as developed by the relevant non-profit clinical specialty associations, but the proposed exception would severely weaken the updated standards. While we acknowledge that the Administration intends to apply the exception narrowly, it is too broad and functionally unravels many of the protections intended in the rule.

This is especially important in pediatric mental health care, as many children have mental health symptoms that impair their functioning without meeting the criteria for a diagnosis, especially young children. For example, a child experiencing grief at the death of a close family member may struggle with their mental health and require treatment to help them to cope and to prevent a worsening mental condition over time, but not meet the criteria for a diagnosis. Insurers use situations like this, such as a lack of a formal diagnosis, to deny coverage for needed upstream care. This is a shortsighted approach with serious consequences; prevention and early intervention for mental health needs in youth can mitigate or preempt the development of more severe mental health conditions and help avoid the need for crisis care.

Additionally, while we support insurers' legitimate efforts to combat, prevent and detect fraud, waste, and abuse, it is not uncommon for health plans to use claims of "fraud, waste, and abuse" to deny or otherwise limit access to medically necessary care. Therefore, we do not support the Administration's attempts to create a "fraud, waste, and abuse" exception to the NQTL requirements, as there is a high risk of overuse or misuse by insurers, and that risk may be even higher within pediatrics where early intervention services are particularly critical. This proposed exception compromises the rule's otherwise strong NQTL requirements.

We urge the Administration to consider the unique needs of youth in implementing this rule, especially for prevention and early intervention, and to eliminate the proposed exceptions.

Prevention and Early Intervention

By some estimates, as many as 19% of children have mental health symptoms that impair their functioning without meeting criteria for a disorder.[vi] Lack of insurance payment for services for children and adolescents whose needs do not yet rise to the level of a diagnosis is a major barrier and contributes to the mental health crisis we are confronting. While some symptoms may ultimately become a diagnosable condition, the lack of insurance payment prevents support for those children and adolescents with emerging problems. In order to have true parity with M/S benefits, mental health screening, prevention, and early intervention must be accessible to youth in need which means they must be routinely paid for by insurers.

Insurers' overreliance on a diagnosis to cover MH/SUD care can be harmful for youth whose care needs are not identified as severe or acute, and it can also be harmful for youth who are in the process of receiving a diagnosis. Some insurers implement limits about which MH/SUD professionals can make diagnoses for which conditions and deny coverage until a specific clinician is engaged or specific evaluation is performed. This is notably common in diagnosing and treating autism spectrum disorder. While AAP appreciates that the Administration clarified that excluding applied behavioral analysis (ABA) for autism spectrum disorder would be considered a violation of the "meaningful benefits" requirement, that clarification is insufficient in addressing a prominent barrier to care. Several members of the AAP reported that insurers would not cover care for autism spectrum disorder unless the diagnosis was performed by a specific type of clinician, such as a developmental-behavioral pediatrician, and the clinician often must conduct an evaluation using a specific testing tool, which can vary across insurers. Most of these providers have long waiting lists, delaying a child's diagnosis and access to appropriate, needed treatment. Under the AAP's clinical practice guidelines, autism spectrum disorder diagnoses can be conducted by trained pediatricians and the diagnosis does not require specific testing.[vii] Insurers must provide coverage to patients as they seek diagnoses. However, this common barrier to autism spectrum disorder diagnosis and treatment is an acute example of how insurers may misuse the proposed exceptions.

Pediatricians are seeing dramatic increases in eating disorders, a very complicated condition that requires multi-disciplinary treatment. Eating disorder diagnoses have increased 25% overall for youth ages 12 to 15 since the onset of the pandemic.[viii] Adolescent medicine and child psychiatry clinicians are seeing many more cases of eating disorders that are more severe and are starting at even younger ages, even down to the age of 8 or 9. Because of the complexity of the treatment for eating disorders, it is extremely difficult to access fully comprehensive care for patients. Despite increasing prevalence rates, most pediatric and adult primary care physicians lack training in eating disorders, with only 20% of medical schools offering any elective trainings in the subject.[ix] There is a need for more services, and the training of more providers, to treat children and adolescents with eating disorders, as well as outpatient care services designed to meet the needs of this population. We urge the Administration to ensure that any barriers to needed services to treat eating disorders, including nutritional counseling as included in the proposed rule, are removed.

Inadequate Networks and Crisis Coverage

The proposed rule requires insurers to revamp their data analysis, particularly around network composition, adequacy, and access. The new standard requires insurers to determine if there is a material difference in access to MH/SUD benefits compared to M/S benefits and to take reasonable action to address discrepancies. This is an essential aspect of the rule and brings the focus of NQTL analyses back to the fundamental purpose of MHPAEA – addressing disparities in insurance coverage for MH/SUD care. At the same time, we are concerned that insurers will broadly interpret the "material difference" standard. Therefore, we ask the Administration to require reasonable action to be taken when the data indicates *any* differences in access.

As insurers conduct data analysis under the new standards, it is important that they evaluate services for children and youth independently from services for adults, rather than conducting aggregate analysis without

this distinction. Many networks, especially for children's MH/SUD services, are insufficient and insurer-maintained directories are often out-of-date or incomplete. This places the burden on patients and families to find a MH/SUD provider that is taking patients, accepts their insurance, and meets their needs.

Certain plans may consider access to adult specialty or subspecialty care as meeting a network adequacy standard, when in fact adult care may not be appropriate for children. Research continues to demonstrate the positive outcomes and quality impacts of care provided by pediatric medical subspecialists and surgical specialists, versus adult specialists and subspecialists for the pediatric population.[x] An adult specialist who agrees to see pediatric patients is not the same as a pediatric specialist, and insurers should take this into account as they analyze and improve their networks in compliance with the proposed rule.

The lack of adequate network coverage combined with coverage delays due to onerous NQTLs often leads to children's care needs escalating. One provider reported referring a child to Cognitive Behavioral Therapy and social skills training at age 5 or 6 due to anxiety, ADHD, and delayed social skills. The patient's family spent many hours with their insurance company trying to find an in-network therapist, then asking for single case agreements- every request was effectively denied. By age 7, the patient was expressing suicidality, and even then, the insurance company could not come up with a single provider that saw children and adolescents who could provide therapy for this child. Eventually, the family found a local therapist with availability, but the insurer refused to provide a single case agreement. Approximately 6 months after the patient's suicidality came to light, the child secured care with an in-network therapist who practiced over 100 miles away, and the family spent hours driving the patient to weekly appointments. The patient's mother had to apply for family leave benefits to take temporary leave from work to drive her child to these appointments. This case example is one of many for why MHPAEA must be strengthened and enforced.

Other pediatricians have echoed the lack of mid-tier MH/SUD treatment options, such as intensive outpatient mental health services for youth who are at risk for harming themselves or others but not acute enough for hospitalization. Inadequate provider networks across the continuum of MH/SUD care ultimately contribute to greater numbers of children not receiving the care they need in a timely manner and while their conditions are more easily managed through outpatient care. Too often, these children and adolescents go to emergency departments in a state of crisis and end up boarding in hospitals – waiting for appropriate treatment to become available. There are significant gaps in coverage for pediatric mental health crisis care and inpatient services, especially for patients with complex medical needs, such as children with intellectual disabilities or G-tubes.

There are also critical gaps in pediatric SUD treatment. Most states do not have withdrawal management services for adolescents that are considered in network.[xi] Some plans require adolescents to go to out of state facilities if they require these withdrawal management services, however this is not tenable for families due to cost, childcare needs, and parent employment. Many in-state withdrawal management facilities do not allow people under the age of 18 to be admitted. Youth who are admitted for treatment may be prematurely discharged as insurers refuse to provide payment. These widespread gaps in network coverage for MH/SUD care at all levels would be unacceptable for M/S care and need to be addressed to reach true parity.

The reviews of provider networks should include an assessment of wait times (including relative wait times between referrals and appointments), ratios of contracted providers to enrollees in different regions, and other metrics in addition to time and distance to assess network composition. They should also examine limitations or exclusions on facility types, such as residential treatment programs, etc. and assessments of claims processing policies and payment rates. Payment delays due to overly burdensome utilization reviews and slow and complicated claims processing, combined with historically low payment rates, are contributing factors to pediatric mental health providers not participating in private plans' provider networks.

The problem of children going without needed mental health services, and facing delays when they do seek out care, is inextricably linked to shortages in pediatric mental and behavioral professionals across disciplines resulting from insufficient payment by insurers for mental health care. Insurers can, and must, quickly take action to fill network gaps by improving payment rates for providers who offer these essential services. Historic under-payment for mental health care has discouraged many providers from accepting health insurance thereby exacerbating the access challenges faced by countless children and families.

Multifaceted solutions to bolster the pediatric mental health care workforce, including expanding training opportunities and other innovative solutions, are needed. Additionally, while telehealth is not a cure-all solution to inadequate networks, it is a useful tool for providers to offer care in many situations and can expand access to mental health care in rural and underserved areas. Care delivered via telehealth should similarly be covered by insurers and paid for at parity with in-person visits.

We also recommend that the insurers be required to collect data on scope of services and take action to address access disparities that may be the result of scope of service limitations. That data should take into account the full range of mental health services that children and youth need, including prevention, screening, early intervention, the full range of outpatient and inpatient treatment modalities, as well as crisis response and stabilization services. In addition, insurers should conduct specific data collection and analyses related to the use and application of clinical guidelines and be required to make available any criteria/guidelines they use to federal and state regulators and enrollees.

Federal policymakers have dedicated enormous effort to standing up the 988 Suicide and Crisis Lifeline and expanding MH/SUD crisis services, which help people get the help they need and avoid needless, and often tragic, encounters with law enforcement. While every benchmark plan includes EMS and emergency transport services, very few include mental health crisis (i.e., emergency) response or crisis stabilization services. This failure to include MH/SUD crisis services under EHB means that many individuals do not have appropriate coverage of these services. A number of states, including California, Virginia, and Washington, have recently required health plans to cover MH/SUD crisis services. Washington has made clear that coverage of MH/SUD crisis services is necessary for health plans to comply with MHPAEA. HHS should include MH/SUD crisis services within the MH/SUD EHB category. Additionally, when finalizing this rule, we encourage the Administration to make clear that, if a plan/issuer covers physical health emergency services (including EMS and emergency transport), it must cover comparable MH/SUD emergency/crisis services (including mobile crisis response) under the same standards (e.g., no prior authorization).

Medicaid and CHIP

We also urge the Administration to act swiftly to take steps to improve parity oversight and compliance in Medicaid and CHIP and appreciate the Administration's action in releasing the request for information on how to best assess Medicaid and CHIP's compliance with MHPAEA.[xii] We ask that the Administration move efficiently in implementing changes according to the feedback received. Medicaid is the single largest payer of behavioral health services in the US and alongside CHIP covers more than 40 million children.[xiii] Yet, in 2018, only about half of non-institutionalized youth enrolled in Medicaid or CHIP who experienced a major depressive episode received mental health treatment.[xiv] In addition, according to the Medicaid and CHIP Payment and Access Commission, the MHPAEA does not appear to have increased access to behavioral health services for individuals with Medicaid and CHIP and this may in part be due to how parity compliance is assessed and documented according to a 2021 brief.[xv] Accordingly, it is important for the Administration to take swift and meaningful action to address MH/SUD treatment parity in Medicaid and CHIP in addition to its efforts to address parity under private insurance.

We urge CMS to align parity enforcement requirements for commercial payers with those for Medicaid and CHIP to the extent possible. That alignment is particularly important given the ongoing "unwinding" of the COVID-19 Public Health Emergency's Medicaid continuous enrollment protections and the potential "churn" between Medicaid and private coverage.

We also remind CMS that access to medically necessary MH/SUD services is guaranteed under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. However, there have been, and continue to be, challenges in implementation and inconsistent application across states leading to gaps in access to needed MH/SUD services. Additional oversight by CMS and requiring states to assess their behavioral health continuum of care can help ensure that the EPSDT benefit meets its promise.

Other Issues

We strongly urge the Administration to place an affirmative obligation on insurers, as part of any corrective action plan in the case of identified noncompliance, to identify affected participants and beneficiaries, reprocess any claims, and notify those who they determine have been impacted by the non-compliant NQTL.

We support the language implementing the elimination of self-funded non-federal government plans' ability to opt out of MHPAEA. Hundreds of thousands of public employees and their family members have for too long been denied critical MHPAEA protections as their public-sector employer affirmatively opted-in to discriminating against individuals needing MH/SUD services.

The Administration must also consider the effects that limitations on cross-state care have on access to MH/SUD treatment. Telehealth has the potential to improve access to quality MH/SUD care for youth across state lines, but providers and insurers also need clarity and guidance on best practices.

AAP is grateful for the opportunity to comment on the proposed rule. Please do not hesitate to contact Tamar Magarik Haro in AAP's Washington office at 202-347-8600 or tharo@aap.org should you have any questions or if you would like to further discuss AAP's recommendations for the forthcoming rule. We look forward to working with you to continue to improve children's access to MH/SUD care.

Sincerely,

Sandy L. Chung, MD, FAAP
President

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