Schaeffer Initiative on Health Policy at BROOKINGS

December 4, 2023

Dr. Daniel Tsai
Deputy Administrator and Director, Centers for Medicaid & CHIP Services

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

Dear Dr. Tsai,

We appreciate your effort to seek comments on issues related to the assessment of compliance with the provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) and its regulations. Our comments focus on how Medicaid and Children's Health Insurance Program (CHIP) can build on recent developments in the regulations under MHPAEA for commercial insurance. The comments that we offer here are grounded in the fact that MHPAEA in Medicaid is entirely focused on Medicaid Managed Care Organizations (MMCOs) and the arrangements they use to manage behavioral health services.

We recognize that MMCOs use a variety of structural and administrative mechanisms to affect the utilization of behavioral health services. These can involve provider network size, as well as composition and utilization management tools, such as prior authorization and concurrent review, in addition to the design of nominal benefits. The Medicaid and CHIP Payment and Access Commission (MACPAC) and others have noted that the process of analyzing the use of non-quantitative treatment limitations (NQTLs), such as those noted here, is complex and burdensome for payers and states. The fundamental reason that the assessment process is burdensome is that it requires the review of numerous policies and procedures within each health plan and making judgements about the degree to which the policies for behavioral health services are more restrictive than those applied to medical/surgical services. To that point, our comments highlight how assessment and measurement of outcomes can effectively identify health plans where significant MHPAEA compliance problems may exist in a fashion that can reduce the administrative burden associated with the existing approaches to assessment of NQTLs. The remainder of this comment addresses barriers to accessing behavioral health care for Medicaid and CHIP beneficiaries as focal points for MHPAEA compliance.

Overall Access to Behavioral Health Care

Much has changed in the delivery of behavioral health care within Medicaid over time. The enactment of MHPAEA and the issuance of guidance and regulations to state Medicaid programs are one set of policy changes. Other changes include both general expansions in coverage through program growth, changes in the organization and financing of services, and

more focused attention on behavioral health care for adults and children. The pandemic served to make access to care more difficult for Medicaid beneficiaries. Yet data from the Medical Expenditure Panel Survey (MEPS) indicates that in contrast to reports from MACPAC and others,[1] behavioral health care utilization rates increased notably prior to the pandemic. Table 1 shows that from 2015 to 2018, there were increases in outpatient utilization rates ranging from 4.5% to 27% by age group.

Table 1: Utilization Rates of Outpatient Mental Health Care Among Those with Medicaid or CHIP

Age group	2015	2018	2021
12 and under	5.9%	7.5%	5.9%
13 to 17	17.8%	18.6%	23.1%
18 and older	16.0%	18.0%	17.4%

Source: Authors' analysis of MEPS data from 2015, 2018, and 2021. Reflects care visits with office-based providers or in the hospital outpatient setting.

In addition, even when considering that the nation was still in the midst of the pandemic in 2021, utilization rates remained flat (for children 12 and under) or increased (by 30% for adolescents aged 13 to 17 and 8.8% for adults aged 18 and over) since 2015. As such, progress has been made.

Focus on Access and Services Utilization Outcomes

The proposed rule entitled Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA) issued by CMS, directed to commercial insurers, highlighted a reorientation of the MHPAEA regulations towards evaluation of outcomes related to access to treatment for mental illnesses and substance use disorders (SUDs). We believe that applying outcomes standards consistently in evaluating adherence to MHPAEA will improve the effectiveness of the policy and strengthen the ability to enforce compliance with specific features of the regulations, such as NQTLs. Choosing a set of indicators based on services utilization can strengthen accountability associated with NQTLs, be deployed in a way that can reduce the burden on payers and bolster the approach to assessing network adequacy.

Example of Indicators

To illustrate the types of outcome measures that are at once practical to collect and potentially useful for assessing access to care, we created a table of simple indicators based on utilization information typically reported in claims and encounter data bases.

[1] Medicaid and CHIP Payment and Access Commission (MACPAC), Implementation of the Mental Health parity and Addiction Equity Act ion Medicaid and CHIP, Issue brief, July 2021.

Table 2: Utilization-Based Access Indicators of Mental Health Care and Primary Care Among Those with Medicaid or CHIP, by Age Group

	Utilization Share		Parity Indicator
	Mental Health Care	Primary Care	Ratio MHC/PC
Accessed care			
Overall	19.4%	62.9%	0.3
12 and under	11.4%	33.1%	0.3
13 to 17	23.4%	47.8%	0.5
18 and older	22.8%	80.9%	0.3
Accessed follow-up			
Overall	89.0%	74.9%	1.2
12 and under	88.4%	57.8%	1.5
13 to 17	95.0%	51.1%	1.9
18 and older	88.0%	81.1%	1.1
Care visits occurring with office-based providers			
Overall	94.5%	94.5%	1.0
12 and under	97.7%	95.0%	1.0
13 to 17	91.0%	96.4%	0.9
18 and older	94.4%	94.4%	1.0
Care visits occurring in hospital outpatient setting			
Overall	5.5%	5.5%	1.0
12 and under	2.3%	5.0%	0.5
13 to 17	9.0%	3.6%	2.5
18 and older	5.6%	5.6%	1.0

Source: Authors' analysis of MEPS data, 2018-2020. Reflects care visits with office-based providers or in the hospital outpatient setting. In the analysis, survey respondents are assigned to the age group consistent with their age in 2018. Respondents are included if they had ever been covered by Medicaid or CHIP during the three-year period.

Table 2 highlights how readily available utilization data can be used to assess adherence to the terms of MHPAEA. The data in the table is sourced from publicly available data files from MEPS, and the table is constructed based upon population averages. These data are like those captured by claims and encounter data collected by health insurance plans. The sample we used includes all visits to hospital outpatient departments or office-based providers for mental health care or primary care services included in the survey between 2018 and 2020, among those who had been covered by Medicaid or CHIP at some point during the three-year period. These visits correspond roughly to the outpatient, in-network category used in MHPAEA. The percentages reported on the table reflect utilization rates of various kinds. For example, among the overall sample, 19.4% of people use a mental health care service. Among those who accessed a mental health care service, nearly 90% received a follow-up visit. Such measures are basic indicators of care utilization for treatment of mental illnesses and SUDs. They can be

used to construct overall norms against which individual insurance plans can be evaluated. Regulators can designate the evaluation standard by identifying the appropriate point in the distribution of utilization to establish the benchmark.

Calculating the ratio of utilization of mental health care and primary care can help illuminate parity in care access. The observed ratio indicates the overall rates of utilization or follow-up care of mental health care relative to medical/surgical care. That ratio can serve as the benchmark for assessing potential compliance with MHPAEA for an individual health plan. For example, consider a health plan that had a utilization rate for children aged 13 to 17 of 10% for mental health care and a rate of 50% for general medical care for outpatient, in-network services; this would imply a parity indicator ratio of 0.20, well below the ratio of 0.5 reported in the table. That difference could be used to trigger further probing of the reasons for the apparent limitation on access to mental health care.

One implication of using such ratios is that it highlights that parity does not mean expecting a one-to-one correspondence between mental health and substance use disorder care and other types of medicine. Such measurements can also be used to probe other dimensions of access to care, such as follow-up treatment utilization by specific demographic groups. This approach to measurement could be implemented without much difficulty within each of the MHPAEA benefit classification groupings. The example also highlights how use of such outcome measures can reduce the burden on plans and states. That reduction would occur by limiting the detailed investigation of MHPAEA compliance to situations only in which there is evidence of differential access to care for people with behavioral health conditions.

Prioritizing NQTLs

In considering which NQTLs to prioritize, indicators of access as measured by utilization rates can also be useful. Variation in access related outcomes across plans according to the NQTLs that are in place can offer an empirical method of identifying the NQTLs that have the biggest impact on utilization patterns overall. Additionally, focusing on NQTLs based on their public health significance can also contribute usefully to prioritization. For example, a great deal of federal investment is being made to establish crisis infrastructure, yet the practices in commercial and some Marketplace-related plans suggest that there are impediments to accessing crisis-related behavioral health services.[2] The degree to which this is also the case for Medicaid could be determined and used to prioritize compliance activity. Likewise, in an era with a rapidly growing population of older adults, many of whom are low-income and qualify for Medicaid, home and community-based services (HCBS) are relied upon to support their needs if they experience functional impairment. However, utilization rates of HCBS by people experiencing mental illnesses and related functional impairment has been reported to be considerably lower than utilization rates of other segments of the population with functional impairment.[3] States appear to take very different approaches to including mental health care in

[2] See https://www.gao.gov/assets/gao-22-104597.pdf
[3] See https://www.macpac.gov/wp-content/uploads/2019/07/Twenty-Years-Later-Implications-of-Olmstead-on-Medicaids-Role-in-LTSS.pdf

their HCBS waiver scope of caregiving.[4] The importance of crisis services and HCBS are examples of areas of great public health significance and conducting targeted assessments of parity implementation in those areas can likely shed light on barriers to accessing care that may not have been considered otherwise.

Barriers to Access Among Medicaid/CHIP Enrollees as Focal Points for MHPAEA Compliance

Children and adults covered by Medicaid and CHIP experience unique barriers to accessing behavioral health treatment. In 2018, nearly half of non-institutionalized youth enrolled in Medicaid or CHIP who experienced major depressive episode (MDE) did not receive treatment.[5] However, adolescents that did receive treatment were more likely to receive treatment in institutional settings as opposed to outpatient care, compared to privately insured peers. Young people face barriers to accessing care due to the availability of providers. Youth that are Medicaid and CHIP beneficiaries are also more likely to receive non-specialty mental health services, such as those provided by a pediatrician. Yet, many pediatricians and general medical providers have limited training in behavioral health, such as in addiction medication administration. These observations indicate that network design in Medicaid may restrict the availability of specialty behavioral health services.

In 2021, 25% of Medicaid or CHIP beneficiaries aged 18 and older with any mental illness in the past year reported that they experienced a time when they needed mental health treatment or counseling in the past year but were unable to receive it; this share jumps to over 50% for adult beneficiaries with serious mental illness.[6] 36% report not being able to afford the cost of care as the reason for their unmet need, which is the most frequently cited barrier to access.[7] These problems with access to care and services suggest priority areas for directing attention to MHPAEA compliance efforts.

We appreciate CMCS seeking input on MHPAEA compliance as a means of promoting greater access to care. We hope you consider our comments for enforcing compliance with parity requirements in Medicaid and CHIP plans.

Sincerely,
Richard G. Frank and Chloe Zilkha
Brookings Institution, Schaeffer Initiative on Health Policy

[4] See https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges/
[5] See https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-3-Access-to-Behavioral-Health-Services-for-Children-and-Adolescents-Covered-by-Medicaid-and-CHIP.pdf
[6] Authors' analysis of 2021 National Survey on Drug Use and Health public use file.
[7] Authors' analysis of 2021 National Survey on Drug Use and Health public use file. This webpage notes that there is a copayment of $75 for institutional care at 100% federal poverty level (FPL), 10% of the cost between 101-150% FPL, and 20% of the cost for over 150% FPL. These results could be driven by the inability to pay for more expensive institutional care such as inpatient hospital or rehabilitation services: https://www.medicaid.gov/medicaid/cost-sharing/cost-sharing-out-pocket-costs/index.html