NAMD
National Association of Medicaid Directors

December 2, 2024

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, the National Association of Medicaid Directors (NAMD) is pleased to offer comments on the Centers for Medicare and Medicaid Services' (CMS) Request for Comments on Templates for Documenting Compliance with Mental Health Parity and Addiction Equity Act Requirements 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 benefits (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. Additionally, parity regulations fail to address the underlying factors that inhibit access to mental health and substance use services, including the provider workforce, a lack of affordable housing, and federal restrictions.

In September 2024, CMS issued a set of templates and instructional guides to document compliance with parity requirements. **NAMD strongly recommends that CMS make use of these templates optional.** While some Medicaid agencies report that the templates would be helpful, other agencies have already invested substantial resources in developing high-performing compliance processes, often in partnership with external experts. Mandatory use of the templates would disrupt these existing high-performing compliance processes.

If CMS does finalize mandatory use of these templates, they should give states and plans substantial time (18 – 24 months) for implementation. This extended implementation deadline would give Medicaid agencies time to train managed care plans on correct use of the templates and ensure data quality.

NAMD is a professional community of state leaders who provide health insurance to almost 80 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.

You can find NAMD's responses below to the specific questions detailed in the Request for Comments. Thank you for the opportunity to provide feedback. 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,

Lisa Lee
NAMD Board President
Commissioner
Kentucky Department for Medicaid Services

Melisa Byrd
NAMD Board President-Elect
Medicaid Director
DC Department of Health Care Finance

Specific Questions for Comment

1. *Do the templates adequately incorporate all the MH/SUD parity requirements that apply to Medicaid managed care, Medicaid ABP, and CHIP?*

   Yes, these templates adequately incorporate all MH/SUD parity requirements in statute and regulation.

2. *Do the templates and instructional guides help to clarify and standardize the information that states are required to submit to CMS to demonstrate compliance with MH/SUD parity requirements in Medicaid managed care, Medicaid ABPs, and CHIP?*

   Medicaid agencies report that the templates accurately reflect MH/SUD parity requirements and may be helpful for some states. **However, use of these templates should be optional, as some Medicaid agencies have already invested substantial resources in developing high-performing compliance processes.** These state-developed frameworks often reflect local conditions, such as behavioral health benefits with state-specific medical necessity criteria. Mandatory use of these templates would disrupt existing processes. Alternatively, if CMS does finalize mandatory use, they could create an exception for states who have high-performing compliance frameworks in place.

   CMS should also clarify next steps after the templates are completed, including: 1) if CMS plans to provide feedback on completed templates; and 2) if states will be expected to use the information from the templates to produce final report summaries for publication on their websites.

3. *Are the requests for information in the templates clear and easy to follow? Are there additional explanations or examples CMS should consider adding to the instructional guide(s)?*

   CMS should provide additional examples of completed templates, including:

   - More complex examples or examples based off real-world parity analyses. Medicaid agencies note that the examples provided in the instructional guides, although helpful, are simpler than typical parity analyses. For example, the instructions for completing item C-2 on the “C_All Limits” tab are unclear and do not reflect real-world scenarios.
   - Examples of fully completed analyses for medical/surgical benefits as compared to mental health/SUD benefits. These examples should include inpatient, outpatient, and pharmacy benefits.

- Examples of completed templates for different types of delivery systems, including fully managed care systems, hybrid fee-for-service/managed care systems, and fully fee-for-service systems.
- Examples of completed NQTL tabs if the state determines the strategies, evidentiary standards, and/or processes are comparable but not identical, and/or if they are no more stringent but not identical.
- Examples of, or additional instructions related to, stringency assessments.

For ease of use, **CMS should consider embedding the examples of strategies, evidentiary standards, and processes into the templates themselves**. This may increase data quality.

Finally, **CMS should provide trainings, office hours, and technical assistance on the use of the templates**. This would help ensure consistency in how states and plans use the templates. Medicaid agencies report specific technical assistance needs around how to work with plans operating in rural or remote areas where benefit limitations or network adequacy may impact parity compliance differently than in more populated regions.

Medicaid agencies appreciate the conditional formatting incorporated into the State Summary Template, which clearly indicates when a state does not need to fill out a corresponding worksheet.

4. *Are the NQTLs highlighted in the templates (i.e., prior authorization, concurrent review, step therapy/fail first, standards for provider network admission, and standards for access to out-of-network providers) the most common and critical NQTLs? Are there others we should consider including or some on this list that are not as critical?*

   The NQTLs highlighted in the templates (prior authorization, concurrent review, step therapy/fail first, standards for provider network admission, and standards for access to out-of-network providers) are the most common and critical NQTLs. Some Medicaid agencies may assess additional NQTLs, based on local conditions and stakeholder feedback; this is adequately captured by the "Other NQTLs" fields.

5. *Would combining the FR and QTL worksheets into a single worksheet help streamline the parity analysis/documentation, since these limits are subject to the same two-part test?*

   NAMD does not have feedback on this question.

6. *Are there any potential risks (e.g., missing important information regarding benefit limitations or NQTLs) that should be considered?*

   No, Medicaid agencies report that these templates adequately incorporate all MH/SUD parity requirements.

7. *Has experience shown that managed care plans apply NQTLs identically across Medicaid managed care, CHIP, and/or ABPs when the benefit packages across the programs are identical? For example, some states have the same managed care benefit package for Medicaid and CHIP children. If the benefit packages are the same, are some or all of the NQTLs typically the same or different in Medicaid and CHIP?*

   Medicaid agencies report that managed care plans typically apply NQTLs identically across Medicaid managed care, CHIP, and/or ABPs when the benefit packages are identical.

8. *In what way could data entry be further streamlined for managed care plans and/or State FFS programs that deliver benefits that are subject to MH/SUD parity requirements across multiple program types?*

   CMS could consider strategies to automate the templates to reduce the risk of human error associated with manual data entry. This could include formulas to reduce duplicate data entry (for example, in situations where the application of an NQTL is identical across benefit packages). CMS could also consider strategies like dropdown options or standardized responses to streamline data entry and analysis.

9. *As we consider how best to structure and format these templates and the number of worksheets that may be needed, it would be helpful to have information in response to the following questions:*
   a. *What is the maximum number of benefit packages that could be expected to be subject to parity requirements in a state?*
   b. *What is a maximum number of entities (i.e., managed care plans and State FFS programs) that could be expected to deliver benefits for a given benefit package in a state?*
   c. *What is the average number of entities that deliver benefits for a given benefit package?*

   NAMD does not have feedback on these questions, as responses will vary by state.

10. *Existing Medicaid MCO, ABP, and separate CHIP programs are already required to have completed an initial parity analysis. Upon which triggering event(s) requiring parity analysis updates (e.g., new managed care plan joins the program, benefit or limit changes are implemented that affect parity compliance, parity deficiencies are corrected) would it be easier, or more challenging, to begin using a standardized template; and how much time should CMS allow for this template conversion?*

    NAMD recommends an overall transition timeline of 18 – 24 months for states and plans to begin using the templates. Medicaid agencies have different views on which triggering events may best align with use of the standardized templates. One Medicaid agency recommends aligning use of the standardized templates with new managed care contracts. Other Medicaid agencies recommend incorporating use of the standardized templates into their existing annual parity reporting cycles; these states indicate that they would need at least 12 months of advance notice to incorporate the standardized templates into their reporting processes.

11. *Once these templates are finalized in accordance with the Paperwork Reduction Act, CMS intends to require states to use them to document their compliance with the parity requirements.*
    a. *What is a reasonable transition period that CMS should consider allowing before requiring the use of these templates?*

        NAMD strongly recommends that CMS make use of these templates optional for states. As discussed above, some Medicaid agencies have already developed strong processes for assessing compliance with parity requirements. These processes were often developed to account for local factors, including unique behavioral health benefits or plan structures. While some Medicaid agencies have requested additional federal support, including templates, other Medicaid agencies would prefer to use their existing tools and processes. If CMS does finalize mandatory use of these templates, they should provide states with 18 – 24 months. This time would allow states to train their plans on template use and ensure data quality.

    b. *Should CMS's transition timeline vary based on the type of program? For example, if CMS is using these templates to document compliance with the parity requirements for Medicaid managed care, ABPs, and/or separate Children's Health Insurance Program (CHIP plans, should the transition timeline vary by these program types?*

NAMD does not have feedback on this question.

c. *Can states provide any initial estimates for the anticipated staff time to complete these templates?*

NAMD does not have a specific estimate, as this will vary by state. However, Medicaid agencies indicated that parity reporting already takes a significant amount of staff time, and that transitioning to the new templates would involve multiple Medicaid agency staff, individuals with managed care expertise, and contracts with external organizations.