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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

Attention: 1210–AC11. Re: 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 more than 200 children's hospitals nationwide, we appreciate the opportunity to comment on the Department of Health and Human Services, Employee Benefits Security Administration and the Internal Revenue Service's (the Departments) proposed rule—*Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA)*. We applaud you for your work to further strengthen the implementation of the MHPAEA to help ensure that individuals' access to mental health and substance use disorder (MH/SUD) services is on par with their access to medical and surgical (M/S) services. 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 impede children and teen's access to needed mental health services.

The nation's children's hospitals are dedicated to advancing child health through innovations in the quality, cost and delivery of care—regardless of payer—and serve as a vital safety net for uninsured, underinsured and publicly insured children. We are regional centers for children's health, providing highly specialized pediatric care across large geographic areas.

We support many key provisions in the rule, but also note that there are areas where it can be strengthened to fully realize its promise of mental health parity for the close to 44 million children with commercial insurance. Our comments focus on those provisions in the rule with implications for children and youth in need of MH/SUD services and highlight their unique needs. They offer specific recommendations to help ensure that children and youth have access to

Champions for Children's Health

timely and appropriate services, across the continuum of care (prevention, intermediate levels of care, inpatient services, crisis services and community-based services), regardless of payer.

In particular, we urge the Departments to:

- Clarify that plan benefits for children and youth must be consistent with pediatric-focused clinical standards and guidelines and must include coverage of the full continuum of services, including prevention and early intervention services, as well as team-based care models. Furthermore, insurers must be held accountable to the MHPAEA Non-Quantitative Treatment Limitation (NQTL) requirements for coverage of developmentally-appropriate services even before a diagnosis is made.
- Require health plans to demonstrate that they contract with an appropriate number of trained mental health professionals and facilities that can provide mental and behavioral health services to infants, children and teens under the proposed rule's network composition standards.
- Require insurers to collect and evaluate wait times data and other metrics, in addition to time and distance, to assess network composition.

In addition, we are pleased that CMS has recognized that ensuring compliance with federal parity requirements in Medicaid and CHIP is fundamental to improving access to care and is seeking stakeholder input on assessing compliance with mental health parity and addiction equity in Medicaid and CHIP. 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 MH/SUD 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. As part of the EPSDT oversight required by the Safer Communities Act, we strongly recommend requiring states to assess their behavioral health continuum of care to help ensure that the EPSDT benefit meets its promise.

Mental Health Challenges Facing the Nations Children and Youth

The mental health challenges facing the nation’s children and teens continue to grow and our hospitals are seeing it firsthand in their emergency departments. Visits for youth suicide attempts have increased dramatically, eating disorder visits have doubled and we are seeing an increase in suicide rates for children and teens, with national data indicating steeper increases among Black boys and girls under age 12. As essential providers dedicated to providing the highest quality pediatric care, addressing the children’s mental health crisis is our top priority.

The statistics illustrate a troubling picture for our children. Prior to the pandemic, almost half of children with mental health disorders did not receive care they needed¹ and there was an alarming increase in children diagnosed with anxiety (27%) and depression (24%) between 2016 and 2020.² Since 2019, children’s hospitals have seen a 50% increase in emergency department visits related to suicide and self-injury and a 30% increase inpatient stays. This trajectory predates the pandemic, with emergency department visits for suicide and self-injury more than tripling since 2016.³ According to the Centers for Disease Control and Prevention, in 2021, 29% of teens reported experiencing poor mental health, while 4 in 10 reported feeling persistent sadness or hopelessness—an increase across all racial and ethnic groups.⁴ Trends related

¹ Daniel G. Whitney and Mark D. Peterson, “US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children,” *JAMA Pediatrics* 173, no. 4 (2019): 389-391, [doi:10.1001/jamapediatrics.2018.5399](https://doi.org/10.1001/jamapediatrics.2018.5399).

² Lebrun-Harris LA, Ghandour RM, Kogan MD, Warren MD. Five-Year Trends in US Children’s Health and Well-being, 2016-2020. *JAMA Pediatr*. Published online March 14, 2022. [doi:10.1001/jamapediatrics.2022.0056](https://doi.org/10.1001/jamapediatrics.2022.0056).

³ CHA (2023). Mental Health Trends Report (Analysis of CHA PHIS data from 2016-2022). Unpublished report.

⁴ “[Youth Risk Behavior Survey Data Summary & Trends Report](#),” Centers for Disease Control and Prevention, February 2023.

to suicide are particularly troubling, as 1 in 5 high school students contemplated suicide and 1 in 10 attempted suicide one or more times, in 2021.⁵

Tragically, far too many children are waiting for needed mental and behavioral health care and “boarding” in emergency departments until an appropriate placement becomes available. This is not limited to one state or one community—children in states across the country face similar challenges accessing the necessary mental health care to address their needs.⁶ Fifty percent of all mental illness begins before age 14⁷ and children often wait years between the appearance of symptoms and when they begin treatment, a delay that too often results in worsening conditions and outcomes.

While the COVID-19 pandemic certainly contributed to the crisis in child and adolescent mental health, we know that this problem and its root causes, which includes inadequate and restrictive insurance practices and a lack of a youth-specific mental health care across the full continuum of service needs, predate the pandemic. We also know that children experience better outcomes when their mental and behavioral health needs are identified earlier on, and they are connected to the care they need to manage their mental and emotional health. Unfortunately, health insurance plans often have gaps within the continuum of care for children and adolescents and a lack of coordination between existing providers and systems. At the core of a strong pediatric mental health care delivery system is a strong, interconnected network of pediatric mental health providers and supportive services, including team-based and other innovative treatment models, that deliver high-quality, developmentally appropriate care.

Strong enforcement of the MHPAEA is critical to the ability of children and youth to access needed mental health services without unnecessary delays due to plan limits or other requirements that are not applied to M/S coverage. It is vital that you move forward to finalize a parity regulation that truly ensures they have access to a full continuum of care.

Detailed Comments

Our detailed comments are below, along with our responses to several of the Requests for Information included in the rule.

Meanings of Terms

We believe the new and revised definitions in the Proposed Rule will significantly improve clarity and will increase access to care. The proposed changes to definitions of “mental health benefits” and “substance use disorder benefits” would ensure that coverage of benefits is consistent with “generally recognized independent standards,” which are tied to the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the mental, behavioral and neurodevelopmental disorders chapter of the International Classifications of Disease (ICD). The rule would also ensure that any state laws that define MH/SUDs in a manner that conflict with “generally recognized independent standards” do not reduce plan members’ protections under MHPAEA.

We urge the Departments to clarify that, for younger children, plans should also look to the *DC:0-5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*, a mental health diagnostic system specifically designed to address the developmental needs of children under age 5. Furthermore, the rule should clarify that “generally recognized independent standards” for children’s mental health services include clinical practice guidelines offered by pediatric professional societies, including the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule, Bright Futures Guidelines, the American Academy of Child and Adolescent Psychiatry (AACAP) Clinical Practice Guidelines; and other clinical practice guidelines.

⁵ Ibid

⁶ Ibid.

⁷ Substance Abuse and Mental Health Services Administration (SAMHSA), [Adolescent Mental Health Service Use and Reasons for Using Services in Specialty, Educational, and General Medicaid Settings](#), March 5, 2016.

At the same time, we remind the Departments of the critical importance of ensuring that children have access to early intervention and prevention services to address mental health needs that are identified by a screening but have not received a specific diagnosis. By some estimates, as many as 19% of children have mental health symptoms that impair their functioning without meeting criteria for a disorder.⁸

Insurers must be held accountable to the MHPAEA NQTL requirements for coverage of developmentally-appropriate mental health services even before a formal diagnosis is made. Unless insurers can demonstrate that they cover and fairly reimburse CPT codes for which there is evidence of effectiveness in preventing mental health conditions in children and addressing family risk factors, they should be found to violate the MHPAEA.

In addition, we are particularly pleased with the definition of eating disorders and autism spectrum disorder (ASD) as MH/SUD disorders. Children’s hospitals are seeing a dramatic increase in eating disorders amongst our youth. Compared to 2016, children’s hospitals across the U.S. in 2021 saw a nearly 100% increase in feeding and eating disorder inpatient visits for youth 10-18. For children and adolescents, eating disorders are now the third most common chronic health condition, behind only asthma and obesity in numbers.⁹ Inclusion of eating disorders in this rule can help ensure that the full continuum of needed mental health and physical health services to prevent and treat eating disorders amongst our children and youth is covered appropriately and adequately.

Requirements Related to Design and Application of the NQTL – Meaningful Benefits of Treatment of a Mental Health Condition or Substance Use Disorder

We support the provision that strengthens the 2013 final rule provisions that require a plan that covers MH/SUD benefits in any of the six benefit classifications to cover them in every classification in which M/S benefits covers them, and to do so in a “meaningful” way. We are particularly pleased that the rule requires the scope of covered MH/SUD benefits in each classification to be “meaningful” as well.

At the same time, we note that there often is a lack of clarity by plans on the breadth of MH/SUD services that must be covered as compared to their M/S benefit. Therefore, we urge the Departments to define “meaningful” to help prevent future disagreements or confusion about whether a covered benefit is, in fact, meaningful. Without a definition, insurers will likely interpret the “meaningful benefit” requirement narrowly, resulting in enrollees having no greater access to care and being forced to assert rights through the appeals process and/or litigation. Specifically, “meaningful” coverage should be defined as coverage of the full continuum of services, including preventive care, intermediate levels of care, inpatient services, crisis services and community-based services.

This definition is especially critical in pediatrics where pediatric well-child visits are covered under the M/S benefit without cost-sharing for patients, but coverage is not always available for preventive mental health visits. Early intervention and other preventive mental health services¹⁰ are often provided in primary care offices as part of an integrated behavioral health program. While a plan will cover the full range of pediatric preventive M/S services, they may only cover an MH initial screening, not the full early intervention range of services. That lack of insurance payment for early intervention is a major barrier to services for children and adolescents with emerging problems.

⁸ Foy JM, Green CM, Earls MF; Committee on Psychosocial Aspects of Child And Family Health, Mental Health Leadership Work Group. Mental Health Competencies for Pediatric Practice. *Pediatrics*. 2019;144(5):e20192757. doi:10.1542/peds.2019-2757.

⁹ American Psychiatric Association. [Special Report: Youth With Eating Disorders—Time Is of the Essence in Achieving Remission](#). Jan. 25, 2023.

¹⁰ Usually represented by the CPT codes 99401, 99402, 99403, and 99404.

In addition, the definition of “meaningful” benefits should include coverage of innovative care models, such as integrated, team-based, behavioral health models that provide immediate access to behavioral health treatment, including care coordination and care provided by mental health therapists, in primary care practices. That coverage should be for all aspects of the program.

In fact, it is not uncommon for families with private insurance to decline these proven, evidence-based services due to their potential out-of-pocket costs. To truly change the trajectory of pediatric mental and behavioral health, integrated and preventative care across physical and behavioral health is needed without separate systems or coverage terms for behavioral health compared to physical health.

Non-Exhaustive List of NQTLs

We support the revisions to the list of NQTLs, particularly those relating to “network composition” and the specific list of medical management techniques. Children’s hospitals often face administrative burdens associated with medical management policies, such as prior authorizations, concurrent and retrospective reviews, and approvals for care transitions that do not exist to the same extent for coverage of treatment for physical health conditions. These additional requirements are time-consuming for providers to navigate and can lead to delays in care for children and slower claims processing.

We also urge the Departments to add “scope of covered services” as an identified NQTL to the list. As noted above, insurers commonly limit the scope of services within the benefit categories – a practice that meets the statute’s definition of a treatment limitation. Those limits mean that a child may not have access to the full continuum of needed MH services, from preventive to partial hospitalization to follow-up services, whereas that range of services would be covered under their M/S benefit.

Standards for Evaluating NQTLs

We strongly support the provision to require insurers to collect and evaluate relevant quantitative data to determine how a NQTL impacts access. The Departments are appropriately bringing the focus of NQTL analyses back to the fundamental purpose of MHPAEA – addressing disparities in access to MH/SUD care.

We are particularly pleased that the Departments are requiring insurers to collect data on the number and percentage of relevant claims denials, reimbursement rates and payment policies and procedures. Inappropriate denials and lengthy appeals processes can delay and prevent child patients from receiving necessary care, place additional stress on the family/caretaker who has to navigate the appeal process, and lead to delayed treatment and worse outcomes.

Furthermore, 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 M/S benefits, particularly around claims processing. For example, though prior authorization is required for both M/S and MH/SUD inpatient services, some children’s hospitals report that they must provide additional documentation after the first day of an inpatient mental health stay, while medical stays are approved for seven days. In addition, it is common for payers to retroactively authorize certain M/S services but not for MH/SUD services. The additional documentation requirements and lack of retroactive authorizations are factors that lead to children in crisis staying in the emergency room longer than necessary as the pending authorization prevents their transfer to a more appropriate site of care (e.g., an inpatient bed).

We encourage the Departments to provide standardized definitions and methodologies for the collection and evaluation of this data, particularly the data related to current reimbursement rates and payment policies and procedures. Data should be collected on the extent of prior authorization and other medical management requirements; the time it takes for a determination on a prior authorization request to be provided, including the time for appeals to be adjudicated; and denial rates for prior, concurrent, and retroactive authorizations.

We support the prohibition against insurers relying on historical plan data from a time when coverage was not subject to MHPAEA or was in violation of MHPAEA, such as calculating reimbursement rates using historical reimbursement data. Reimbursement rates have historically been lower for mental health services, particularly for pediatric mental health services, leading to provider shortages and lack of access for children in need of services.

It is also critical that the Departments specifically include the collection and evaluation of 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 MH/SUD 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, the evaluation of NQTLs must include a requirement that insurers conduct specific data collection and analyses related to the use and application of clinical guidelines. The Departments should require that insurers make available any criteria/guidelines they use to federal and state regulators and enrollees. Specific data should be collected and evaluated on:

- How the MH/SUD criteria/guidelines they use diverge from “independent professional medical or clinical standards,” including pediatric-specific guidelines.
- The use of medical necessity/appropriateness determinations. Data should be collected on the number of authorizations and denials issued for children and youth across the spectrum of care, including after a determination of medical necessity. Data should also be collected and evaluated on the average length of stay and treatment duration.

We also strongly support the requirement that plans/issuers take “reasonable action” to address differences in access shown by this data and are pleased that the rule specifies actions that would be considered “reasonable,” including:

- Ensuring that special effort is taken to contract with a broad range of MH providers who are available by authorizing greater compensation or other inducements.
- Expanding telehealth to address regional shortages.
- Ensuring that plans reach out to treating providers to see if they will enroll in the network.
- Ensuring provider directory accuracy.
- Notifying enrollees about toll-free numbers for assistance in finding a provider.

However, we are concerned that reasonable action would only be necessary when such differences are “material,” which is not defined. We urge the Departments to require plans to take action whenever the data shows *any* difference in access. If the Departments choose to maintain a “material differences” standard, we recommend that it be narrowly defined so it does not impede access to needed care.

Furthermore, under the rule, insurers that can demonstrate that the material differences in access to MH/SUD services compared to M/S are due to provider shortages plans will not be held out of compliance with the NQTL parity requirements. While we concur that there are serious shortages of mental health service providers, particularly in pediatrics, we urge the Departments to adopt very stringent standards for the documentation that insurers must provide to substantiate a claim that the differences are attributable to a true shortage and not to contracting and reimbursement practices. Insurers must be able to demonstrate their actions to contract with, and adequately reimburse, all appropriate levels of providers who have the training to provide the requisite services. Strict requirements for plans to substantively prove that a shortage of providers is the primary cause of an accessibility issue will help curb inappropriate use by insurers of this flexibility.

Special Rule for NQTLs Related to Network Composition

We support the proposed rules relating to “network composition” and the higher level of scrutiny that will be afforded to network-related NQTLs, including:

- Standards for provider and facility participation in the network.
- Methods for determining reimbursement rates.
- Credentialing standards.
- Procedures for determining whether the network includes an adequate number of each type of provider and facility to provide coverage under the plan.

Currently, it is not unusual for health plans to have many fewer pediatric providers at all levels of care in their mental health networks than they do in their M/S networks. In fact, inadequate networks are one of the most significant barriers to children and youth accessing needed MH/SUD care, particularly step-down services, such as partial hospitalization and intensive outpatient programs. These intermediate levels of care meet the needs of children and teens in crisis so they may safely return home.

Robust pediatric network adequacy standards and assessments are a key aspect of ensuring compliance with the MHPAEA by private payers. To ensure that the proposed rule’s network composition standards work for children and youth, they must include specific requirements that health plans demonstrate they contract with, and adequately reimburse, an appropriate number of trained mental health professionals and facilities across the care continuum (including intermediate levels of care), with expertise in a range of child and adolescent mental and behavioral health diagnoses, who are capable of treating children at their various stages of development (i.e., infancy, early childhood, school-age, adolescence).

We are pleased that the data collection requirements related to network composition include claims data on in-network and out-of-network utilization rates; network adequacy metrics; data on providers accepting new patients; and provider reimbursement rates. However, it is important for the Departments to recognize that a sole reliance on time and distance standards is not appropriate for the assessment of network adequacy in relation to inpatient pediatric providers, given the regionalization of pediatric inpatient care. Therefore, insurers must be required to collect and evaluate wait times data (including relative wait times between referrals and appointments), ratios of contracted pediatric providers to enrollees in different regions, and other metrics appropriate for the accurate assessment of pediatric provider network composition.

Furthermore, network adequacy reviews should examine limitations/exclusions related to facility types – such as residential treatment programs and partial hospitalization programs – and innovative models of care, including team-based models. They should also assess claims processing policies and payment rates. Reimbursement delays due to overly burdensome utilization reviews and slow and complicated claims processing, combined with historically low reimbursement rates, are contributing factors to pediatric mental health providers not participating in private plans’ provider networks.

We understand that the Departments plan to provide additional guidance on the data that will need to be collected and evaluated by insurers to demonstrate the adequacy of their provider networks. We respectfully remind the Departments that children are not little adults and their mental health needs and service delivery system is different from that of adults. As you move forward on the establishment of those data requirements, we urge you to work closely with pediatric mental health experts to ensure that they adequately reflect those differences so children and youth have true access to mental health services as promised under the MHPAEA. Our more detailed comments are provided in our response to the Departments’ *Technical Release on Network Composition*.

Effect of Final Determination of Noncompliance

We strongly support the provision that gives the Departments the authority to direct an insurer to stop imposing an NQTL if it is found to be in noncompliance and recommend that the rule clearly specify that states also have this authority. We believe the regulatory language can be strengthened to ensure compliance by change the “may” to a “shall” to indicate that the plan will not be permitted to apply a non-compliant NQTL. We also urge the Departments to clarify that, if an insurer cannot demonstrate that an NQTL is compliant, it should not be allowed to be imposed.

Exception to NQTL Requirements

We urge the Departments 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. While we appreciate the Departments’ statement in the preamble that the exceptions are meant to be “narrow,” we believe they open the door to insurers implementing significant benefit exclusions and administrative barriers to services.

Children and youth needing MH/SUD care must have access to the most clinically and age-appropriate care and it is critical that payers do not impose unwarranted limits on that care through NQTLs that misrepresent those standards or are based on inappropriate standards. As noted above, it is critical that the definitions of what is considered “generally recognized independent clinical standards” for pediatrics reflect the expertise of pediatric providers and that the necessity of care is not tied to a diagnosed mental illness. For example, children may need mental health treatment for grief or trauma, without having a diagnosed disorder. By removing the “independent professional medical or clinical standards” exception and creating a strong definition for this term that is tied to pediatric nonprofit professional association criteria/guidelines, the Departments can ensure that access to needed services is not impeded.

Furthermore, 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 Departments’ attempts to create a “fraud, waste, and abuse” exception to the NQTL requirements, as there is a very high risk of overuse or misuse by insurers. While we support insurers’ legitimate efforts to combat, prevent and detect fraud, waste, and abuse, this proposed exception compromises the rule’s otherwise strong NQTL requirements.

NQTL Comparative Analysis Requirements

We support the addition of new requirements related to the NQTL comparative analyses that insurers are required to conduct under the Consolidated Appropriations Act of 2021. These detailed requirements are necessary to ensure there is clarity on what insurers’ analyses must contain and to hold plans accountable for following these requirements. We urge the Departments to require insurers—as part of their corrective action plans when they are found to be in noncompliance—to identify and notify affected enrollees and reprocess any claims.

Treatment Of Non-Federal Government Plans

We support the language implementing the elimination of self-funded non-federal government plans’ ability to opt out of MHPAEA. The end of the opt-out represents important progress towards ensuring that public employees and their families have MHPAEA protections.

Requests for Information

- **Are there ways to enhance access to MH/SUD services through provider directory standards, particularly in underserved and rural areas where internet access may be limited?**

We urge the Departments to require provider directories to explicitly indicate pediatric MH/SUD providers, those that are accepting new patients and those that are available via telehealth. Independent third-party testing of provider directories—including through the use of secret shoppers—should be done on a regular basis (at least quarterly) to assess the accuracy and appropriateness of information. We recommend that the Departments look to the proposed

Medicaid Managed Care rule, *Managed Care Access, Finance, and Quality (CMS-2439-P)*, and adapt its strong provider directory standards and monitoring and oversight standards.

In addition, we recommend that the Departments ensure that enrollees who do not have timely access to a needed provider due to an inaccurate directory or an inadequate network have timely access to out-of-network services. In these circumstances, requirements must be in place to protect enrollees from any additional out-of-pocket costs above what they would have paid for an in-network provider. Insurers should also be required to operate call centers so enrollees with limited internet access can call a single number to reach a well-trained person who can help them find a provider, including out-of-network services if necessary. For ease of use, plans should use the same call center number for both mental and physical health services.

- **How can the Departments use telehealth to enhance access to MH/SUD treatment for both routine and crisis care under existing authorities, including through parity requirements?**

Providing mental health services through telehealth has been a crucial means of connecting children and adolescents to mental and behavioral health care services. As the youth mental health crisis persists, it is vital that CMS ensure beneficiaries have continued access to mental health services via telehealth. Telemental health services have been described as an ideal application of digital health services. These services are complementary and synergistic to in-person care and in some cases have enhanced care delivery, providing insights that clinicians would not see otherwise, such as being able to do more frequent mental health care check-ins. Furthermore, anecdotal experience indicates patients may be more comfortable seeking behavioral health services using video or audio-only modalities and no-show rates for these types of appointments have declined.

Telehealth has also been an important tool for prescribing needed medications and for ensuring the **continuity of medication/long term management of conditions, particularly in rural areas**. Often there are no behavioral health providers located in pediatric patients' communities and telehealth provides access to regular needed care without having to travel far distances.

We know that private insurers often adopt Medicare policies and were pleased that the proposed CY 2024 Physician Fee Schedule rule implements the Consolidated Appropriations Act of 2023 provision to delay the requirement for an in-person visit with the physician or practitioner within six months prior to initiating mental health telehealth services. We believe these and other regulatory telehealth flexibilities should be permanently adopted by private payers so commercially covered children and youth have access to appropriate telemental health services. We urge the Departments to require private payers to adopt these policies and encourage you to assess the impact of how making these telehealth flexibilities permanent may impact the pediatric population and their access to high-quality mental health services for children.

At the same time, we caution that telemental health services may not be appropriate for some populations (such as children of younger ages). Furthermore, requiring plans to cover and reimburse for telemental health services, should not absolve them of their obligation to ensure adequate in-person access to services across the care continuum and for all ages.

- **How can the Departments leverage ERISA's and the Affordable Care Act's existing claims procedure requirements to help facilitate access to mental health and substance use disorder benefits?**

We appreciate the Departments' interest in ensuring that MH/SUD claims procedures, including enrollee processes for disputing denials align with existing protections. First, we believe plan's complete comparative analyses of their NQTLs must be made available to enrollees upon request. That information is critical to an enrollee's ability to submit an appeal of an inappropriate MH/SUD claims denial. Any adverse benefit determinations and the related

explanation of benefits should include clear instructions on how to request and receive any NQTL compliance analysis(es) related to the determination.

In addition, in the event of an authorization denial for a specific level of care, the insurer must be required to provide an explanation of how a particular NQTL was applied to particular benefits. There also must be a requirement that the insurer identify a lower level of care that it believes would be more appropriate, along with information related to the coverage of such service in the plan and the availability of network providers to deliver the lower level of service. In the case of pediatric MH/SUD services this information must be pediatric-appropriate. The Departments should put in place meaningful enforcement mechanisms to ensure that insurers fulfill their obligation to provide participants/beneficiaries with legally required and meaningful information, upon request

- **Crisis services**


- **Are there ways to increase access to crisis services within existing authorities, including in rural and underserved areas?**
- **How should community-based behavioral health crisis services be classified in relation to the six M/S benefit classifications and what are those services?**
- **Should crisis services, including mobile crisis and call center services, be specifically delineated as a covered service in the ACA's Essential Health Benefits?**
- **How can parity in crisis services be strengthened including in areas where there are provider shortages?**

Federal policymakers have dedicated enormous effort to standing up the 988 Suicide and Crisis Lifeline and expanding MH/SUD crisis services, which help people get the help they need and avoid needless, and often tragic, encounters with law enforcement. While every ACA Essential Health Benefit (EHB) benchmark plan includes EMS and emergency transport services, very few include mental health crisis (i.e., emergency) response or crisis stabilization services. The full array of crisis services should be covered, and adequately reimbursed, by all payers. A number of states, including [California](#), [Virginia](#), and [Washington](#), have recently required health plans to cover MH/SUD crisis services. In particular, Washington has made clear that [coverage of MH/SUD crisis services is necessary for health plans to comply with MHPAEA](#).

Additionally, when finalizing this rule, we encourage the Departments to make clear that, if a plan/issuer covers physical health emergency services (including EMS and emergency transport), it must cover comparable MH/SUD emergency/crisis services (including mobile crisis response) under the same standards (e.g., no prior authorization) and based on the patient/family's definition of "crisis".

In conclusion, we applaud you for releasing this critically important rule. We look forward to working with you to ensure that it fulfills its promise of ensuring mental health parity for the close to 44 million children with commercial insurance. Should you have any questions or need further information, please reach out to Jan Kaplan at jan.kaplan@childrenshospitals.org or 202-753-5384.

Sincerely,



Aimee Ossman
Vice President, Policy
Children's Hospital Association