October 17, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Lisa M. Gomez
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20002

The Honorable Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
U.S. Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224

Re: RIN 0938-AU93, 1210-AC11, 1545-BQ29 "Requirements Related to the Mental Health Parity and Addiction Equity Act"

Dear Secretary Becerra, Assistant Secretary Gomez, and Deputy Commissioner O'Donnell:

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 US Department of Health and Human Services, Employee Benefits Security Administration, and the Internal Revenue Service's (the Administration) proposed rule, *Requirements Related to the Mental Health Parity and Addiction Equity Act*.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (MHPAEA) prevents insurers from imposing more stringent benefit limitations on mental health and substance use disorder treatment compared to benefits for medical/surgical care. Since its passage, there has been a persistent need to improve oversight and compliance with the requirements of MHPAEA. This proposed rule is an important step in supporting MHPAEA's underlying goal to increase equitable access to mental health treatment and prevent insurers from imposing treatment limitations that overly burden young patients seeking mental health care.

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.[i] In 2021, 42% of high school students reported feeling persistently sad or hopeless, and 29% reported experiencing poor mental health.[ii] 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.[iii]

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.[iv] Nearly half of youth suffering with mental health disorders do not receive treatment from mental health professionals.[v] The proposed rule is essential to addressing this need by supporting access to pediatric mental and behavioral health care. We remind the Administration 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.

Ensuring Parity

CAMH strongly supports many provisions in the proposed rule, which requires private insurers to provide meaningful coverage for mental health conditions across the scope of needed services, address treatment limits that are disproportionately applied to mental health care, examine their mental health provider networks, and adjust provider reimbursements to align with medical/surgical care.

Often, insurers inconsistently apply nonquantitative treatment limits (NQTLs) such as prior authorization and stepwise therapies to mental health care compared to medical/surgical benefits. These burdensome limits can delay and prevent patients from receiving necessary care. The Administration is correct to hold insurers accountable for disproportionately applying these limits to mental health care over medical/surgical care.

We urge the Administration to remove the provisions that provide exceptions from parity requirements to NQTLs that are based on independent professional or medical standards or are related to the prevention of fraud, waste, and abuse. We are concerned that the proposed exception for such treatment limits that follow "independent medical or clinical standards (consistent with generally accepted standards of care)" will be mis- and over-used by insurers to avoid compliance with the spirit of the rule. While we acknowledge that the Administration intends to apply the exception narrowly, it is too broad and functionally unravels many of the protections intended in the rule. We do believe, however, that health plan medical decision-making should adhere to generally accepted mental health and substance use disorder standards of care as developed by the relevant non-profit clinical specialty associations. This is especially important in pediatric mental health care, as many children have mental health symptoms that impair their functioning without meeting the criteria for a disorder, especially young children. For example, a child experiencing grief at the death of a close family member may struggle with their mental health and require treatment to help them to cope and to prevent a worsening mental condition over time. Insurers use situations like this, such as a lack of a formal diagnosis, to deny coverage for needed upstream care. This is a shortsighted approach with serious consequences; prevention and early intervention for mental health needs in youth can mitigate or preempt the development of more severe mental health conditions and help avoid the need for crisis care.

While we support insurers' legitimate efforts to combat, prevent and detect fraud, waste, and abuse, it is not uncommon for health plans to use claims of "fraud, waste, and abuse" to deny or otherwise limit access to medically necessary care. Therefore, we do not support the Administration's attempts to create a "fraud, waste, and abuse" exception to the NQTL requirements, as there is a high risk of overuse or misuse by insurers, and that risk may be even higher within pediatrics where early intervention services are particularly critical. This proposed exception compromises the rule's otherwise strong NQTL requirements.

Prevention and Early Intervention

By some estimates, as many as 19% of children have mental health symptoms that impair their functioning without meeting criteria for a disorder.[vi] Lack of insurance payment for services for children and adolescents whose needs do not yet rise to the level of a diagnosis is a major barrier and contributes to the mental health crisis we are confronting. While some symptoms may ultimately become a diagnosable condition, the lack of

insurance payment prevents support for those children and adolescents with emerging problems. In order to have true parity with medical/surgical benefits, mental health screening, prevention, and early intervention must be accessible to children and youth in need which means they must be routinely paid for by insurers.

Data Analysis

The proposed rule requires insurers to revamp their data analysis, particularly around network composition, adequacy, and access. The new standard requires insurers to determine if there is a material difference in access to mental health benefits compared to medical/surgical benefits and to take reasonable action to address discrepancies. This is an essential aspect of the rule and brings the focus of NQTL analyses back to the fundamental purpose of MHPAEA – addressing disparities in insurance coverage for mental health care and ensuring access to appropriate care. At the same time, we are concerned that insurers will broadly interpret the "material difference" standard. Therefore, we ask the Administration to require reasonable action to be taken when the data indicates *any* differences in access.

As insurers conduct data analysis under the new standards, it is important that they 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 mental health services, are insufficient and insurer-maintained 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 mental health care. This places the burden on patients and families to find a mental health provider that is taking patients, accepts their insurance, and meets their needs. Inadequate mental health 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 mental health care at all levels would be unacceptable for medical/surgical 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. They should also examine limitations or exclusions on facility types, such as residential treatment programs, etc. and assessments of 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 mental health providers not participating in private plans' provider networks.

The problem of children going without needed mental health services, and facing delays when they do seek out care, is inextricably linked to shortages in pediatric mental and behavioral professionals across disciplines resulting from insufficient payment by insurers for mental health care. Insurers can, and must, quickly take action to fill network gaps by improving payment rates for providers who offer these essential services. Historic under-payment for mental health care has discouraged many providers from accepting health insurance thereby exacerbating the access challenges faced by countless children and families.

CAMH will continue to advocate for multifaceted solutions to bolster the pediatric mental health care workforce, including expanding training opportunities and other innovative solutions. Additionally, while telehealth is not a cure-all solution to inadequate networks, it is a useful tool for providers to offer care in many situations and can expand access to mental health care in rural and underserved areas. Care delivered via telehealth should similarly be covered by insurers and paid for at parity with in-person visits.

We also recommend that the insurers be required to collect data on scope of services and take action to address access disparities that may be the result of scope of service limitations. That data should take into account the full range of mental health services that children and youth need, including prevention, screening, early intervention, the full range of outpatient and inpatient treatment modalities, as well as crisis response and stabilization services. In addition, insurers should conduct specific data collection and analyses related to the use and application of clinical guidelines and be required to make available any criteria/guidelines they use to federal and state regulators and enrollees.

Medicaid and CHIP

We also urge the Administration to act swiftly to take steps to improve parity oversight and compliance in Medicaid and CHIP and appreciate the Administration's action in releasing the request for information on how to best assess Medicaid and CHIP's compliance with MHPAEA.[vii] We ask that the Administration move efficiently in implementing changes according to the feedback received. Medicaid is the single largest payer of behavioral health services in the US and alongside CHIP covers more than 40 million children.[viii] 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.[ix] In addition, according to the Medicaid and CHIP Payment and Access Commission, the MHPAEA does not appear to have increased access to behavioral health services for individuals with Medicaid and CHIP and this may in part be due to how parity compliance is assessed and documented according to a 2021 brief.[x] Accordingly, it is important for the Administration to take swift and meaningful action to address mental health parity in Medicaid and CHIP in addition to its efforts to address parity under private insurance.

We urge CMS to align parity enforcement requirements for commercial payers with those for Medicaid and CHIP to the extent possible. That alignment is particularly important given the ongoing "unwinding" of the COVID-19 Public Health Emergency's Medicaid continuous enrollment protections and the potential "churn" between Medicaid and private coverage.

We also remind CMS that access to medically necessary mental health services is guaranteed under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. However, there have been, and continue to be, challenges in implementation and inconsistent application across states leading to gaps in access to needed mental health services. Additional oversight by CMS and requiring states to assess their behavioral health continuum of care can help ensure that the EPSDT benefit meets its promise.

CAMH is grateful for the opportunity to comment on the proposed rule. Please do not hesitate to contact Tamar 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 for the forthcoming rule. We look forward to working with you to continue to improve children's access to mental health care.

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Foundation for Suicide Prevention
American Psychiatric Association
Association of Children's Residential & Community Services (ACRC)
Association of Maternal & Child Health Programs
Catholic Health Association of the United States
Center for Law and Social Policy (CLASP)
Children's Hospital Association

Clinical Social Work Association
Eating Disorders Coalition for Research, Policy, & Action
Family Voices
First Focus on Children
Futures Without Violence
Georgetown University Center for Children and Families
MomsRising
National Alliance on Mental Illness (NAMI)
National Association of Pediatric Nurse Practitioners
National Children's Alliance
National League for Nursing
Nemours Children's Health
School Social Work Association of America
School-Based Health Alliance
Society for Adolescent Health and Medicine (SAHM)
The National Alliance to Advance Adolescent Health
The Youth Power Project
Voice for Adoption
Youth Villages

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