AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

July 27, 2015

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2390-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Child and Adolescent Psychiatry (AACAP), please accept our comments to the Centers for Medicare and Medicaid Services (CMS) pursuant to the public notice for comment [CMS-2390-P] on the proposed rule "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability" (hereafter referred to as the MCO Proposed Rule).

AACAP is a nearly 9,000 member-strong, professional medical organization comprised of child and adolescent psychiatrists. These uniquely trained physicians promote healthy human development by their evaluation, diagnosis, and treatment of children, adolescents and their families who are affected by disorders of feeling, thinking, learning, and behavior.

AACAP wishes to offer its appreciation to CMS for this comprehensive MCO Proposed Rule. Given the sweeping breadth of the proposed changes, AACAP has chosen to focus on five key issues related to child and adolescent mental health, with a specific focus on network adequacy and workforce-related items.

Pediatric Populations Differ from the General Population

The MCO Proposed Rule specifically "request[ed] comment on whether standards for behavioral health providers should distinguish between adult and pediatric providers." Additionally, it stated that "Network adequacy is often assessed without regard to practice age limitations which can mask critical shortages and increase the need for out-of-network authorizations and coordination."

AACAP agrees and states it is imperative that any new standards include distinguishing characteristics for adult and pediatric providers due to differing standards of care, provider training, access-related issues, and population dynamics. Additionally, any development of pediatric-specific network adequacy standards and benchmarks should bear in mind the three "A"s of delivering high quality mental health care—ensuring adequacy, accuracy, and accessibility.

The revision of the medically necessary services criteria to comply with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for those under age 21 in the rule also highlights the need to distinguish between the adult and pediatric populations. The pediatric population requires care tailored to its needs and the unique distinction from the adult population, which would assist in supporting such a change in diagnosis and provision of care.

Recognizing the need to differentiate this population for the purposes of standards development is easily determined by the high incidence rate, onset of lifetime symptoms, and ability to treat and/or mitigate some disorders. Namely, one in five American children currently live with a mental health disorder[1] and 50 percent of all lifetime cases begin by the age of 14 and 75 percent by the age of 24.[2] Tragically, the existing mental health medical structures have largely failed America's youth due to a lack of access—total number and accessibility of providers, early assessment, and treatment. Up to 80 percent of those with symptoms indicating mental health treatment needs did not receive any mental health services in the past year.[3] Emerging neuroscience indicates that the early identification and treatment of some mental health disorders can help patients overcome or mitigate the harmful effects of these illnesses.[4]

The failure to deliver mental health treatment to youth contributes to higher overall societal costs by way of an increase of incarcerated youth, decreased productivity, school absenteeism, and higher overall health costs in the future as an adult.[5] In fact, even among incarcerated youth, studies indicate that when youth received mental health treatment, recidivism rates were up to 25 percent lower than their peers who did not receive treatment.[6]

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[1] Merikangas, K.R., He, J.P., Burstein, M., Swanson, S.A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication—Adolescent Supplement (NCS-A). J Am Academy Child Adolescent Psychiatry 49(10):980-9

[2] National Institutes of Health (US); Biological Sciences Curriculum Study. Bethesda (MD): National Institutes of Health (US); 2007.

[3] Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. Children: Variation by ethnicity and insurance status. American Journal of Psychiatry, 159(9), 1548-1555.

[4] Bertelsen M, Jeppesen P, Petersen L, et al. Five-Year Follow-up of a Randomized Multicenter Trial of Intensive Early Intervention vs Standard Treatment for Patients With a First Episode of Psychotic Illness: The OPUS Trial. *Arch Gen Psychiatry.* 2008;65(7):762-771. doi:10.1001/archpsyc.65.7.762.

[5] National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention and Deployment (2001). Blueprint for Change: Research on Child and Adolescent Mental Health. Rockville, MD: National Institute of Mental Health.

[6] I Gendreau, P., & Goggin, C. (1996). Principles of effective correctional programming. Forum on Correctional Research, 3, 1-6.

Ensuring Uniform Network Adequacy Standards

AACAP applauds CMS for seeking feedback on the inclusion of network adequacy standards in the MCO Proposed Rule. The adoption, publication, and enforcement of reasonable network adequacy standards are an important benchmark toward improving access to mental health care, particularly for pediatric populations.

In discussing this issue, CMS explains the use of the standards as follows [emphasis added]: "Appreciating that provider networks can vary between geographic areas of a state and states have different geographic areas covered under managed care contracts, as proposed in paragraph (b)(3), states would have to establish time and distance standards for specific provider types that reflect the geographic scope of the program. **Our proposal would permit states to vary those standards in different geographic areas** to account for the number of providers practicing in a particular area. Our proposal would not limit states to only the mandatory time and distance standards but also would have **states consider additional elements** when developing network adequacy standards."

We contend that, particularly with pediatric populations, CMS should require the adoption of additional standards rather than suggesting states consider the adoption of these standards. If CMS maintains the standards-setting adoption is the purview of the states, then we strongly encourage CMS' suggestion of transparency metrics associated with such standards, as noted by CMS in the MCO proposed rule: "…states would have to publish the network adequacy standards developed in accordance with §438.68 on the Medicaid managed care Web site under n §438.10."

Additionally, AACAP concurs with CMS that if states are the primary architects of network adequacy standards, then compliance should mirror commercial standards, if and where they exist and be inclusive of historical patterns of Medicaid utilization. In addition to these recommendations, prospective data trends regarding utilization should be used as well, because historical Medicaid utilization rates may not necessarily be reflective of future use.

More specifically, despite our collective best efforts, a sizable portion of the population still lacks adequate screening and treatment for mental health, substance abuse, and behavioral disorders. Additionally, as CMS notes elsewhere in the MCO proposed rule, in some cases pediatric populations have not been considered as a separate population.

Developing Effectual Network Adequacy Standards will Require Additional Elements Beyond Population, Time, and Location

AACAP fears that simply establishing a standard of travel time, distance, and provider type will not prohibit a plan from simply listing a provider with a nearly-full or full practice, thereby denying actual in-network access. Strong consideration should also be given to the inclusion of accuracy, acceptance of new patients, and actual wait times as network adequacy standards.

Pursuing these basic time, distance, and provider type standards without regard for accuracy-based requirements will effectively negate the purpose of instituting network adequacy by continuing to structurally deny access to care.

There still exists serious access to care issues due to inaccurate provider network data[7] in some states that have these existing standards. Often referred to as "phantom networks," these provider networks include old data with non-physicians, inaccurate specialty data, inaccurate contact information, over-worked providers not accepting new patients, and more. In the case of one MCO studied by the Mental Health Alliance of New Jersey, 33 percent of providers had inaccurate contact information lists, only 51 percent accepted new patients, and significant wait times of one to nine months were reported. [8]

AACAP therefore recommends adopting more comprehensive standards to include accuracy-related items and additional standards, specifically to ensure:

- Timely and accurate updating of provider network directories;
- Periodic reflection among external and internal directories of providers accepting new patients;
- Utilization of ongoing surveys of existing network enrollees to determine whether needs are being met;
- Pioneering of innovative solutions to access issues through non-traditional delivery methods, such as telemedicine (telepsychiatry) and integrated care models; and
- Periodic issuing of comparative reports to similar government and private payers.

Exceptions to Network Adequacy Standards

The MCO Proposed Rule specifically notes the need for transparency to "situations that may arise where…an exception to state established provider network standards" and publication of reports regarding the use of exceptions. AACAP agrees with this assessment if CMS divests oversight to states; however, AACAP believes exceptions should have clinical and best practice documentation to support any exception-granting privileges.

AACAP also believes this is an opportunity for CMS to clarify the appropriate use and payment of telepsychiatry and telemedicine services to impacted patients. Telepsychiatry is a viable alternative in hard-to-reach areas where provider coverage is extremely limited or non-existent.[9]

Additionally, the MCO Proposed Rule should consider ways to promote and enhance team-based models of coordinated care. AACAP's President-Elect, Gregory Fritz, MD has undertaken this concept as his presidential-initiative "to integrate physical and mental health care, an effort that would

[7] MHA of New Jersey. (2014). Managed Care of Network Adequacy Report. MHANJ News. Accessed 07/20/2015: http://www.mhanj.org/wp-content/uploads/2014/09/Network-Adequacy-Report-Final.pdf.
[8] MHA of New Jersey. (2014). Managed Care of Network Adequacy Report. MHANJ News.
[9] Practice Parameter for Telepsychiatry With Children and Adolescents. Myers, Kathleen et al. Journal of the American Academy of Child & Adolescent Psychiatry. Volume 47, Issue 12, 1468-1483.

entail training psychiatrists so they can be effective in non-mental health medical settings, and primary care physicians to deal with psychiatric problems."[10]

Network Adequacy Standards, without Workforce Enhancement Initiatives, Fail Patient Needs

Efforts to implement network adequacy standards should always be paired with short-and-long-term solutions related to workforce issues. Simply seeking inclusion of more physicians of a certain subspecialty, such as child and adolescent psychiatry, does not necessarily alleviate a shortage.

Facilitating true network adequacy when it comes to child and adolescent psychiatrists will require increasing workforce accessibility. AACAP continues to pursue methods to complement access through enhanced telepsychiatry, and integrated care initiatives, but these methods cannot keep pace with the growing shortage.

The second annual report on the "Evaluation of CMS FQHC APCP Demonstration" by the Rand Corporation, stated that clinician and staff experience (CASE) analyses demonstrate approximately 60 percent were making efforts to increase their patients' access to mental health services. This is despite fewer than 20 percent of CASE respondents who reported easy access to high-quality mental health services.[11]

AACAP estimates there are approximately 8,300 practicing child and adolescent psychiatrists (CAPs) nationwide, whereas studies indicate the capacity need is closer to 30,000 CAPs. Unfortunately, subspecialty fellowship slots are not being completely filled at the same time as the average age of a CAP has risen to 57 years old, resulting in a growing shortage that will only increase in the years to come.

With this aging workforce and limited supply, average initial wait times have grown to nearly 8 weeks—a figure that is inclusive of all forms of payment including cash and private payer insurance. (This figure does not take into account individuals who did not pursue the scheduling of an appointment due to the extended initial wait time.)

AACAP believes that economic considerations are one of the largest driving factors behind our workforce shortage, and that they weigh heavily on the minds of medical students and recent graduates. According to the American Association of Medical Colleges (AAMC), the median medical school student, taking forbearance through his or her education and residency, completes medical school with $328,000 of debt[12]. This figure is compounded by the fact that CAPs require an additional two years of subspecialty fellowship training following a general residency training program in psychiatry.

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[10] Hall, P. (2015, Spring). The Fighter. *Brown Medicine.* Retrieved from http://www.brownmedicinemagazine.org/blog/the-fighter/

[11] Rand Corporation. (2015, July). *Evaluation of CMS FQHC APCP Demonstration. Second Annual Report.* Retrieved from http://innovation.cms.gov/Files/reports/fqhc-scndevalrpt.pdf

[12] Association of American Medical Colleges (2014). Medical Student Debt Card. Retrieved from https://www.aamc.org/download/152968/data/debtfactcard.pdf

A strong correlation exists between payment and provider acceptance of patients. A study in the journal, *Psychiatric Services*, concluded that "Increased access may be achieved through increased federal support for clinical training in mental health professions and a decrease in the administrative and financial disincentives to participation in these health plans. If current trends in the psychiatric workforce and public and private reimbursement for mental health care are not reversed, the treatment access crisis will only worsen."[13] In fact, the broader field of psychiatry's annual compensation ranked among the bottom of all physicians alongside their primary care colleagues.[14]

As CMS tenders suggested network adequacy standards to states as part of the MCO Proposed Rule, they should also pursue federal workforce enhancements and encourage states to follow suit where feasible.

Conclusion

AACAP applauds CMS' suggested inclusion of network adequacy standards to MCOs as an important initial step toward improving access to care for beneficiaries. AACAP holds that such standards should be required, rather than optional to states and that they should be expanded to include additional measures as addressed above. All of these efforts should be paired with efforts to address workforce issues among providers to ensure true in-network access is met.

Finally, on behalf of the children and adolescents our members serve, AACAP thanks CMS for inquiring whether the pediatric subpopulation ought to be considered separately. Delivery of mental health care to this most vulnerable population must be a standard to meet.

AACAP stands ready and willing to assist in efforts to improve access, treatment, and delivery of mental health care. Please direct any questions you may have to AACAP's Director of Government Affairs & Clinical Practice, Ronald Szabat, JD, LLM, at 202-587-9666, or by email at rszabat@aacap.org.

Sincerely,

Paramjit T. Joshi, MD
President, American Academy of Child & Adolescent Psychiatry

[13] Wilk et al., "Access to Psychiatrists in the Public Sector and in Managed Health Plans."
[14] Medscape Physician Compensation Report (2014). Retrieved from http://www.medscape.com/features/slideshow/compensation/2014/psychiatry#2