NAMD
National Association of Medicaid Directors

December 4, 2023

Chiquita Brooks-LaSure
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on your Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP.

Parity regulations prohibit health plans, including Medicaid managed care organizations (MCOs), from applying more restrictive financial requirements or treatment limitations to mental health and substance use services (MH/SUD) than they apply to medical and surgical benefits (M/S). NAMD strongly supports the aim of ensuring that Medicaid members have access to mental health and substance use services. However, Medicaid Directors report that current processes for assessing compliance with parity requirements are ineffective, confusing, and burdensome.

NAMD recommends that CMS:

- Clarify and streamline processes for assessing compliance, including by providing technical assistance, templates, and model language.
- Provide clarity on federal expectations around which or how many non-quantitative treatment limitations should be assessed.
- Engage with Medicaid Directors, providers, and academic researchers to assess which measures reliably indicate potential parity violations.
- Work across federal agencies to address other factors that reduce access to behavioral health services, including workforce shortages, housing instability, and federal policies like the "institutions for mental diseases" exclusion.

NAMD is a professional community of state leaders who provide health insurance to almost 90 million individuals and families through Medicaid and the Children's Health Insurance Program in each of the 50 states, the District of Columbia, and the U.S. Territories. NAMD elevates thought leadership on core and emerging policy matters, amplifies the experience and expertise of Medicaid and CHIP directors, supports state programs in continuous improvement and innovation, and optimizes federal-state partnerships to help millions live their healthiest lives.

Parity Regulations are Overly Complex and Compliance Assessments are Ineffective

Medicaid Directors report substantial challenges with the current framework for assessing compliance with parity requirements. Parity regulations are complex and rely on the "predominant/substantially all" test, which is difficult to translate into usable assessments. Medicaid agencies describe their efforts to implement the 2016 final rule and monitor compliance ongoing as requiring substantial staff time, deep expertise on parity within the agency, and contracts with external organizations. Medicaid agencies also report that managed care organizations (MCOs) require a significant amount of technical assistance to accurately complete compliance assessments and that external stakeholders are consistently confused over what constitutes a parity compliance issue. These challenges are particularly acute in states/territories with high numbers of MCOs and where MH/SUD benefits are in a different delivery system than M/S benefits (e.g., carved into fee-for-service).

This level of administrative burden may be warranted if parity requirements were driving substantial improvements in access to behavioral health services. However, Medicaid Directors report that they do not find substantial compliance issues with quantitative treatment limitations (QTLs) and financial requirements. Quantitative treatment limitations – such as copays and hard limits on visits – are often set by the Medicaid agency, not by the managed care organization. This limits the utility of compliance assessments for QTLs and financial requirements.

In contrast, Medicaid agencies report that monitoring non-quantitative treatment limitations (NQTLs) – such as prior authorization and medical necessity criteria – is important, as MCOs set these standards. However, Medicaid agencies indicate substantial challenges in assessing compliance with NQTLs. Under the current regulation, the potential universe of NQTLs that could be examined is quite large (utilization management, provider network processes, reimbursement rates, prescription drug formularies, etc.). In the absence of clearly stated federal expectations, Medicaid agencies have no way of knowing if their NQTL analyses are comprehensive enough to meet the regulatory requirement, which makes it difficult to develop a standardized process that can be used year-over-year.

Addressing these challenges may ultimately require simplifications to the underlying parity regulations. In the absence of regulatory change, CMS should consider strategies to streamline compliance processes, identify priority NQTLs, and clarify compliance requirements to MCOs and providers.

Strategies to Clarify and Streamline Compliance Documentation Processes (Question 1)

In the RFC, CMS seeks comment on strategies to improve the efficiency and effectiveness of compliance documentation. As discussed above, Medicaid Directors report that developing compliance assessment processes is difficult and requires substantial staff time. CMS should provide additional tools and technical assistance to support Medicaid agencies in their compliance efforts.

CMS should consider providing:

- **An expanded toolkit for parity compliance**, including plain language descriptions of federal requirements, best practices around identifying metrics for review, and a recommended set of NQTLs.
- **A protocol review tool** to focus state/territory review on specific measures and NQTLs.
- **Standard definitions of common NQTLs** to support alignment across states/territories and MCOs.
- **A template to document instances of non-compliance.**
- **Model parity language** to include in MCO contracts.
- **A CMS parity consultant** who can provide one-on-one TA to states and territories.

States/territories also report a need for clarity on specific circumstances that are not contemplated in the parity regulation. Medicaid agencies highlight specific questions around assessing compliance for alternative benefit plans (ABPs) and assessing compliance in situations where different payment methodologies (e.g., diagnosis-related groups) are used for MH/SUD versus M/S benefits. Medicaid agencies also note questions around assessing compliance in situations where MH/SUD services and M/S services are administered through different delivery systems, as the federal standards for authorization review determination timeframes are different for fee-for-service and managed care. As noted above, CMS should contract with a full-time parity consultant who can provide one-on-one TA to states and territories on these types of situations.

Additional tools should be developed with input from Medicaid agencies and external experts, including accreditation partners like URAC. **NAMD strongly recommends that, if CMS issues any templates, toolkits, or models, the use of these resources be optional for Medicaid agencies.** While some Medicaid agencies report the need for additional federal support, other agencies have already invested substantial resources in developing high-performing compliance processes, often in partnership with external experts. CMS should ensure that any new resources build on learnings from, and do not disrupt, states/territories with high-performing compliance frameworks.

CMS should also look for areas where redundancy in compliance documentation can be reduced. For example, one Medicaid agency notes that some of their managed care

organizations offer coverage for Medicaid members ages 21 and older, Medicaid members ages 20 and younger, and CHIP members. Per the federal requirements, these services are split into three benefit packages with three separate compliance reviews. However, plans typically have the same NQTLs across these benefit packages, meaning that they submit the same tool with identical information. Allowing MCOs to combine their analyses when responses are identical across benefit packages would reduce administrative burden on Medicaid agency staff and MCOs.

Strategies for Determining Whether Coverage Policies are Comparable (Question 2)

Medicaid agencies report a variety of strategies for comparing coverage policies across MH/SUD and M/S benefits. These include requiring MCOs to submit data on service authorization and appeal rates, reviewing member and provider materials such as handbooks, and direct communication with providers and members. One state also reports using URAC's ParityManager tool to collect information on NQTLs.

Identifying Compliance Challenges with Non-Quantitative Treatment Limitations (Questions 3 – 5)

CMS seeks comment on strategies for identifying high-priority NQTLs. As discussed above, Medicaid agencies report challenges with their NQTL compliance analyses. The potential universe of NQTLs that could be evaluated is large and Medicaid agencies report confusion over which and how many NQTLs they are expected to analyze. Without clarity on federal expectations, Medicaid agencies are continually uncertain if their NQTL analyses are comprehensive enough or if they will be expected to add additional metrics each year; this makes it difficult to develop a standard compliance tool and train MCOs on accurate reporting.

To address this challenge, CMS could work with Medicaid agencies, providers, and accreditation partners to develop a list of recommended NQTLs and associated definitions. If a Medicaid agency uses this recommended list, they should be given CMS's assurance that their NQTL analysis is comprehensive enough to meet federal expectations. This would promote standardization across states/territories and reduce confusion over which NQTLs should be prioritized.

Medicaid Directors report that they consider utilization management policies (prior authorization, fail-first or step therapy, etc.), provider credentialing standards, and medical necessity criteria to be higher-priority NQTLs. Some states also evaluate reimbursement rates, non-quantitative service limitations (e.g., prohibitions on same-day claims), and tiered drug formularies. **If CMS does pursue efforts to more formally define high-priority NQTLs, NAMD strongly recommends engaging with Medicaid agencies, providers, and accreditation partners to gather additional feedback.**

Measures that May Indicate Potential Parity Violations (Questions 6 & 7)

In the RFC, CMS seeks comment on various measures that may be used to identify potential parity violations, including comparisons of coverage denials, appointment wait times, payment rates, prevalence rates of conditions vs. percent of members receiving treatment, time from receipt of claim to payment of claim, and providers actively submitting claims across MH/SUD and medical/surgical providers.

Medicaid Directors underscore the complexity of identifying potential parity violations from these types of data. Although these measures may provide important information about access to services and provider experience, they do not independently indicate parity compliance issues. Medicaid Directors note that many factors could lead to differential rates between MH/SUD and M/S benefits, including workforce availability, stigma, and provider behavior. For example, research indicates that many individuals do not seek out substance use treatment due to fears of legal repercussions and social stigma; this likely results in a larger treatment gap (i.e., individuals with SUD who are not receiving treatment) for SUD than for other medical conditions. Similarly, Health Resources & Services Administration (HRSA) data indicate acute workforce shortages among mental health providers; this likely drives increased appointment wait times for mental health providers as compared to primary care. Finally, Medicaid agencies note that it is appropriate for different provider types to receive different rates for different services, so rates may be different across MH/SUD and M/S providers without indicating a parity issue.

CMS also seeks comment on measures related to provider network composition and admission, including methods for determining rates, credentialing standards, and procedures to ensure network adequacy. Medicaid Directors generally agree that examining credentialing standards and provider enrollment processes is important for identifying potential parity violations. However, it is important to note that differences in these measures across MH/SUD and M/S benefits may not necessarily indicate a parity violation; for example, shortages in child psychiatrists may lead to network adequacy challenges, even if the MCO is offering competitive rates and has appropriate provider enrollment processes.

Before requiring certain measures or datapoints, NAMD strongly recommends that CMS engage with Medicaid Directors, providers, and academic experts to better understand which measures reliably indicate parity issues. Requiring Medicaid agencies to collect and submit a wide range of access data would be inefficient if those data are not effective at identifying parity violations; CMS should explore if data that Medicaid agencies already report (such as MCPAR managed care reporting and CCBHC reporting) can be used to identify potential parity violations. Medicaid agencies would also need information on how to determine if disparities in these measures indicate a true parity violation or are caused by another factor, such as workforce shortages.

Processes for Assessing Potential Parity Violations (Question 8)

As discussed above, Medicaid agencies note that many of the access measures proposed by CMS do not directly indicate parity violations. CMS should provide additional guidance on which measures most reliability indicate potential parity violations and how to determine if a disparity on a measure indicates a compliance issue or is due to an external factor, such as workforce shortages.

Generally, states and territories indicate that when they identify a parity violation, they place the managed care organization on a corrective action plan and require documentation of remediation of the issue. If a plan fails to resolve a corrective action plan, the state/territory can use enhanced monitoring (with additional technical assistance and more frequent meetings) and, if that fails to resolve the issue, administrative or monetary penalties.

Additional Processes for Assessing Compliance (Question 9)

CMS seeks comment on additional processes for assessing compliance with Medicaid and CHIP parity requirements. **NAMD recommends that CMS not conduct random audits of Medicaid agencies around parity compliance.** As discussed above, Medicaid agencies report substantial confusion over federal expectations for compliance analyses. Without clarity on federal expectations, random audits would be challenging for Medicaid agencies and may not drive meaningful improvements in access.

Instead, CMS should consider strategies that empower Medicaid agencies to advance parity compliance efforts. This could include the guidance, toolkits, and templates discussed above. CMS could also consider allowing states to leverage their External Quality Review Organizations (EQROs) to support parity compliance assessments. Finally, Medicaid agencies recommend that CMS develop and fund a behavioral health ombudsman program.

Barriers to Access and Parity (Questions 10 & 11)

CMS seeks comment on barriers to mental health and substance use treatment for Medicaid members. States and territories report that workforce challenges and provider availability are the largest barriers to care. CMS should work with their partners at HRSA, DOL, and other federal agencies on workforce solutions, and with their partners at the Drug Enforcement Administration (DEA) to support increased access to medications for opioid use disorder. Guidance on strategies to integrate behavioral health services into primary care would also be helpful.

Medicaid agencies also note that housing instability and other health-related social needs are major barriers to mental health and substance use treatment. NAMD supports CMS's efforts to allow Medicaid agencies to fund housing supports and other

services through 1115 waivers and other authorities. CMS could explore administratively simpler strategies to cover these services, and could work with federal agencies like the U.S. Department of Housing and Urban Development (HUD) and the Substance Abuse and Mental Health Services Administration (SAMHSA) on efforts to increase access to housing and other social services for individuals living with behavioral health conditions.

Finally, Medicaid agencies raise specific access concerns around residential treatment for mental health and substance use conditions, including residential substance use treatment and residential services for children with high acuity and medical complexity. These access challenges may be driven by a variety of factors, including provider availability, medical necessity determinations, and medical clearances. However, it is important to note that federal regulations limit access to inpatient MH/SUD services; per the 2016 managed care final rule, Medicaid members can only receive inpatient MH/SUD care in an IMD for 15 days per month – a restriction that is not applied to medical and surgical benefits. Medicaid members should have access to the full continuum of care for mental health and substance use conditions, including inpatient care when it is clinically appropriate. NAMD recommends that CMS explore flexibilities under current regulations (such as the Section 1905(h) flexibilities for children under age 21) to lower federal barriers to inpatient care.

For a comprehensive overview of NAMD's recommendations related to mental health and substance use, please reference our 2022 letter to HHS.

Conclusion

Medicaid Directors strongly support CMS's aim of ensuring that Medicaid members have access to mental health and substance use services. However, Medicaid Directors report that current processes for assessing compliance are confusing and burdensome. CMS should explore strategies, including technical assistance, templates/compliance tools, and policy simplifications, to streamline the compliance process. Medicaid Directors report specific challenges around determining which and how many NQTLs they should assess; CMS could consider creating a recommended list of NQTLs to clarify federal expectations.

Although parity regulations aim to increase access to mental health and substance use services, their jurisdiction is limited to managed care organization's policies and processes. Medicaid Directors report that other factors, including workforce availability, a lack of affordable housing, and federal restrictions, represent more significant barriers to behavioral health services than parity compliance issues.

Thank you for the opportunity to provide comments. NAMD looks forward to continuing to work with CMS to ensure Medicaid members have access to high-quality mental health and substance use services.

Sincerely,

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