



December 4, 2023

The Honorable Daniel Tsai
Deputy Administrator and Director, Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP

Dear Deputy Administrator Tsai:

On behalf of the Child and Adolescent Mental Health (CAMH) Coalition, a group of organizations representing a diverse array of perspectives, dedicated to promoting the mental health and well-being of infants, children, adolescents, and young adults, we write to provide comments on the Center for Medicaid and CHIP Services' (CMCS) request for comments on processes for assessing compliance with mental health parity and addiction equity in Medicaid and the Children's Health Insurance Program (CHIP).

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (MHPAEA) prevents most Medicaid and CHIP enrollees from encountering more stringent benefit limitations on mental health and substance use disorder (MH/SUD) treatment compared to benefits for medical/surgical (M/S) care. Unfortunately, there is evidence of noncompliance with the requirements of MHPAEA throughout Medicaid managed care, Medicaid Alternative Benefit Plans (ABPs), and CHIP. This is especially concerning for children and youth, as Medicaid is the single largest payer of behavioral health services in the US and alongside CHIP covers more than 40 million children.ⁱ As of 2021, approximately 85% of children enrolled in Medicaid were in comprehensive managed care plans.ⁱⁱ 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.ⁱⁱⁱ

Mental health concerns are on the rise for youth across the nation. In October 2021, the American Academy of Pediatrics, 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.^{iv} In 2021, 42% of high school students reported feeling persistently sad or hopeless, and 29% reported experiencing poor mental health.^v 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.^{vi}

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 to appropriately address their mental and behavioral health needs. The US falls woefully short of meeting these needs.^{vii} Nearly half of youth suffering with mental health disorders do not receive treatment from mental health professionals.^{viii} Improving parity in Medicaid and CHIP is essential to addressing this need by supporting access to pediatric mental and

behavioral health care. We remind CMCS that the experiences and needs of children and adolescents are different from those of adults, and the system must be prepared to address their unique needs across the continuum of mental health care services.

EPSDT and Parity

Access to medically necessary MH/SUD services that are coverable under section 1905(a) of the Medicaid statute is guaranteed under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Proper implementation of EPSDT requires that children and youth under the age of 21 are provided the full range of MH/SUD care they need for prevention and treatment. CMCS released a guide reiterating the commitments of EPSDT and a recent informational bulletin reiterating that the obligation to provide all medically necessary care under EPSDT extends to prevention, screening, assessment and treatment for mental health and substance use disorders.^{ix} Due to the strength of EPSDT requirements, it follows that states would likely meet parity requirements for children and youth under 21; in fact, under current statute, states are able to be deemed in compliance with parity if they also provide and are in compliance with EPSDT requirements, including requirements such as providing or arranging for the provision of certain services. However, this is not the case in practice. There have been, and continue to be, challenges in EPSDT implementation, inconsistent application across states, and limited federal enforcement, leading to gaps in access to needed MH/SUD services. Additionally, EPSDT requirements do not apply to stand alone CHIP programs.

Full EPSDT implementation and parity enforcement are both vital layers that work in tandem to ensure that states have robust coverage for MH/SUD treatment and services through both Medicaid and CHIP. Additional oversight by CMS, meaningful and robust execution and enforcement of the EPSDT provisions of the Bipartisan Safer Communities Act,^x and requiring states to assess their behavioral health continuum of care can help ensure that the EPSDT and parity mandates meet their promise.

Alignment and Consistency

The Administration must not allow weaker rules for parity to persist in Medicaid and CHIP compared to those for private insurance. Both EPSDT and parity implementation can be improved through greater uniformity in benefits. This holds true across states as well as all types of public and private insurance. CAMH recently submitted comments in response to the Administration's proposed rule, "Requirements Related to the Mental Health Parity and Addiction Equity Act," about parity requirements for private insurance.^{xi} We urge CMCS to align parity enforcement requirements for commercial payers with those for Medicaid and CHIP to the extent possible and to swiftly enact the needed changes. The Administration should pay particular attention to non-quantitative treatment limits (NQTLs), such as prior authorization, and requirements for insurers as they conduct data analysis.

Alignment between parity rules for Medicaid and CHIP and private insurance is particularly important given that Medicaid and CHIP serve lower-income children and families who are disproportionately Black, Latino, Native American, or from other minoritized communities. Another important reason for consistency between parity in Medicaid and CHIP and private insurance is the ongoing "unwinding" of the COVID-19 Public Health Emergency's Medicaid continuous enrollment protections. We have already seen over 2 million children unenrolled from Medicaid and CHIP^{xii} and anticipate the potential for "churn" between Medicaid and private coverage. As children transition from Medicaid and CHIP to private insurance and back, continuity of care should be a priority, and having consistent parity requirements between these forms of insurance will help.

Data Analysis and Compliance

Throughout most, if not all, states, reviews of Medicaid and CHIP parity compliance have been insufficient and infrequent, and we appreciate CMCS' attention to this issue. States were required to provide CMCS with documentation of Medicaid and CHIP compliance with parity requirements in 2017, but few states conducted

truly comprehensive reviews at that time, nor do many regularly update these reviews to show ongoing compliance. We urge CMCS to at least require states to ensure that Medicaid managed care, ABPs and CHIP conduct detailed parity analyses in a manner consistent with those expected of commercial insurers. CMCS should also assess whether insurance “carve outs” under Medicaid and CHIP exacerbate MHPAEA non-compliance and, conversely, whether integrated care delivery systems contributed to higher levels of compliance with MHPAEA.

As CMCS considers changes to its review of states’ Medicaid and CHIP compliance with federal parity requirements, we recommend taking advantage of a wide range of existing and new data sources. A 2021 brief from the Medicaid and CHIP Payment Access Commission found that MHPAEA does not appear to have increased access to behavioral health services for individuals with Medicaid and CHIP, and this may be attributed to how parity is assessed and documented.^{xiii} Improvements in data analysis and the frequency of CMCS’ ongoing compliance reviews may help. CMCS should consider leveraging data sources including EPSDT information, quality measures, managed care data and information, and data to be collected under the proposed access and managed care rules that the Administration released earlier this year. This extensive data will likely produce a valuable, accurate, and up-to-date picture of parity compliance and potential violations.

Comprehensive data analysis is vital to improving parity in Medicaid and CHIP, and CMCS can likely align the scope of collected data closely with the Administration’s proposed requirements for private insurers. The proposed rule requires private insurers to evaluate network composition, adequacy, and access, among other factors, then determine if there is a material difference in access to MH/SUD compared to M/S benefits and to take reasonable action to address discrepancies.

In these reviews, it is important to consider 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 provider directories are often out-of-date or incomplete. In fact, inadequate networks are one of the most significant barriers to children and youth accessing needed MH/SUD care. This places the burden on patients and families to find a MH/SUD provider that is taking patients, accepts Medicaid or CHIP, and meets their needs. Inadequate MH/SUD provider networks 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 crisis care, especially for patients with complex medical needs.

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. Network adequacy reviews should also ensure access to all applicable forms of appropriate care in Medicaid-compliant facilities, including residential treatment, and also review 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 MH/SUD providers not participating in Medicaid and CHIP provider networks.

Support, Transparency, and Oversight

As CMCS introduces changes to Medicaid and CHIP parity compliance reviews, CAMH asks for transparency from states and strong federal support and oversight throughout the process. States’ parity compliance reports must be made public in an accessible and timely manner, and states must then swiftly take steps to address

violations. Publicly providing this data, along with the expectation of prompt follow-up action, will improve understanding of common gaps in parity and may lead states to implement innovative solutions, such as integrating behavioral health care into the primary care environment. In addition to states publicly sharing their parity compliance data, CMCS should improve oversight and enforcement of EPSDT. As stated earlier, EPSDT and MHPAEA are complementary means of improving access to MH/SUD care for the nation's youth.

CMCS should also issue detailed guidance for states that improves clarity on MHPAEA's requirements for Medicaid managed care, ABPs and CHIP. This guidance should provide detailed examples, information about how states must address MHPAEA noncompliance, and the mechanisms by which states and plans will be held accountable. CMCS should also be prepared to provide technical assistance and best practices as states implement changes to their parity compliance reporting and seek to remedy existing parity violations. CMCS should also provide guidance to healthcare providers and families so that they can better understand and assess what it means to be compliant with MHPAEA's requirements.

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

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Foundation for Suicide Prevention
American Psychiatric Association
Association of Maternal & Child Health Programs
Children's Hospital Association
CLASP
Family Voices
First Focus on Children
Georgetown University Center for Children and Families
MomsRising
National Alliance on Mental Illness (NAMI)
Nemours Children's Health
Society for Adolescent Health and Medicine
The National Alliance to Advance Adolescent Health
The Youth Power Project
Voice for Adoption
Youth Villages

ⁱ Centers for Medicare and Medicaid Services. July 2023 Medicaid and CHIP Enrollment Trends Snapshot; 2023. <https://www.medicare.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

ⁱⁱ Medicaid and CHIP Payment and Access Commission. Exhibit 30. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2021; 2023. <https://www.macpac.gov/wp-content/uploads/2023/10/EXHIBIT-30.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2021.pdf>.

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- ^{iv} National Vital Statistics System. Leading Causes of Death, United States. Centers for Disease Control and Prevention; 2020 <https://wisqars.cdc.gov/data/lcd/home>.
- ^v Youth Risk Behavior Survey Data Summary & Trends Report, 2011-2021. Centers for Disease Control and Prevention; 2023. https://www.cdc.gov/healthyyouth/data/yrbs/yrbs_data_summary_and_trends.htm
- ^{vi} Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. US Department of Health and Human Services; 2020. <https://www.samhsa.gov/data/report/2019-nsduh-annual-national-report>; Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. US Department of Health and Human Services; 2023. <https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report>
- ^{vii} Substance Abuse and Mental Health Services Administration. Behavioral Health Workforce Report. US Department of Health and Human Services; 2022. <https://www.samhsa.gov/sites/default/files/behavioral-health-workforce-report.pdf>
- ^{viii} Study: One in Six U.S. Children has a Mental Illness. American Academy of Family Physicians; 2019. <https://www.aafp.org/news/health-of-the-public/20190318childmentalillness.html>
- ^{ix} Centers for Medicare and Medicaid Services. EPSDT - a guide for states: coverage in the Medicaid benefit for children and adolescents; 2014. https://www.medicare.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf. Centers for Medicare and Medicaid Services. CMCS Informational Bulletin: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth; 2022. <https://www.medicare.gov/sites/default/files/2022-08/bhccibo8182022.pdf>.
- ^x Center for Children and Families. The Bipartisan Safer Communities Act: Where Things Stand on the Medicaid and CHIP Provisions. Georgetown University McCourt School of Public Policy; 2023. <https://ccf.georgetown.edu/2023/08/23/new-brief-where-things-stand-on-the-medicare-and-chip-provisions-of-the-bipartisan-safer-communities-act/>.
- ^{xi} Child and Adolescent Mental Health Coalition. CAMH Mental Health Parity Rule Comment; 2023. <https://www.camhcoalition.org/our-work/mh-parity-rule-comment>.
- ^{xii} Center for Children and Families. Medicaid Enrollment Declines During Unwinding. Georgetown University McCourt School of Public Policy; 2023. <https://ccf.georgetown.edu/unwinding-enrollment-data/>.
- ^{xiii} Medicaid and CHIP Payment and Access Commission. Implementation of the Mental Health Parity and Addiction Equity Act in Medicaid and CHIP; 2021. <https://www.macpac.gov/wp-content/uploads/2021/07/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf>.