

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

W W W . A A C A P . O R G

Council

President
Warren Y.K. Ng, MD, MPH

President-Elect
Tami D. Benton, MD

Secretary
Debra E. Koss, MD

Treasurer
Neal D. Ryan, MD

Chair, Assembly
of Regional Organizations
of Child and Adolescent Psychiatry
Marian A. Swope, MD

Past President
Gabrielle A. Carlson, MD

Shirley Alleyne, MB,BS
Alicia A. Barnes, DO, MPH
Matthew G. Biel, MD, MSc
Jennifer L. Derenne, MD
Lisa R. Fortuna, MD, MPH
Lisa Hutchison, MD
Adam J. Sagot, DO
Shawn Singh Sidhu, MD
Jose Vito, MD
Sala Webb, MD

Jerry M. Wiener
Resident Member
Evelyn N. Ashiofu, MD, MPH

John E. Schowalter
Resident Member
Jessica Stephens, DO

DEI Emerging Leaders Fellow
Tashalee R. Brown, MD, PhD

Executive Director/CEO
Heidi B. Fordi, CAE

JAACAP Editor-in-Chief
Douglas K. Novins, MD

AACAP News Editor
Uma Rao, MD

May 2, 2023

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

Re: CMS-0057-P: Medicare and Medicaid Programs, Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicals, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program

Dear Administrator Brooks-LaSure:

I write today on behalf of the American Academy of Child and Adolescent Psychiatry (AACAP), the professional home to more than 10,000 child and adolescent psychiatrists, child and adolescent psychiatry fellows, residents, and medical students. Our mission includes promoting the healthy development of children, adolescents, and families. AACAP worked closely with the American Medical Association to help develop its *Prior Authorization and Utilization Management Reform Principlesⁱ* and we believe that these principles remain relevant. We commend the agency's focus on improving prior authorization (PA) processes across federal health programs, shortening prior authorization decision timeframes, enhancing communication about PA decisions with patients and payers, and recognizing the need to improve health equity through appropriate technologies, in addition to recognizing the ways that prior authorization requirements contribute to physician burnout. We also appreciate consideration of our comments outside of the rulemaking process for this proposed rule.

Requirements for PA Decision Timeframes

AACAP has long been concerned about PA requirements imposed by payers, especially with respect to inpatient or residential mental health treatment of children and adolescents and prescription medications. We believe that the exclusion of drugs covered under a medical benefit from the electronic PA technology improvements proposed in this rule is a serious gap that should be addressed in future rulemaking, since disrupting access to long-standing medication regimens, due to insurance coverage policy changes or burdensome PA requirements, can have disastrous effects on patients. These effects are felt even more deeply by children and adolescents in foster care, and other vulnerable populations.

We appreciate CMS' recognition that PA decision timeframes should be standardized and reduced. The current proposals suggest that payers make PA decisions within 7 days for non-urgent medical treatment, and within 72 hours for urgent PA decision requests. However, a child or adolescent presenting with a psychiatric crisis needs immediate evaluation and treatment. If the evaluation indicates that a medically necessary treatment in an intensive outpatient program, an inpatient setting, or residential treatment facility is needed, the proposed 72-hour PA decision timeframe would be excessive. AACAP suggests a carve-out across all federal health plans for patients with psychiatric emergencies. For other urgent situations, we suggest the timeframe be shortened to 24 hours, though AMA survey data suggest that there are situations where this would be too longⁱⁱ and delays and denials have caused unnecessary patient harm and even deathⁱⁱⁱ. For standard, non-urgent care, 48 hours should be the maximum amount of time for payers to make their PA decisions. AACAP also suggests that PA decisions be accessible 24/7. Psychiatric crises and medical emergencies do not always happen during business hours. Physicians and other clinicians work seven days a week, around the clock, every day of the year. The ability to have rapid PA decisions should align with the realities of the practice of medicine.

Reason for Denial

CMS proposes to improve communication between payers and physicians about PA decisions and AACAP applauds the requirement for transparency about denial decisions. If a denial decision is made, that decision should be based on affirmative evidence of ineffectiveness and the reason provided promptly to the physician. To further enhance the communication about denials, CMS could go further and align with the *AMA Prior Authorization and Utilization Management Reform Principles*^{iv} item #11 which states:

Utilization review entities should provide detailed explanations for prior authorization or step therapy override denials, including an indication of any missing information. All utilization review denials should include the clinical rationale for the adverse determination (e.g., national medical specialty society guidelines, peer-reviewed clinical literature, etc.), provide the plan's covered alternative treatment and detail the provider's appeal rights.

With respect to children and adolescents, service intensity instruments such as the Child and Adolescent Service Intensity Instrument^v and the Early Childhood Service Intensity Instrument^{vi}, standardized assessment tools that provide determinations of the appropriate level of service intensity needed by a particular child or adolescent and his or her family, could assist payers in the process of determining service intensity need. These tools assess the service intensity needs of children and adolescents presenting with psychiatric, substance use, medical and/or developmental concerns. They incorporate holistic information on the child within the context of his/her family and community by assessing the service intensity needed and would therefore support payers in making appropriate coverage determinations relating to mental health and substance use services.

AACAP also agrees with proposals that would require payers to communicate PA decisions directly with patients through application programming interface technologies of their choice.

Health Equity

AACAP supports the focus on health equity throughout the proposed rule. Pursuant to the *Advancing Racial Equity and Support for Underserved Communities* Executive Order issued by the Administration in January of 2021, we appreciate CMS' commitment to pursuing a comprehensive approach to advancing health equity by mitigating existing inefficiencies in policy and technology that can have a negative impact on underserved patients. Disparities in treatment for mental health conditions are even more pronounced. It is only through sustained attention and effort that health inequities can be addressed, and we appreciate the strong focus on equity and proposed improvements.

Behavioral Health RFI

AACAP appreciates the questions posed by CMS on improving the delivery of behavioral health, and strongly encourages the use of digital tools to improve communication between behavioral health practitioners and other healthcare and educational systems that support the healthy emotional development of children. However, Medicare-focused incentives do not impact pediatricians and child and adolescent psychiatrists, and many behavioral health clinicians have been excluded from programs that provide federal monetary incentives to adopt EHRs. Resources directed specifically at pediatricians and pediatric behavioral health providers could help level the playing field. AACAP has member experts who would welcome the opportunity to partner with CMS to develop both short-term and longer-term strategies to support these developments and to collaborate on solutions.

CMS asks if applications using Fast Healthcare Interoperability Resources (FHIR) APIs could facilitate data exchange between behavioral health providers and their patients without greater electronic health record (EHR) adoption. Currently Health Information Exchanges and EHRs have different definitions and require alignment. FHIR resources for pediatric behavioral health would need to be developed for this to facilitate the needed data exchange.

CMS also asks how existing criteria under the Office of the National Coordinator for Health Information Technology (ONC) ensure applications used by behavioral health providers enable interoperability, and what updates to existing criteria, or new criteria, could better support exchange by behavioral health clinicians. First, AACAP notes that the United States Core Data for Interoperability (USCDI)^{vii} standards do not have fields that directly address behavioral health issues. Discrete behavioral health elements should and could be captured in a number of ways, including the addition of a “previous treatment in a medical system” field. There is often a breakdown in follow-up care after a crisis behavioral health assessment. A field called “date of last contact with crisis mental health services” would alleviate this current gap.

Electronic prescribing systems are more broadly utilized than more comprehensive EHRs. Enhancing capabilities with respect to sharing prescription registries with their associated diagnosis, along with brief comments by prescribers, could be a short-term bridge to enhanced collaboration and communication, and would be a way to include pharmacists as members of a more comprehensive treatment team. This could be especially significant in rural areas to provide health education and support.

Thank you for your consideration of our comments, and please reach out if you would be interested in partnering with AACAP to help develop both short and longer-term strategies to encourage greater adoption of EHRs in children’s mental health. Should you wish to reach out or have questions, please contact Karen Ferguson at kferguson@aacap.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Warren Y.K. Ng', with a stylized flourish at the end.

Warren Y.K. Ng, MD, MPH
President

ⁱ [Prior Authorization and Utilization | AMA \(ama-assn.org\)](#)

ⁱⁱ [Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" \(OEI-09-18-00260\) \(hhs.gov\)](#)

ⁱⁱⁱ [8 prior authorization terms that drive every doctor crazy | American Medical Association \(ama-assn.org\)](#)

^{iv} [Prior Authorization and Utilization | AMA \(ama-assn.org\)](#)

^v [CASII \(aacap.org\)](#)

^{vi} [ECSII \(aacap.org\)](#)

^{vii} [United States Core Data for Interoperability \(USCDI\) | Interoperability Standards Advisory \(ISA\) \(healthit.gov\)](#)