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December 2, 2024

The Honorable Daniel Tsai
Deputy Administrator and Director, Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

Submitted via email to MedicaidandCHIP-Parity@cms.hhs.gov

Re: Request for Comments on Mental Health Parity and Addiction Equity Act Requirements in Medicaid and CHIP

Dear Deputy Administrator Tsai,

On behalf of the Community Behavioral Health Association of Maryland (CBH), 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. CBH is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 89 members serve the majority of those accessing care through the public behavioral health system. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

We are grateful to the Centers for Medicare & Medicaid Services' (CMS') efforts in developing these guidance and template documents to streamline and strengthen MHPAEA enforcement in Medicaid and we commend CMS for your ongoing work to improve access to mental health and substance use care in Medicaid and CHIP.

The proposed guidance and template documents are an important start, and we offer the following recommendations based on our members' experience in community mental health and substance use services. Overall, our recommendations suggest more closely aligning the templates and guidance documents with MHPAEA statute and regulation. Again, we are grateful for your efforts and consideration, and we are eager to work with you to meet the needs of all Medicaid and CHIP enrollees with mental health and substance use conditions.

1. Amend the Templates to Require Separate Analysis and Reporting of Mental Health and Substance Use Conditions

MHPAEA requires a separate analysis for mental health benefits compared to medical/surgical benefits and substance use benefits compared to medical/surgical benefits, however the current templates collapse mental health and substance use into one category. As a result, these analyses will miss or mask key differences in mental health and substance use 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 mental health and substance use 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 non-quantitative treatment limitations (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 mental health and substance use 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
- Likelihood of improvement (i.e. requiring plans to consider the likelihood of a patient improving before approving specific types of care, such as inpatient treatment).

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. We believe 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 mental health and substance use 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 mental health and substance use benefits and incorporate them into these templates.

4. 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.

The Community Behavioral Health Association of Maryland appreciates the opportunity to provide these comments and we are grateful for your work in advancing MHPAEA compliance and access to mental health and substance use care in Medicaid. We welcome any questions or further discussion about the recommendations described here. Please contact me at Shannon@MDCBH.org. Thank you for your time and consideration.

Sincerely,

Shannon Hall
Executive Director