American Association of Child & Adolescent Psychiatry

August 1, 2024

The Honorable Diana DeGette
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Larry Bucshon, MD
U.S. House of Representatives
Washington, D.C. 20515

Dear Congresswoman DeGette and Congressman Bucshon:

On behalf of the American Association of Child and Adolescent Psychiatry (AACAP) and the over 11,000 child and adolescent psychiatrists, fellows, residents, and medical students that we represent, I am writing in response to your request for information (RFI) on the policies included in the Cures 2.0 Act (Cures 2.0), particularly to share the perspectives of child and adolescent psychiatrists. AACAP applauds the progress that has been made since the 21st Century Cures Act (Cures) and is grateful for your continued work to improve access to substance use disorder and mental health care in the United States.

Among the many contributions of the 21st Century Cures Act, its contributions to the fields of mental health and behavioral health prevention, treatment and recovery were profound. In fact, an entire division of the bill is devoted to addressing our nation's mental health crisis. In keeping with the spirit of Cures in this regard and in acknowledging that our nation's mental health crisis persists, AACAP respectfully requests that Cures 2.0 similarly develop a title focused on mental and behavioral health. Cures authorized grants and programs that laid the groundwork for 9-8-8, mental health access in school settings, increased integration of behavioral health in primary care settings, and support for early intervention and treatment of youth with substance use disorders.

AACAP encourages Congress to build on these accomplishments and invest in programs that were not considered in Cures including grants to promote prevention of pediatric mental illness through behavioral health well child visits and funding to support mental health care in foster care and juvenile correction systems, to name a few. Additionally, AACAP asks that Cures 2.0 address the critical shortage of pediatric behavioral health providers, including child psychiatrists, especially in rural and underserved areas. The workforce shortage fuels the current mental health crisis. To that end, AACAP offers comments on a few additional policies that could strengthen the impact of Cures 2.0.

<u>Supporting state innovation to respond to pediatric mental health crisis</u>

Cures established a grant program available to states to combat the opioid crisis. These "opioid state targeted response grants" allowed states to innovate on how to address the opioid crisis locally. Multiple states, for example, funded hospitals to build "bridge programs" that bridge opioid overdose patients to outpatient care. AACAP encourages Congress to consider a similar

program within Cures 2.0 that would allow states to innovate on how to address the pediatric mental health crisis locally.

Funding for child behavioral health services

The current pediatric behavioral healthcare infrastructure cannot sufficiently meet the demand for behavioral healthcare, across all service intensity levels. Most communities have significant gaps in the mental health care service array. These gaps in intermediate levels of care, for example, can force patients and families into services that don't match their needs. Given the persistent child mental health crisis, funding to bolster the delivery of pediatric behavioral healthcare is desperately needed. H.R. 2412, the Helping Kids Cope Act, a bipartisan bill, would integrate pediatric behavioral health care across a wide range of child-facing systems of care, bolster the pediatric mental health workforce and invest in community mental health infrastructure.

Protecting access to telehealth services

Telepsychiatry has been used with patients across diverse groups and in multiple settings including primary care, schools, correctional settings, and the home. An evolving evidence base has established that telepsychiatry is feasible, practical, and as effective as care delivered in person. It may be superior to mental healthcare provided in the primary care setting for selected populations such as children with attention-deficit hyperactivity disorder or for children with developmental disabilities who do not tolerate the clinic setting well.[1]

During the COVID pandemic, the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) allowed DEA-registered prescribers to prescribe a controlled substance without an in-person exam if the prescriber conducted a telehealth communication via audio-visual, real-time, two-way communication. This has been enormously beneficial for access to child psychiatric services considering the disproportionate supply of child psychiatrists as compared to the population of children needing mental health care. As such, the DEA and SAMHSA have temporarily extended this prescription flexibility through December 31, 2024. We urge that the flexibility to prescribe medications that support substance use disorder and mental health treatment, including stimulant medications, via telehealth without an in-person exam be extended permanently**.**

During the COVID pandemic, HHS also waived a Medicare policy that requires an in person visit prior to and regularly after a telemental health visit. As mentioned above, telepsychiatry has proven to be an efficacious means of mental health care delivery and extends the child and adolescent psychiatry workforce. H.R. 3432, the Telemental Health Care Access Act, a

[1] American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Telepsychiatry and AACAP Committee on Quality Issues. Clinical Update: Telepsychiatry With Children and Adolescents. J Am Acad Child Adolesc Psychiatry. 2017 Oct;56(10):875-893. doi: 10.1016/j.jaac.2017.07.008. Epub 2017 Jul 25. PMID: 28942810.

bicameral bill, would eliminate these in-person requirements and further supports access to child psychiatric services for our most at-risk youth.

Supporting patient access through parity reforms

The discriminatory lack of coverage for behavioral health services by commercial insurers compounds insufficient access to the full array of services. A landmark study from the Research Triangle Institute analyzing 2019-2021 commercial insurance claims data found that, despite legislation prohibiting disparities in coverage between behavioral healthcare coverage and medical or surgical coverage, such coverage disparities are persistent. This means that either patients go without care or that families of children requiring behavioral health care experience considerable financial burden. According to the study, in-network reimbursement levels of office visits were much lower for behavioral health providers as compared to medical/surgical providers. Out-of-network use of behavioral healthcare is many times greater than that of medical/surgical treatment. For example, patients went out-of-network 8.9 times more often for psychiatrist office visits than for visits to medical or surgical specialist physicians. While child psychiatry provider shortages contribute to these disparities, they have been found not to be sufficiently explanatory of such coverage disparities and out-of-network utilization.[2] The demonstrated history of reimbursement disparities for behavioral health visits cyclically worsens behavioral healthcare access, quality, and availability. AACAP urges that Cures 2.0 include policies that would ensure full parity across public and private payers and support behavioral health integration in primary care by increasing reimbursement rates for behavioral health care in Medicaid and Medicare.

Prior authorization burden reduction

Prior authorization, or the requirement that approval be sought from a health plan prior to coverage of a service or prescription, is a time-intensive and costly burden on physicians, including child and adolescent psychiatrists, that leads to delays or denials of vital services for children. A 2017 American Medical Association (AMA) survey found that the average physician spends 14.6 hours per week processing prior authorizations and that many practices have found it necessary to allocate crucial funds to employ an individual whose sole responsibility is managing prior authorizations. According to the AMA survey, 78% of physicians reported that patients abandon treatments when waiting for prior authorizations to be completed.[3] Administrative burdens should not exist between children and the care they desperately need and deserve.

The bipartisan, bicameral bill, H.R. 8702, Improving Seniors' Timely Access to Care Act, would streamline and standardize prior authorization in Medicare Advantage plans by establishing an electronic prior authorization process and a process for "real-time decisions" for routinely approved items and services, by improving transparency of the use of prior authorization

[2] Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International.

[3] 2017 AMA Prior Authorization Physician Survey. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf

process, and by encouraging the use of evidence-based medical guidelines in this process in consultation with physicians. These policies, should they be adopted in Medicaid and commercial insurance plans, would significantly improve timely access to pediatric behavioral health care.

AACAP is grateful for the opportunity to share recommendations that support fully realizing the goals of 21st Century Cures Act and Cures 2.0. Should you have questions, please contact Alexis Geier Horan, Chief of Advocacy and Practice Transformation, at ahoran@aacap.org.

Sincerely,

Tami D. Benton, MD
President