Georgetown University
McCourt School of Public Policy
CENTER FOR CHILDREN
AND FAMILIES

VIA ELECTRONIC TRANSMISSION

December 4, 2023

The Honorable Daniel Tsai
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare & 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,

Thank you for the opportunity to provide comments on processes for assessing compliance with mental health parity and addiction equity in Medicaid and the Children's Health Insurance Program (CHIP). The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes through Medicaid and CHIP.

As the single largest payer of behavioral health services in the US, covering about half of all children, and paying for over 40 percent of all births, Medicaid (alongside CHIP) plays an essential role in providing comprehensive, affordable health coverage and mental health and substance use disorder care to millions of Americans including Black and Latino children who experience significant disparities in receiving mental health care. Access to mental health services in Medicaid is particularly crucial right now with higher rates of anxiety, depression and post-traumatic symptoms among children – especially children of color. Yet according to data from the Medicaid and CHIP Payment and Access Commission, in 2018, only about half of non-institutionalized youth enrolled in Medicaid or CHIP who experienced a major depressive episode received mental health treatment.

We appreciate the Administration's ongoing efforts to improve access to care for individuals covered by Medicaid and CHIP, including mental health and substance use disorder (MH/SUD) services. However, more must be done to meet the MH/SUD needs of individuals covered by Medicaid and CHIP and we welcome the opportunity to

comment on processes for assessing compliance with mental health parity and addiction equity. Below are CCF's comments in response to the Center for Medicaid & CHIP Services' (CMCS) request. As noted throughout our comments, we encourage CMCS to use the full array of tools available in its purview, including both parity and other available levers, as it works to ensure individuals covered by Medicaid and CHIP have access to the MH/SUD services they need.

EPSDT and Parity

As the definitive standard for children's health coverage, Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires states to provide comprehensive services and furnish all coverable, appropriate and medically necessary services, even if such services are not included in the Medicaid state plan. Medicaid's EPSDT benefit is designed to ensure that individuals under the age of 21 covered by Medicaid have access to the services they need to prevent, ameliorate, and treat health conditions, including MH/SUDs.

We applaud CMCS for reiterating the obligation to provide all medically necessary care under EPSDT extends to prevention, screening, assessment and treatment for MH/SUDs in its 2022 informational bulletin on leveraging Medicaid, CHIP, and other federal programs in the delivery of behavioral health services for children. However, in practice, there continue to be ongoing challenges in EPSDT implementation, inconsistent application across states, and limited federal oversight and enforcement, leading to gaps in access to needed MH/SUD services.

As noted in CCF's 2015 comments in response to the Administration's proposed rule related to parity in Medicaid and CHIP, we recommended that the Centers for Medicare & Medicaid Services (CMS) require states to document that all children and adolescents covered by Medicaid and CHIP—including those with EPSDT benefits under either program and those enrolled in Medicaid fee-for-service—can access appropriate and timely MH/SUD services. The 2016 final rule made some modifications to the EPSDT parity deeming provisions included in the 2015 proposed rule, however, state assurances of EPSDT compliance remain insufficient to ensure compliance with the requirements for providing EPSDT benefits in accordance with 1902(a)(43) of the Medicaid statute. The reality is that many state Medicaid programs are not meeting EPSDT obligations and not providing youth under the age of 21 with the full range of MH/SUD services required by law.

Accordingly, we reaffirm CCF's recommendation that CMCS require states to fully and meaningfully document that all children and adolescents covered by Medicaid and CHIP have access to timely and appropriate MH/SUD services—including the full range of services covered under the EPSDT benefit. In ensuring compliance with EPSDT and parity requirements, CMCS must go beyond state assurances and simple paperwork reviews and actively work with families, stakeholders and states to ensure the EPSDT benefit is working for the individuals the benefit was created to protect. It should also go without saying that such documentation and actions should be required *before* CHIP or

Alternative Benefit Plans (ABPs) programs that include the full coverage of EPSDT are deemed in compliance with parity.

Full EPSDT implementation and parity enforcement are critical 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 CMCS, meaningful and robust execution and enforcement of the EPSDT provisions of the Bipartisan Safer Communities Act, and requiring states to assess, document, and improve their behavioral health continuum of care can help ensure that the EPSDT and parity mandates meet their promise.

Aligning and Improving Non-Quantitative Treatment Limits

We appreciate the Administration's efforts in its recent proposed rule, "Requirements Related to the Mental Health Parity and Addiction Equity Act," related to parity requirements for individual marketplace and employer-based plans including improvements to non-quantitative treatment limit (NQTL) requirements. However, the Administration must also act to ensure there are not weaker rules for parity in Medicaid and CHIP than commercial coverage. This is particularly critical given that: (1) the US is in the midst of a national emergency in child and adolescent mental health and Medicaid and CHIP cover about half of all children; (2) Medicaid and CHIP disproportionately covers individuals and families of color, who are more likely to struggle with MH/SUD than white individuals; and (3) the nation remains in a maternal mortality crisis with Medicaid (and CHIP to a lesser degree) playing a key role in covering pregnant and postpartum individuals in whom MH/SUD conditions remain a leading cause of pregnancy-related maternal mortality.

As noted in CCF's comments on the "Medicaid Program; Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality; Proposed Rule" (CMS-2439-P), we support of many of the Administration's proposals to improve access to care in Medicaid and CHIP such as proposed waiting time standards and requirements for conducting secret shopper surveys and enrollee experience surveys. As CMCS works to advance network adequacy in Medicaid and CHIP, we also support requiring Medicaid managed care, ABPs and CHIP to conduct regular parity compliance analyses that mirror the requirements for individual marketplace and employer-based plans set forth in the Administration's recently proposed rule including requirements around assessing provider networks as an NQTL. Ensuring regular parity compliance analysis and assessing Medicaid and CHIP provider networks as an NQTL along with appropriate data collection and evaluation as part of Medicaid and CHIP parity efforts would advance the Administration's larger ongoing efforts to ensure sufficient access to needed services throughout Medicaid and CHIP.

In addition, alignment of MHPAEA requirements across the commercial and public insurance markets, where appropriate, would promote consistency between markets, reducing the burden on individuals who may move between Medicaid and commercial coverage and also on plans which often offer products in both the commercial and public markets.

Accordingly, in support of the Administration's ongoing efforts to improve access to MH/SUD care in Medicaid and CHIP, we encourage CMCS to review the proposals within the MHPAEA proposed rule related to individual marketplace and employer-based plans and apply those requirements and protections to Medicaid and CHIP (including Medicaid managed care, ABPs and CHIP plans) where appropriate and without undue delay. We also recommend as we did in our 2015 comments on the Medicaid and CHIP proposed parity rule that CMCS offer additional direction to states about NQTLs as they relate to children and adolescents with MH/SUD diagnoses.

Finally, when reviewing NQTL improvements within Medicaid and CHIP we also urge CMCS to review and improve prior authorization processes, including for MH/SUD services. Prior authorization is a time-consuming process that can burden providers, divert valuable resources away from direct care, and cause delays in access to needed services and treatment. According to a recent study by the Office of the Inspector General, individuals enrolled in Medicaid managed care may not be receiving necessary health services due to the high number and rates of denied prior authorization requests, limited oversight of prior authorization denials, and limited access to external medical reviews. Thus, we also encourage CMCS to review CCF's comments submitted in response to the "Advancing Interoperability and Improving Prior Authorization Process Proposed Rule" (CMS-0057-P), and in particular, CCF's recommendations related to exemption of EPSDT and maternity care services from prior authorization. Such exemptions could help address potential NQTL parity violations and promote access to MH/SUD care including for children and pregnant and postpartum individuals in Medicaid and CHIP.

Leveraging and Improving Measures, Datapoints, and Other Information
In the request for comment, CMCS asks for measures, datapoints, or other information that could help identify potential parity violations in Medicaid managed care, ABPs, and CHIP. Such data can serve a critical role in identifying potential parity violations and assessing meaningful access to MH/SUD care in Medicaid and CHIP when paired with accurate reporting and meaningful evaluation.

As mentioned above, we encourage CMCS to review and align the parity data collection and evaluation requirements within the MHPAEA proposed rule related to individual marketplace and employer-sponsored plans with Medicaid managed care, ABPs and CHIP as appropriate. The proposed rule requires commercial 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 medical/surgical benefits and to take reasonable action to address discrepancies. Such data collection and evaluation requirements would also be beneficial in Medicaid and CHIP including specific analyses of for children and youth that are disaggregated from data for adult populations to appropriately capture pediatric network composition, adequacy, and access.

We also strongly urge CMCS to leverage other Medicaid and CHIP measures, data, and information such as EPSDT data, Medicaid and CHIP health quality measure data, T-

MSIS data, managed care performance (e.g., claims denials, prior authorization requirements, outcomes, successful referrals) and other relevant information to inform and improve access to MH/SUD care throughout Medicaid and CHIP. Requiring states and managed care plans to facilitate and document access to behavioral health services, especially for populations for whom there have been historic or ongoing access barriers, would also enhance parity compliance with the Administration's health equity priority.

In leveraging information to identify potential parity violations and improve access to MH/SUD care, we also encourage CMCS to work with states to collect and employ data on real world experiences, such as through secret shopper surveys and enrollee experience surveys. We remain concerned about "ghost" or "phantom" networks, with one state study finding that nearly 60 percent of network directory listings were providers who did not see Medicaid patients, including about 60 percent of mental health providers. Accordingly, we encourage CMCS to go beyond paperwork reviews in its information collection and analysis to ensure the real-world experiences of individuals are captured.

Finally, as part of these efforts, CMCS should also improve the type and quality of data reported and collected from states and managed care plans to allow for meaningful evaluation. For example, as noted in CCF's response to the Administration's request for information on improving access within Medicaid and CHIP, we encourage CMCS to improve the CMS-416 and/or leverage TMSIS data to better monitor the performance of states and managed care plans in meeting EPSDT requirements. CMCS should also work with states to improve the quality of T-MSIS data, make data publicly available and more easily accessible, and develop a methodology for analyzing the T-MSIS database of enrollee encounters with network providers to help identify access programs in individual managed care plans, including problems related to MH/SUD services.

Increasing Transparency and Oversight

In addition to data collection and evaluation, we also urge CMCS to take additional steps to increase transparency and oversight of parity and access to MH/SUD care in Medicaid and CHIP. According to a 2021 brief from the Medicaid and CHIP Payment and Access Commission (MACPAC), MHPAEA does not appear to have increased access to behavioral health services for individuals covered by Medicaid and CHIP. According to MACPAC, this may in part be due to how parity is assessed and documented. Improvements to transparency and oversight along with appropriate data collection and evaluation are critical to ensuring meaningful compliance with parity requirements and access to MH/SUD care.

CMCS can take a number of steps to bolster transparency and oversight to improve parity and access to MH/SUD services in Medicaid and CHIP. For example, CMCS should ensure timely public posting of state Medicaid and CHIP parity compliance reports on a single website as well as regular and timely public posting of managed care program annual reports (MCPARs). As noted in CCF's comments in response to the Administration's request for information on improving access within Medicaid and CHIP, CMCS should also create and maintain a child health dashboard on Medicaid.gov that displays performance information for each managed care plan. In the majority of states

and for the majority of children, access to Medicaid-covered services including MH/SUD services for children is determined by the managed care plan in which they are enrolled. However, in most states, information about the performance of individual managed care plans, including for children, is not publicly available. A publicly-accessible child health dashboard that includes relevant information such as EPSDT data including data related to MH/SUD services would promote transparency and accountability.

We also support additional guidance and technical support to states, providers, and individuals covered by Medicaid and CHIP to improve access to MH/SUD care and compliance with parity requirements including information on opportunities for state capacity building including federal and administrative matching opportunities, information for individuals and providers so that they can better understand and assess what it means to be complaint with MHPAEA requirements, additional guidance to states about how they should address MHPAEA noncompliance, and best practices related to managed care contracting, oversight, and enforcement.

Populations At Risk

Finally, in prioritizing oversight efforts, we encourage CMCS to consider populations who may be at increased risk given their unique MH/SUD needs and the role of Medicaid and CHIP in meeting those needs such as children and youth – especially youth involved in the child welfare system or juvenile justice systems – and pregnant and postpartum individuals.

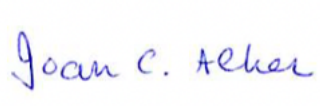
For example, as noted in CCF's 2021 review of Medicaid managed care for children and youth in foster care, in six states with Medicaid managed care organizations that furnished services on a statewide basis exclusively to children and youth in foster care and other vulnerable populations, *none* of the Medicaid agency websites posted all of the minimum data elements required by federal regulations, and *none* of them posted information sufficient to enable stakeholders to assess the performance of the managed care plans. This is despite the fact that more than one-quarter of children in foster care – who are generally covered by Medicaid – have a mental health diagnosis and are more likely to experience developmental delays and speech/language disorders than their peers.

Pregnant and postpartum individuals are also at increased risk given that MH/SUD conditions are a leading cause of pregnancy-related maternal mortality. Medicaid serves as the primary financing mechanism for maternity care for low-income individuals in the US, yet states vary considerably in the amount and type of information they make publicly available regarding the performance of Medicaid managed care plans on maternal health. According to a recent CCF review of 12 states, *none* of the states' Maternal Mortality Review Committee reports examined the role of individual Medicaid managed care plans in managing pregnant or postpartum enrollees.

We appreciate your efforts to improve access to mental health and substance use disorder services for individuals covered by Medicaid and CHIP and thank you for considering

CCF's comments. If you need more information, please contact Anne Dwyer (Anne.Dwyer@georegetown.edu).

Sincerely,



Joan Alker
Research Professor
Executive Director