July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244

Attention: CMS 2439-P

Re: Medicaid and Children’s Health Insurance Program Managed Care Access, Finance and Quality - Submitted Electronically

Dear Administrator Brooks-LaSure:

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to support the Centers for Medicare and Medicaid Services’ (CMS) proposed improvements to the Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance and Quality Notice of Proposed Rulemaking. AACAP is the professional home to more than 10,000 child and adolescent psychiatrists, fellows, residents, and medical students with a mission to promote the healthy development of children, adolescents and families through advocacy, education, and research. On behalf of the physicians we represent, and the children and youth they serve, we commend the agency for its focus on improving access to services in these critical federal health care programs which we believe, over time, will help ease the ongoing children’s mental health crisis and help ensure mental health parity. We also appreciate the recognition of the equity issues inherent in improving access to needed health care services, given that Medicaid and CHIP are the primary sources of health care coverage for racially and ethnically diverse populations.
Appointment Wait Time Standards/Network Adequacy

AACAP is pleased to see that the agency is focusing on improved access through appointment wait time standards in four key areas: primary care, obstetrics/gynecology (OB/GYN), behavioral health, and one area to be chosen by each state’s Medicaid Managed Care Organizations (MCO) that is tailored to its population, and agree with the maximum wait times proposed for routine appointments (10 business days for routine mental health and substance use appointments and 15 days for routine primary and OB/GYN care). We appreciate that the proposals also differentiate between adult medicine and pediatrics with respect to wait times, providing states with the ability to modify wait times to meet the specific needs of their Medicaid population, if they do not exceed the maximum wait times proposed. AACAP recommends that Medicaid MCOs ensure that these wait time standards apply equally to specialty mental health providers such as child and adolescent psychiatrists, neurodevelopmental specialists, and developmental pediatric specialists. In addition, evidence-based collaborative care models, with physician-led teams, would help ensure that high-quality mental health care is not sacrificed to help meet the new wait time standards. AACAP is also aware that Medicaid MCOs often provide triage-type appointments for mental health conditions. We would urge safeguards against counting these appointments as treatment in order to meet the new wait time standards.

To make the proposed wait times a reality, AACAP sincerely appreciates the focus on ensuring an adequate supply and variety of health care providers. As the agency has heard clearly from stakeholders previously, this is a complex issue related to adequate payment rates and available workforce. While workforce issues for pediatric specialties, including child and adolescent psychiatrists, cannot be addressed overnight, AACAP appreciates the recognition of the relationship that exists between payment rates in Medicaid MCOs and the supply of healthcare providers. AACAP applauds the proposed new payment transparency requirements for states that should provide greater insight into how Medicaid payment levels affect access to care. Longstanding issues related to inadequate payments in Medicaid plans can severely limit the number of available healthcare providers in any given network. Strengthening and holding plans accountable for the new wait time standards, coupled with payment transparency requirements, will encourage states and plans to invest in strengthening access to care in Medicaid and CHIP.

For children especially, access to screenings for developmental delays or emerging mental health issues is critical, as availability of pediatric provider types to address them. Early identification and treatment of these issues can positively change the trajectory of a child’s life. We also support the broad flexibility the agency provides states to deliver some of this care via telehealth across all populations served, and the option for states to develop quantitative
network adequacy standards and specific wait time standards for telehealth services, in addition to quantitative network adequacy standards, in addition to appropriate appointment wait times, for mental health and substance use disorder treatment in-person appointments.

AACAP also supports the proposed use of “secret shopper” surveys and patient experience-of-care surveys in Medicaid and CHIP plans as additional data sources to monitor plan performance, in addition to making this information publicly available.

Terminology

AACAP supports changing the term “behavioral health” throughout 42 CFR part 438 to “mental health and substance use disorder.” We agree with CMS that this terminology is much more precise and unambiguous. We request that CMS work with its counterparts across the Department of Health and Human Services (HHS) to ensure that the revised definition is reflected across all HHS programs.

Payment Transparency

Medicaid’s equal access provision requires that state Medicaid provider payments be “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” However, Medicaid fee schedules and capitated payments to both primary care and subspecialty clinicians are substantially lower than payments for the same services from Medicare and private insurance plans. Low Medicaid payment rates, and confusing or burdensome payment policies and administrative requirements contribute to limited provider participation in Medicaid plans, undermining the most well-intended access to care policies.

The proposed rule would require states to submit an annual payment analysis that compares Medicaid MCO’s payment rates for certain services as a proportion of Medicare’s payment rate. AACAP feels this is an essential step to provide stakeholders with more information related to payments, in addition to providing a basis for flagging inadequate payments that may prevent beneficiary access to care. However, CMS should require any state below a 100% Medicaid-to-Medicare fee ratio for pediatric behavioral health and primary care services to demonstrate on an annual basis that they are fully meeting the equal access provision for children enrolled in Medicaid. This requirement should apply to both MCO and fee-for-service plans.
In closing, AACAP is grateful for the agency’s focus on improving access to care for Medicaid and CHIP beneficiaries in addition to addressing systemic disparities in the nation’s health care delivery system. Should you have questions for AACAP, please contact Karen Ferguson at kferguson@aacap.org.

Sincerely,

[Signature]

Warren Y.K. Ng, MD, MPH
President