NEMOURS CHILDREN'S HEALTH | Well Beyond Medicine

National Office of Policy & Prevention

1201 15th St. NW
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Washington, DC 20005

December 1, 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 Nemours Children's Health, we thank you for the opportunity to provide comments on this request for information (RFI) for assessing compliance with mental health parity and addiction equity in Medicaid and the Children's Health Insurance Program (CHIP). We appreciate CMS' attention to addressing barriers impeding access to mental health and substance use disorder (MH/SUD) services and ensuring such services provided through managed care are on par with access to medical and surgical services in compliance with federal regulations.

Nemours Children's Health is one of the nation's largest multistate pediatric health systems, which includes two free-standing children's hospitals and a network of more than 70 primary and specialty care practices. Nemours Children's seeks to transform the health of children by adopting a holistic health model that utilizes innovative, safe, and high-quality care, while also caring for the health of the whole child beyond medicine. Nemours Children's also powers Nemours KidsHealth.org, a pioneer and leader in pediatric health content. The Nemours Foundation, established through the legacy and philanthropy of Alfred I. duPont, provides pediatric clinical care, research, education, advocacy, and prevention programs to the children, families and communities it serves. For more information, visit Nemours.org.

As you are aware, Medicaid is the single largest payer of behavioral health services in the US and, alongside CHIP, covers more than 40 million children. 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. In addition, according to the Medicaid and CHIP Payment and Access Commission, the Mental Health Parity and Addiction Equity Act (MHPAEA) does not appear to have increased access to behavioral health services for individuals with Medicaid and CHIP, likely in part due to how parity compliance is assessed and documented. This RFI is an important step in ensuring equitable access to mental health treatment and has the potential to prevent insurers from imposing treatment limitations that impede access to needed MH/SUD services. Accordingly, it is important for CMS to take swift and meaningful action to align parity enforcement requirements for commercial payers with those for Medicaid and CHIP to the extent possible.

As CMS contemplates responses to this request, it is critical to underscore that the experiences and needs of children and youth are different from those of adults, and

the system must be prepared to address their unique needs across the continuum of MH/SUD services. We urge CMS to take this into consideration when assessing priority issue areas for parity compliance in Medicaid and CHIP. As such, our comments focus broadly on the access barriers in place that impede timely, equitable access to MH/SUD services for children and youth. Below we provide specific comments in response to the questions posed in the RFI for your consideration.

Are there any MH conditions or SUDs that are more prevalent among enrollees in Medicaid MCOs, Medicaid ABPs, or CHIP? What are the most significant barriers to accessing treatment among enrollees with these conditions?
The most significant barriers experienced across our health system when providing MH/SUD services relate to process challenges with Medicaid managed care plans around reimbursement, prior authorization, and provider credentialling and enrollment. Below we provide more details on these specific barriers and the impact it has on treatment access for the patients we serve.

Insufficient Reimbursement Rates & Contract Negotiations
Before even arriving at a formal diagnosis for many of the patients we serve, our providers continually experience challenges with reimbursement rates and payer barriers that present critical access challenges. Medicaid managed care plans and CHIP, along with other payers, have historically provided insufficient coverage and payment for MH/SUD services. Payment rates for behavioral health providers are typically based on a fee schedule that is considerably lower than that of a medical/surgical provider. Lower rates based on these fee schedules have spillover effects on contract negotiation with payers, challenging children's hospitals to successfully contract with payers in a way that appropriately reimburses for mental and behavioral health services. When such negotiations are not successful, access to services becomes even more limited in a patient's covered provider network. 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. Further, when mental health and SUD concerns are not addressed early, they risk becoming more complex down the road, which requires increased treatment and higher health care costs.

In addition, plans that carve out MH/SUD services often have a separate agreement with a MH/SUD vendor to cover these services. The plan and the vendor often go back and forth negotiating which entity should cover the service, leaving pediatric providers confused about who to send the claim to and who should pay it. There also does not appear to be much automated data exchange between the managed care plan and the contracted vendor for MH/SUD services, creating a challenge for the managed care plan to effectively meet the state's own requirements for tracking patients as they are referred outside of what falls under their purview. Finally, it is not uncommon for reimbursement rates for MH/SUD services to be so low to the point where health systems have to make the difficult decision not to contract with certain plans that refuse to negotiate rates. These issues significantly impede children from achieving timely access to services.

Prior Authorization
Policies around obtaining prior authorization for certain MH/SUD evaluations and screenings create another barrier to timely and appropriate access to care. It is not uncommon for plans to deny critical diagnostic testing or appropriate hours needed to adequately complete the testing and screenings needed to make a formal diagnosis. As an example, the standard practice for obtaining a formal diagnosis for autism necessitates 10 hours of screening and evaluations. Our providers have experienced denials for necessary diagnostic testing, or receive approval for far less

hours than needed to complete those tests, with plans stating such tests are “not medically necessary.”

Not only does this create challenges with having approved coverage for the screenings and evaluations needed to arrive at a diagnosis, but it also places health systems in a position of deciding whether to cover the additional hours needed to comprehensively evaluate a patient. This presents barriers for obtaining the needed information to diagnose and provide a care plan for the children we serve. Inappropriate denials and lengthy appeals processes can delay and prevent patients from receiving necessary care, place additional stress on the family/caretaker and can lead to delayed treatment and worse outcomes.

Provider Credentialing and Enrollment
Another persistent barrier faced across our system is challenges with credentialling and enrolling our MH/SUD clinicians with our contracted Medicaid managed care plans. Credentialling of providers often differs by plan, which causes fragmentation in which types of pediatric providers can be enrolled into the provider network. In considering care options for patients who reside out of state, or for health systems like ours that span multiple state borders, one state Medicaid program may not accept another type of licensed clinical provider from a different state based on a licensing technicality. An example of this is a licensed professional counselor (LPC) not being accepted as an eligible provider under a state Medicaid program because the credentials for that profession look different (i.e. licensed mental health practitioner, which is the same profession as an LPC). This discrepancy creates workforce implications for pediatric MH/SUD providers. Further, health systems are often hamstrung by the amount of time it takes to panel new providers upon hiring. It often takes months longer to get new providers paneled through managed care plans compared to commercial plans, which creates equity access concerns and significant delays in care, given we have providers who are ready to see patients and are prohibited from doing so by this cumbersome process.

For the reasons provided, we recommend CMS consider factors related to insufficient provider reimbursement rates, denial rates for authorization for MH/SUD services, and experiences related to provider credentialing and claims processing as key areas for review in assessing potential parity compliance issues in Medicaid managed care arrangements, Medicaid ABPs, and CHIP.

Which NQTLs and/or benefit classifications should be prioritized for review?
There are various NQTLs and benefit classifications that should be prioritized when reviewing MH/SUD parity compliance. Children’s hospitals often face challenges navigating health plan payment policies for MH/SUD services that are more complicated and restrictive than those imposed on medical and surgical (M/S) benefits, particularly around claims processing. One example is working with managed care plans in navigating the Health Behavior Assessment and Intervention (HBAI) CPT codes used to reimburse psychologists for providing psychological assessments, services and interventions to assist in the treatment and management of physical health conditions. Psychologists are often included in a care plan to provide such services during medical visits for patients with chronic medical conditions such as diabetes, obesity, or chronic pain to improve treatment adherence and outcomes, promote healthy behaviors, and provide safe, cost-effective care.

CMS has clearly defined HBAI codes and the circumstances for which they can be used; however coverage when such codes are used is consistently denied. A challenge is that, given Medicaid managed care plans often carve out mental and behavioral health services, the vendors contracted out to provide such services do not cover these codes. This is because HBAI codes are not neatly classified as "mental health"

services; rather, they are intended to be used as part of a primarily physical health diagnosis for which a mental/behavioral health issue is presenting and an assessment or intervention is needed. This results in a lack of accountability and ownership around the approval of these codes and the circumstances in which they should be billed, leading to a lack of clarity for pediatric providers around justification and pathways forward when such codes are denied.

Further, our health system has experienced challenges with managed care plans not enrolling the types of MH/SUD providers (e.g. PhD level psychologists) that are eligible to bill such codes given MH/SUD services are carved out from the plan, despite the fact that these code are intended to be billed through the medical plan. As such, managed care plans won't cover the services these psychologists provide, nor do the MH/SUD plans that are contracted out to deliver such services reimburse for the services delivered using these codes. This creates gaps in medical coverage and barriers in accessing the qualified psychologists (for whom the codes were specifically developed for) who can provide these services as part of an integrated care plan.

Additionally, prior authorization also plays a significant role in which MH/SUD benefits are accessible and should be a priority when reviewing parity for MH/SUD services in Medicaid. Specifically, prior authorization processes that present challenges to children's access to services should be prioritized for review. This can include examining different lengths of initial approval for certain MH/SUD services where prior authorization is required, the length of time it takes to receive a prior authorization for certain services, and the ability to get retro-authorization for services.

What are some measures or datapoints or other information that could help identify potential parity violations in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?

Time spent providing care and overhead costs are datapoints that can help identify potential parity violations in pediatric MH/SUD care. MH/SUD services require extra administrative work due to additional requirements for providers and the broader care team to obtain authorizations for services, screenings, and evaluations. Managed care plans sometimes require peer-to-peer review for certain tests and evaluations, typically after denials, which require additional time by providers to get approval for that service. Data should account for the provider's time during a visit, support staff time and the time entailed for providers needed to attempt a peer-to-peer review, since current reimbursement rates do not account for any of the additional time and administrative costs. Not only do these issues contribute to delays for children accessing MH/SUD care, but they also pose an administrative burden on pediatric providers who could be spending this time on patient care.

State Medicaid agencies should also measure prior authorization processing timelines/delays and denials for MH/SUD services compared to M/S services. This would include examining the time from submission of an authorization request from a provider to the payer's response, the number of requests for additional information for a prior authorization request from a payer to the provider, through to final disposition, and the initiation date of a service. Authorization or denial rates are helpful to examine, but it is the timeframe from when a provider determines that care is necessary to initiation of the service that impacts the child's care most.

Recommendations for assessing and improving parity requirements in Medicaid and CHIP

Based on our above comments, we offer the following recommendations for assessing and improving compliance with Medicaid and CHIP parity requirements:

- CMS should issue detailed guidance to states to improve 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. As part of this effort, we encourage CMS to include guidance on enforcement options related to plans that are not appropriately covering mental and behavioral health services, including codes for Health Behavior Assessment and Intervention services that are incorporated into care plans for patients with chronic medical conditions.
    - CMS 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.
- CMS should require insurers 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 mental health services, are insufficient, and insurer-maintained directories are often out-of-date or incomplete. This creates a significant barrier to children and youth accessing needed MH/SUD care.
- Providers should have a more streamlined and simplified process of reporting complaints. This would allow pediatric providers, including those from children's hospitals, to highlight key issues that contribute to noncompliance in pediatric MH/SUD parity, which would give states more accurate information in their parity assessments. CMS should also provide guidance to health care providers and families so that they can better understand and assess what it means to be compliant with MHPAEA's requirements.

Conclusion

Nemours appreciates your consideration of our comments and recommendations. Please do not hesitate to reach out to Daniella.Gratale@nemours.org or Casey.Osgood@nemours.org if we can be of further assistance.

Sincerely,

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