December 2, 2024

The Honorable Daniel Tsai
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Deputy Administrator Tsai,

Thank you for the opportunity to provide comments on the templates and instructional guides for documenting compliance with Mental Health Parity and Addiction Equity Act (MHPAEA) requirements in Medicaid and CHIP. We are grateful to the Centers for Medicare & Medicaid Services (CMS) for being responsive to our previous comments and developing these guidance and template documents to streamline and strengthen MHPAEA enforcement in Medicaid. We also commend CMS for your ongoing work to improve access to mental health (MH) and substance use disorder (SUD) care in Medicaid and CHIP, including the recent Medicaid Access and Managed Care Access final rules, and we appreciate this additional opportunity to continue to work with you on this important goal.

The undersigned 67 organizations believe these guidance and template documents are a good start to improve parity compliance and access to care for the 40% of Medicaid enrollees with MH and SUD. We offer the following recommendations based on our experiences working in states, and we are eager to continue to work with you to meet the needs of all Medicaid and CHIP enrollees with MH and SUD:

A. Strengthen the Medicaid MHPAEA Regulations to Promote Greater Alignment and Enforcement

Before we discuss our recommendations on the templates and guidance documents themselves, we believe the following changes are necessary to the Medicaid MHPAEA regulations to promote greater consistency between commercial insurance and Medicaid and to strengthen enforcement to ensure the rights of Medicaid enrollees with MH and SUD are meaningfully protected.

1. Align the Medicaid MHPAEA Regulations with Those in Private Insurance and Adopt the Six-Step Comparative Analysis Framework for These Templates

We strongly support CMS's goal and progress thus far in working collaboratively across the agency to strengthen, improve, and align policies and operations across the 3Ms: Medicare, Medicaid, and the Marketplace. Consistent with this priority, we recommend CMS conform the Medicaid MHPAEA regulations with those recently finalized by the Departments of Health & Human Services, Labor, and Treasury governing MHPAEA in private insurance plans including

the Marketplace,[1] prior to the adoption of new templates and guidance. There are critical new requirements and protections in these final regulations,[2] and Medicaid enrollees deserve no less.

Aligning the MHPAEA regulations across payer systems will ease the administrative burden on both regulators and carriers, as well as ensure parity is made a reality for all individuals enrolled in Medicaid and CHIP. Regulators can rely on the guidance and self-compliance tools as well as previous and ongoing enforcement efforts of sister agencies, and health plans that operate in multiple payer systems will be able to streamline their compliance efforts. Moreover, at least eleven states (CO, DC, DE, GA, IL, MD, MA, NV, NY, OR, TN) already require Medicaid managed care entities to follow the six-step process for the non-quantitative treatment limitations (NQTL) comparative analyses codified in the Consolidated Appropriations Act of 2021 and outlined in these final regulations, so adopting this policy uniformly across the country would promote greater consistency and standardization. Regulators using this framework have identified many NQTL violations – in both Medicaid managed care plans and in commercial insurance plans – that were not discovered in the pre-stepwise analysis environment, and we believe this approach is necessary to meaningfully evaluate parity. At a minimum, we urge CMS to amend these templates to mirror the stepwise NQTL comparative analysis approach in place for health insurance issuers and group health plans in MHPAEA statute (42 U.S.C. 300gg-26(a)(8)(A)) and these new federal regulations. We also recommend CMS enable Medicaid enrollees and their authorized representatives to be able to request these comparative analyses to the same extent as participants in commercial insurance plans.

2. Strengthen Enforcement Provisions of MHPAEA in Medicaid and CHIP

We appreciate CMS's ongoing work to provide greater clarity and guidance for States on how to document compliance with MHPAEA. Nonetheless, we remain concerned that States and Medicaid managed care plans are failing to take these legal requirements seriously, as demonstrated by a number of recent reports by the U.S. Department of Health & Human Services Office of Inspector General, discussed further below. The Department of Labor and a number of states have conducted substantial enforcement activities to root out discriminatory practices in private insurance that limit access to MH and SUD care, and we know that similar practices remain all too pervasive in Medicaid. We encourage CMS to leverage these enforcement actions and reports from sister agencies to ensure that the same and similar barriers to MH and SUD benefits in Medicaid cannot continue.

Furthermore, when MHPAEA violations are identified, as well as when States or managed care plans fail to submit sufficient or complete analyses or reports, we encourage CMS to adopt strong consumer protections to ensure appropriate resolution of and investment in resolving these disparities. At a minimum, States and plans should be required to reprocess all relevant claims and provide sufficient notice to ensure claims that were not submitted can now be processed. In addition, we encourage CMS to adopt the enforcement provision in the final regulations for

[1] Requirements Related to the Mental Health Parity and Addiction Equity Act, 89 Fed. Reg. 77586 (Sept. 23, 2024).
[2] For example, the new purpose section, updated definitions, requirement to cover "meaningful benefits," prohibition on using discriminatory evidentiary standards and factors in the design of NQTLs, outcomes data test for NQTLs to ensure no material difference in access to MH and SUD benefits, the six-step NQTL comparative analysis process and timeline for requesting the comparative analyses, and enforcement provisions.

commercial insurance plans, wherein the appropriate regulatory authority may require a managed care plan to cease imposing a non-compliant NQTL to MH and SUD benefits in the classification where such a violation has occurred.

B. Amend the Templates and Guidance Documents to More Closely Align with the MHPAEA Statute, Regulations, and Fundamental Purpose

1. Amend the Templates to Require Separate Analysis and Reporting of MH and SUD

MHPAEA requires a separate analysis for MH benefits compared to medical/surgical benefits and SUD benefits compared to medical/surgical benefits, however the current templates collapse MH/SUD into one category. As a result, these analyses will miss or mask key differences in MH and SUD benefits, as well as the comparisons to medical/surgical benefits, which has been an ongoing problem in States' MHPAEA compliance analyses for Medicaid. We recommend CMS separate out MH and SUD such that Medicaid plans and States can separately identify when a benefit falls into one of these categories and then separately analyze how it compares to medical/surgical benefits to ensure any treatment limitations are comparable and no more restrictive.

2. Amend the Templates to Require an Analysis of All NQTLs

MHPAEA requires all treatment limitations – including NQTLs – applied to MH and SUD benefits to be comparable to and no more stringent than the predominant treatment limitations applied to substantially all medical/surgical benefits in the same classification. However, the current template only requires managed care plans and States to evaluate and report on five NQTLs: prior authorization, concurrent review, step therapy/fail first, standards for provider network admission, and standards for access to out-of-network providers. We appreciate CMS's question as to whether these NQTLs are the most common and critical. We note that without conducting an analysis of all of the NQTLs, neither States nor stakeholders will know whether these are the most common or critical, and thus it is imperative that all NQTLs be analyzed in these templates. States must be able to demonstrate that any limitations on MH and SUD benefits are comparable to and no more stringent than those on medical/surgical benefits and thus compliant with MHPAEA, or else it merely shifts the burden back onto Medicaid enrollees to demonstrate their rights have been violated despite lacking the same information and resources that the plans and States have. Once all such NQTLs are analyzed and reported, CMS can always prioritize a subset of NQTLs for stricter scrutiny and enforcement. Conducting and documenting a complete analysis of all NQTLs is necessary to meaningfully protect Medicaid enrollee rights and would better equip managed care plans, States, and CMS to timely and sufficiently respond to enrollee and provider complaints and appeals.

In particular, advocates have previously identified a number of potential MHPAEA violations related to NQTLs that would not be captured in this list, including:

- Reimbursement rate setting practices
- Network adequacy and composition, including with respect to sub-populations (i.e. maternal mental health, youth and adolescents, cultural and linguistic capabilities)

- Service limitations (i.e. restrictions on same-day billing for different benefits, age limits for autism spectrum disorder services)
- Application of medical necessity criteria
- Scope of service coverage
- Limitations on settings/facilities where services can be delivered
- Retrospective review
- Post-payment audits, outlier review, and other means of detecting fraud, waste, and abuse

Furthermore, we note that the final regulations for private insurance plans highlight the importance of conducting and documenting a full comparative analysis of the non-exhaustive list of NQTLs. As previously discussed, greater uniformity across the payer systems will ultimately alleviate burdens on regulators, carriers, and enrollees. Accordingly, we recommend CMS amend these templates and guidance to require states and plans to conduct the six-step comparative analysis, as outlined in the MHPAEA statute and final commercial insurance regulations, for **all** NQTLs.

3. Require the Collection and Evaluation of Relevant Outcome Data to Assess MHPAEA Compliance in Operation

One critical aspect of the new MHPAEA regulations in private insurance plans is the collection and evaluation of outcome data as part of the test for NQTLs to ensure comparability and no more stringency in the application or operation of such treatment limitations, which a number of State Medicaid programs already require. The U.S. Department of Health & Human Services Office of Inspector General found strikingly limited access to MH and SUD providers in Medicaid managed care plans, which prevents enrollees from accessing the care they need. This type of outcome data, among others, is essential for meaningfully enforcing MHPAEA and ensuring Medicaid enrollees have equitable access to MH and SUD benefits as compared to medical/surgical benefits in operation. We strongly recommend CMS identify and include key outcome data measures that would ensure the design and application of NQTLs are no more restrictive than the predominant NQTLs for substantially all medical/surgical benefits.

In particular, we urge CMS to include the following outcome data metrics in these templates:

- Denial rates
- Utilization review rates, including prior authorization, concurrent review, and retrospective review
- Frequency at which first-level clinical review goes to physician/medical director review and frequency of peer-to-peer review
- In-network and out-of-network utilization rates
- Average and median appointment wait times, stratified by level of urgency (emergency, urgent, and routine) and including both initial and follow-up appointments
- Reimbursement rates, stratified by service and provider license/credential, as compared to billed charges

We encourage CMS to work with its sister agencies to identify appropriate outcome data measures that will most meaningfully ensure equitable access to MH and SUD benefits, and incorporate them into these templates.

4. Require Separate Analysis by Sub-Populations to Ensure all Enrollees Have Equitable Access to MH and SUD Care

We commend CMS for its ongoing and critically important work to advance health equity. As highlighted in the CMS Framework for Health Equity 2022-2032, this includes expanding data collection; assessing causes of disparities and addressing inequities; building capacity in the workforce to reduce disparities; advancing language access, health literacy, and the provision of culturally tailored services; and increasing all forms of accessibility. These templates and guidance offer a unique opportunity for CMS to incorporate many of these priorities to ensure that Medicaid enrollees with disproportionately limited access to MH and SUD services can get the care they need. Accordingly, we recommend CMS amend these templates to include specific requirements for plans to evaluate access to MH and SUD benefits stratified by sub-populations including racial/ethnic minorities, gender identity and sexual orientation, pregnant and postpartum individuals, age (i.e. youth, adolescent, adult, geriatric), language, sex, and disability. By expanding this data collection, CMS can more meaningfully assess the causes of disparities in access to MH and SUD care for these sub-populations and address these inequities.

5. Require Medicaid Plans and States to Submit Analyses at Least Annually

We appreciate CMS's clarification in the June 2024 guidance that all Medicaid managed care and separate CHIP analyses must be updated when benefits, quantitative treatment limitations (QTLs), NQTLs, or financial requirements change; when deficiencies are corrected; or when managed care plans are added to a managed care program or there is a delivery system change for separate CHIPs. However, we are concerned that this framework is too vague, and fails to account for the myriad of ways that the operation of plans and benefits changes and may limit or impose a greater burden on access to MH and SUD care compared to medical/surgical care. Accordingly, we recommend that Medicaid plans and states be required to complete these templates no less frequently than annually, in addition to whenever the written changes are made. In so doing, CMS would ensure that all states are meeting their obligations under MHPAEA, both as written and in operation.

6. Promote Greater Transparency By Posting Completed Templates and Summaries on State Websites and the CMS Website

We commend CMS for finalizing the regulations in the Managed Care Access rule to require transparency of the documentation demonstrating MHPAEA compliance on State Medicaid websites, consistent with the existing MHPAEA regulations. As the U.S. Department of Health & Human Services Office of Inspector General reported, States consistently failed to meet this legal requirement and notable MHPAEA violations were left unchecked and uncorrected. To further ensure that Medicaid enrollees and their advocates have access to the documentation they would need to understand and enforce their rights under MHPAEA, we encourage CMS to require that the completed templates be posted on state websites, as well as in a centralized location on CMS's website. States and advocates currently benefit from seeing other State Plan Amendments and correspondence with CMS to leverage new opportunities they can replicate and adapt. By publishing these completed reports, we believe that more States will be able to better identify MHPAEA violations and potential corrective actions they can take in their own

programs, and more Medicaid enrollees will be able to take appropriate action to enforce their rights.

We would encourage CMS to, at a minimum, post summary documents of these analyses in plain language so Medicaid enrollees and their authorized representatives can get meaningful information about whether and how their plan is in compliance with MHPAEA. These summaries should be accompanied by additional instructions for consumers on how they can get claims processed or reprocessed when a violation has been identified, and how they can enforce their rights if they believe they have been subject to discrimination.

* * *

Thank you for considering our comments. We are grateful for all the work you are doing to improve MHPAEA compliance and access to MH and SUD care in Medicaid, and we look forward to continuing to work with you to ensure these templates and instructional guides are sufficient to help states root out discriminatory policies and practices and improve health equity. Please do not hesitate to contact Deborah Steinberg at the Legal Action Center, dsteinberg@lac.org, with any questions or if you would be interested in discussing our comments further.

Sincerely,

Legal Action Center
Inseparable
Mental Health America
The Kennedy Forum
Advocates for Human Potential
American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Association for Marriage and Family Therapy
American Association for Psychoanalysis in Clinical Social Work
American Association of Psychiatric Pharmacists
American Association on Health and Disability
American Counseling Association
American Foundation for Suicide Prevention
American Psychiatric Association
American Society of Addiction Medicine
American Therapeutic Recreation Association
Association for Ambulatory Behavioral Healthcare
Atlanta Behavioral Health Advocates
Autism Speaks
Child Neurology Foundation
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Children's Hospital Association
Children's National Hospital
Clinical Social Work Association

Community Catalyst
Drug Policy Alliance
Eating Disorders Coalition for Research, Policy, & Action
Epilepsy Foundation of America
Georgians for a Healthy Future
Global Alliance for Behavioral Health & Social Justice
Health Law Advocates
Healthy Mothers Healthy Babies, Coalition of Georgia
HealthyWomen
Hydrocephalus Association
International OCD Foundation
James' Place Inc.
Justice in Aging
Lakeshore Foundation
Lucero
Lupus and Allied Diseases Association, Inc.
Maryland Addiction Directors Council
Maryland Heroin Awareness Advocates, Inc.
Massachusetts Association for Mental Health
Meaghan Hetherington Psychotherapy
NAMI Miami-Dade County
National Alliance on Mental Illness
National Association for Behavioral Healthcare
National Association of State Mental Health Program Directors
National Council for Mental Wellbeing
National Federation of Families
National League for Nursing
Nevada Psychological Association
New Jersey Association of Mental Health and Addiction Agencies, Inc.
Partnership to End Addiction
Postpartum Support International
Psychotherapy Action Network (PsiAN)
REDC Consortium
School Social Work Association of America
Shatterproof
TAADAS - TN Association of Alcohol, Drug and other Addiction Services
The Carter Center
The National Alliance to Advance Adolescent Health
Third Horizon
Vibrant Emotional Health
VICTA, LLC
Virginia Behavioral Health Providers Coalition
Western Youth Services