

November 27, 2023

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

**Re: Request for Comments on Processes for Assessing Compliance with
Mental Health Parity and Addiction Equity in Medicaid and CHIP**

Dear Deputy Administrator Tsai,

The below-signed mental health and substance use disorder advocacy organizations appreciate the opportunity to comment on the Center for Medicaid and CHIP Services' (CMCS) request for comments on processes for assessing compliance with mental health parity and addiction equity in Medicaid and the Children's Health Insurance Program (CHIP).

We appreciate the opportunity to comment on this critically important issue. Unfortunately, we believe there is widespread noncompliance with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) in Medicaid managed care, CHIP, and Medicaid Alternative Benefit Plans (ABPs). With tens of millions of individuals across the country enrolled in these plans, the lack of parity compliance is an urgent public health issue.

This is an urgent equity issue given that these plans primarily serve low-income individuals and families from marginalized communities; about 6 in 10 Medicaid beneficiaries are people of color. Moreover, these groups have a higher incidence of untreated mental health and substance use disorders (MH/SUD).¹ While parity compliance is inadequate across public and private payers subject to MHPAEA, as we describe below, the woefully inadequate MHPAEA oversight efforts by nearly all state Medicaid agencies – with little past accountability from CMCS – is a glaring equity issue that demands action. Therefore, we are grateful for CMCS's request for comment to finally begin addressing widespread parity noncompliance in Medicaid managed care, CHIP, and ABPs.

We are disturbed by widespread parity noncompliance in Medicaid managed care, CHIP and ABPs and the current two-tier system in which those in public programs have less parity protections than those in private plans, especially as the Administration finalizes stronger MHPAEA rules for individual marketplace and employer-based plans. Accordingly, we urge CMCS to prioritize the following:

¹ See, e.g., Nirmita Panchal et al., *Five Key Findings on Mental Health and Substance Use Disorders by Race/Ethnicity* (2022), <https://www.kff.org/mental-health/issue-brief/five-key-findings-on-mental-health-and-substance-use-disorders-by-race-ethnicity>.

- Develop guidance and provide resources to State Medicaid agencies to develop MHPAEA expertise and support compliance oversight efforts; hold agencies accountable for non-enforcement;
- Require Medicaid managed care, CHIP, and ABPs to conduct regular parity compliance analyses that mirror the requirements for private plans set forth in Consolidated Appropriations Act, 2021 (CAA 2021) for all current and future MH/SUD benefits, and submit their analyses to the state Medicaid program and CHIP as appropriate;
- In addition, require state Medicaid programs and CHIPs to include language in their managed care contracts that requires the MCEs to conduct parity analyses whenever changes/amendments are made to their plans;
- Require the state Medicaid programs and CHIPs to review and compile the analyses from all managed care, CHIP, and ABPs to ensure compliance, and address any non-compliance, and submit a compliance report to CMS at least every three years;
- Publicly post state Medicaid program and CHIP parity compliance reports on a single website;
- Perform additional monitoring and enforcement to ensure that Medicaid programs and CHIPs have addressed any findings of non-compliance;
- Work with state Medicaid programs and CHIPs to ensure each has established a process to rigorously monitor whether contracted managed care plans are disclosing information consistent with their parity obligations;
- Work with state Medicaid programs to ensure that state Medicaid programs provide children and youth under age 21 with the full range of MH/SUD services required by law; and
- Develop a standardized process for receiving and investigating parity complaints in Medicaid and communicating that process publicly.

Our full comments are as follows.

Flawed Current Parity Approach

Broad Parity Noncompliance

State Medicaid programs and CHIPs were required to provide CMS with “documentation of compliance” with the parity requirements by October 2017.² Yet, since plans initially reported on their compliance with these requirements over six years ago – a process that, in retrospect, was inadequate and does not meet current best practices – the vast majority of state Medicaid agencies have failed to conduct even the most basic reviews to evaluate ongoing compliance with MHPAEA. Unlike with individual marketplace and employer-sponsored plans, where many state insurance departments and all federal regulators are prioritizing reviews of health plans’ parity compliance analyses for non-quantitative treatment limitations (NQTLs), state Medicaid

² 42 C.F.R. § 438.930 (states using MCOs); id. § 440.395(e)(4) (ABPs); id. § 457.496(g) (CHIPs).

agencies rarely require or review such analyses. In fact, we are aware of only one state that is vigorously enforcing MHPAEA in Medicaid and CHIP: The New York State Department of Health (NYS DOH). In NYS DOH's comprehensive reviews of MHPAEA compliance across a range of NQTLs, it found near-universal noncompliance. Its [2022 detailed report](#) found a literal sea of noncompliance as shown below:

| Phase I NQTLs | | | | |
|---------------|---------------------|-------------------|----------------------------|------------------|
| Plan | Prior Authorization | Concurrent Review | Medical Necessity Criteria | Formulary Design |
| Affinity | Noncompliant | Noncompliant | Compliant | Noncompliant |
| Amida Care | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| CDPHP | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| Emblem | Noncompliant | Noncompliant | Noncompliant | Compliant |
| Excellus | Compliant | Compliant | Compliant | Noncompliant |
| Fidelis | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| Healthfirst | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| HealthNow | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| HealthPlus | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| IHA | Noncompliant | Compliant | Compliant | Noncompliant |
| MetroPlus | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| Molina | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| MVP | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| UHC | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| VNSNY | Compliant | Noncompliant | Noncompliant | Compliant |
| WellCare | Noncompliant | Noncompliant | Noncompliant | Noncompliant |
| YourCare | Compliant | Compliant | Compliant | Noncompliant |

| Phase II NQTLs | | | | | |
|----------------|--------------|------------------------|-------------------------|---------------|-------------------------|
| Plan | Coding Edits | OON Coverage Standards | Geographic Restrictions | Reimbursement | Provider Type Exclusion |
| Affinity | Compliant | Noncompliant | Compliant | Noncompliant | Compliant |
| Amida Care | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant |
| CDPHP | Noncompliant | Compliant | Compliant | Noncompliant | Compliant |
| Emblem | Noncompliant | Compliant | Compliant | Noncompliant | Compliant |
| Excellus | Compliant | Compliant | Compliant | Noncompliant | Compliant |
| Fidelis | Noncompliant | Noncompliant | Compliant | Noncompliant | Compliant |
| Healthfirst | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant |
| HealthNow | Noncompliant | Noncompliant | Compliant | Compliant | Compliant |
| HealthPlus | Noncompliant | Noncompliant | Compliant | Compliant | Compliant |
| IHA | Noncompliant | Noncompliant | Compliant | Noncompliant | Compliant |
| MetroPlus | Noncompliant | Noncompliant | Compliant | Noncompliant | Compliant |
| Molina | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant |
| MVP | Noncompliant | Compliant | Compliant | Noncompliant | Compliant |
| UHC | Noncompliant | Compliant | Compliant | Noncompliant | Compliant |
| VNSNY | Compliant | Noncompliant | Compliant | Noncompliant | Compliant |
| WellCare | Noncompliant | Noncompliant | Compliant | Noncompliant | Compliant |
| YourCare | Compliant | Compliant | Compliant | Noncompliant | Compliant |

| Plan | Phase III NQTLs | | | | | | | | | |
|-------------|-----------------|----------------|--|--------------|------------------------|-----------|---------------------|-------------------------|--|---------------------|
| | Retro Review | Outlier Review | Experimental/ Investigational Determinations | Fail First | Provider Credentialing | Cert Req. | Unlicensed Provider | UCR Rate Determinations | Exclusions for Court-Ordered Treatment | Failure to Complete |
| Affinity | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant | Noncompliant |
| Amida Care | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| CDPHP | Compliant | Compliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| Emblem | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| Excellus | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| Fidelis | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| Healthfirst | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| Highmark* | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| HealthPlus | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Noncompliant | Compliant | Noncompliant | Noncompliant |
| IHA | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| MetroPlus | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| Molina | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Noncompliant |
| MVP | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| UHC | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant | Compliant |
| VNSNY | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Noncompliant | Compliant | Compliant | Compliant | Compliant | Compliant |

*Highmark f/k/a. HealthNow

Given that New York State is the only state we are aware of that has done such thorough reviews, as well as the overwhelming noncompliance that the Departments of Health and Human Services and Labor are finding in private insurance coverage, we strongly believe that MHPAEA noncompliance is widespread in Medicaid managed care, CHIP, and ABPs. Without up-to-date and comprehensive parity compliance reviews, state Medicaid agencies are inherently limited in their ability to assess compliance. Examining NQTL comparative analyses is the *only* way to test whether plans are meeting the requirements of the federal NQTL rule. Since nearly all states are failing to do such reviews, most Medicaid beneficiaries can at best only hope that their state Medicaid agency identifies and addresses the most glaring MHPAEA violations. And, even then, our experience suggests that most state Medicaid agencies fail to identify and correct even clear parity issues.

In contrast, state insurance departments and federal regulators are regularly finding noncompliance in commercial plans.³ Many of the same companies operate both public and commercial plans, meaning that violations being discovered in companies' commercial plans are very likely to also be occurring in their public plans. But without parity compliance reviews by the states, we are operating in the dark e1 the full scope of the problem. The failure of state Medicaid agencies to enforce MHPAEA is not acceptable.

Lack of Accountability and Transparency

The widespread MHPAEA noncompliance in Medicaid managed care, CHIP, and ABPs described above is the result of the systemic lack of accountability and transparency across the country from the vast majority of state Medicaid agencies and from CMCS. We are grateful that CMCS is seeking to finally address this urgent problem. Simply put, to the degree states consider parity compliance at all, it is usually an afterthought, with few resources and little expertise devoted to the complex coverage barriers that plans use to inappropriately limit access to MH/SUD care.

While we recognize that, in 2017, CMCS required the completion of parity compliance reviews, these were both flawed and very dated. The analyses performed by most states to collect information relating to parity solicited inadequate information and data. They are also now incompatible with parity compliance best practices. Most importantly, the 2017 reviews did not test all aspects of the federal NQTL rule and, thus, do not align with the requirements for individual marketplace and employer-sponsored plans that were passed as part of the Consolidated Appropriations Act, 2021 (CAA 2021). Additionally, many states have failed to conduct any parity analyses since then, despite

³ A range of states are regularly collecting and reviewing private plans' MHPAEA compliance analysis. States including [Illinois](#), [Maryland](#), and [Washington](#) have recently issued MHPAEA fines. The National Association of Insurance Commissioners has a [MHPAEA Working Group](#) to improve oversight with members from 31 states and Washington DC. In [2022](#) and again in [2023](#), the Departments of Labor, Treasury, and Health and Human Services have issued damning reports to Congress on private plans' MHPAEA violations and failure to demonstrate compliance across a range of NQTLs.

making changes to their benefits and reimbursement rates that would affect their compliance with the law.

While we wish Congress had extended the CAA 2021 requirements to Medicaid managed care, CHIP, and ABPs, that this was not done should not absolve CMCS or state Medicaid agencies of their responsibility to test the longstanding federal NQTL rule. State Medicaid agencies and CMCS have the inherent authority to require that detailed parity compliance analyses be conducted, even if federal law does not mandate that they do so, as demonstrated by CMCS's 2017 requirements. Therefore, we strongly urge CMCS to require states to ensure that Medicaid managed care, CHIP, and ABPs conduct such analyses in a manner that aligns with the CAA, 2021's parity analysis requirements, which test the foundational NQTL rule that applied to both Medicaid and commercial plans, and to do so on at least an annual basis and before any plan changes are implemented. Unfortunately, we believe most state Medicaid agencies have limited MHPAEA expertise and have in most instances made little attempt to obtain it either on staff or through contracts with outside experts. This lack of expertise inhibits even well-meaning state Medicaid agencies from holding plans accountable for compliance. Accordingly, we recommend that CMCS assist states in training staff on MHPAEA's requirements and have the MHPAEA expertise necessary (either on staff or through independent external organizations) to do a full parity compliance review, just as New York has done. We urge CMCS to hold training sessions and also make parity a focus area in the [Medicaid and CHIP Learning Collaboratives](#).

This lack of expertise, when accompanied by little accountability, means parity is rarely prioritized. Even when coverage problems and potential parity violations are brought to the attention of state Medicaid agencies, there is little recourse for failure to investigate, let alone to take action if violations exist. We are aware of no formal processes or mechanisms that states must utilize in accepting complaints about MH/SUD coverage problems and potential parity violations. Even when a problem is recognized by states, there is often confusion and finger pointing about how to resolve the problem. For example, we are aware of instances where state law or State Plan Amendments contain requirements that affect MH/SUD coverage that result in parity violations, yet the state (wrongly) claims its hands are tied. In the context of opioid treatment programs, it is very common for states to impose more onerous requirements for individuals to access OTPs than what federal law imposes, although those limits are not in line with best evidence and standard of care and are contributing to making it harder for individuals to access effective, medically necessary treatment.⁴ In such instances, it has not been clear how to file a complaint with CMCS and whether CMCS will force changes necessary to remedy the parity violation.

An additional problem includes the current ability of states to assert parity compliance for youth simply by attesting to the state's compliance with Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate. While we recognize

⁴ See Sheri Doyle, the Pew Charitable Trusts, *Overview of Opioid Treatment Program Regulations by State* (2022), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2022/09/overview-of-opioid-treatment-program-regulations-by-state>.

that EPSDT “deeming” with respect to MHPAEA is a statutory provision, simply allowing such a self-serving attestation to occur allows states to avoid parity scrutiny. CMS must ensure that state Medicaid programs provide children and youth under age 21 with the full range of MH/SUD services required by law. The EPSDT provisions of the Medicaid Act are designed to ensure that youth in Medicaid have access to the services they need to prevent, ameliorate, and treat MH/SUDs. The EPSDT mandate is extremely broad and requires Medicaid programs to cover health services for youth under age 21 when they are necessary to correct or ameliorate a MH/SUD. For youth under age 21, compliance with EPSDT would likely mean no parity issues because EPSDT requires access to all services needed to correct or ameliorate a youth’s MH/SUD. Because, unlike other health coverage programs, in Medicaid, EPSDT already provides a strong foundation that requires states to provide youth with a broad range of MH/SUD services and applies the same medical necessity standard to both MH/SUD and physical health services, parity compliance in Medicaid is readily met when Medicaid programs comply with EPSDT.

We greatly appreciate that CMS recently issued an informational bulletin to guide state implementation of the EPSDT benefit, particularly with the explicit note that the obligation to provide all medically necessary care under EPSDT extends to prevention, screening, assessment and treatment for mental health and substance use disorders (SUDs). However, many state Medicaid programs do not provide the range of MH/SUD services youth under age 21 need. Too often, families and their advocates have had to resort to litigation to ensure that youth in Medicaid programs receive the MH/SUD services to which they are entitled. CMS must hold states to a higher standard than an assurance and independently analyze whether Medicaid programs are providing their beneficiaries under age 21 with all the MH/SUD services they need.

The need for more CMS oversight of states’ compliance with EPSDT is particularly urgent in the context of SUD because few states have worked to ensure access to SUD treatment under EPSDT, in part due to a lack of understanding about the standard of care for youth with SUD or at-risk of SUD. We encourage CMS to work with SAMHSA to provide states with additional guidance about what services and under which circumstances must be covered for youth with SUD.

Finally, there is little consistency across states on what their contracts with Medicaid and CHIP managed care plans contain. Nor has CMS instructed states on the kind of contract language necessary to ensure managed care plans comply with parity requirements. As described in more detail later in these comments, these binding legal contracts between states and plans are ideal places to put in place detailed parity requirements.

Equal Parity Protections Across Public and Private Insurance

Consistent Rules, Enforcement Tools, and Guidance

Medicaid managed care, CHIP, and ABP beneficiaries deserve the same MHPAEA protections as individuals with private health insurance, which aligns with CMS's goal of consistency across delivery systems. Regulators of individual marketplace and employer-based plans have expended significant efforts to strengthen MHPAEA rules, improve enforcement tools, and issue guidance to increase access to care and to clarify plans' MHPAEA obligations. Similar efforts have been notably absent until this request for comment, despite Medicaid's greater complexity, which makes clarity on obligations, public transparency, and accountability essential.

The lack of parity in MHPAEA enforcement between public and private insurance cannot be justified, and the likelihood that the Administration will (appropriately) soon finalize stronger MHPAEA rules for individual marketplace and employer-based plans threaten to create even bigger gaps in Medicaid MHPAEA compliance. It is imperative that CMS move quickly to propose and finalize equally robust rules for Medicaid managed care, CHIP, and ABPs without delay after the finalization of this proposed rule. The Administration must not allow a strong set of MHPAEA rules for individuals in individual and group plans, but a weaker set of rules for individuals in Medicaid managed care, CHIP, and ABPs. This is particularly critical given that these plans serve lower-income individuals and families who are disproportionately Black, Latino, Native American, and from other marginalized and underserved communities. We strongly believe that all Medicaid managed care, CHIP and ABPs must be required to conduct detailed MHPAEA compliance reviews for all NQTLs in each classification of care, meeting the same requirements – and using the same tools – as have been proposed for private-sector plans.

As noted above, MHPAEA is critical in structuring Medicaid, CHIP, and ABP benefits and can no longer be relegated as an afterthought by state Medicaid agencies and CMCS. Given that parity compliance can be affected by *anything* – whether as written or as applied – affecting the scope or duration of MH, SUD, or M/S treatment, CMCS must build robust MHPAEA reviews into everything relating to states' coverage of MH, SUD, or M/S benefits. Examining changes to M/S benefits and treatment limitations are also critical because any steps to increase access to M/S treatment likely necessitate changes to MH and SUD benefits as well. Such reviews should not be limited to future changes. There should be a top-to-bottom review of states' coverage of MH, SUD, and M/S services and imposition of treatment limitations to ensure full parity compliance, including for SPAs and waivers previously approved.

CMCS should also issue detailed guidance for states that improves clarity on MHPAEA's requirements for Medicaid managed care, CHIP, and ABPs. This guidance should provide detailed examples, how states must address MHPAEA noncompliance, and the mechanisms by which states and plans will be held accountable. With the inherent complexity in these programs, we also strongly urge CMS to increase its in-house MHPAEA expertise to assist states in meeting their obligations. Particularly where states are voluntarily working to identify and remedy MHPAEA noncompliance, we support robust assistance to help make parity a reality for beneficiaries.

Ensuring Transparency and Accountability

We strongly believe that, not only should CMCS mandate completion of NQTL parity compliance analyses that align with the requirements for private insurance, but it should also mandate that states ensure the availability of these analyses to both beneficiaries and the general public. In its recent proposed rule on Medicaid Managed Care Access, CMS proposed to require states to post their documentation of compliance with parity on their state websites, while articulating that states were already required to do so. However, our review of the 50 states and District of Columbia yielded only 26 publicly accessible reports, 15 of which were posted before 2020. Without the availability of NQTL analyses, it is impossible for advocates or the general public to assess MHPAEA compliance. ERISA beneficiaries are entitled to receive NQTL analyses upon request, and Medicaid and CHIP beneficiaries deserve no less. Indeed, even greater public transparency is warranted to ensure the proper use of taxpayer dollars to administer Medicaid and CHIP benefits. Required public disclosure should also extend to NQTL data collection and analysis requirements that should be imposed as currently proposed for private-sector plans. It is particularly important to have public transparency on network composition and reimbursement rates, including whether Medicare rates are a basis for reimbursement. As noted in [Mental Health Liaison Group's comments](#) to the proposed MHPAEA rule, we strongly support the proposed MHPAEA rule's provision prohibiting discriminatory factors and evidentiary standards. CMS should use caution when allowing plans and states to use the Medicare Fee Schedule to demonstrate that their reimbursement rates are MHPAEA compliant by citing the Medicare Fee Schedule, particularly given that CMS recently [recognized](#) the Schedule undervalues MH/SUD services in the recently proposed updates to the reimbursement rate for psychotherapy.⁵

To further ensure transparency and accountability, we recommend CMS require state Medicaid programs and CHIPs to include language in their managed care contracts that requires the MCEs to comply with MHPAEA and to conduct parity analyses whenever changes/amendments are made to their plans. The most recent [Ohio managed care contract](#) serves as a strong model for what we believe all states should be doing. Putting an affirmative obligation on MCEs to comply with parity and to conduct and report on their analyses will ensure that the entities who are developing policies are doing so in a way that ensures equitable access to MH and SUD care.

As noted previously, we understand that the statute allows states to attest that they are in compliance with EPSDT as a way to assert MHPAEA compliance with respect to CHIP, yet CMCS must do more to ensure that states are actually complying with EPSDT. More analysis and enforcement of compliance with EPSDT, particularly in terms of Medicaid beneficiaries under the age of 21's access to Mental Health and SUDs, is urgent given the challenges with EPSDT compliance across states. Regardless of a beneficiaries' age, MHPAEA compliance should have to be

⁵ See detailed discussion of these concerns at pp. 6-7 [these comments](#) on the Technical Release submitted by the Kennedy Forum and more than a dozen other groups.

demonstrated – not merely attested to – especially given the nation’s ongoing youth mental health crisis.

Finally, for states not taking concerted action to ensure MHPAEA compliance, we call upon CMS to hold states accountable, including refusing to approve SPAs and waivers. Without consequences for failing to *demonstrate* compliance, we believe that many states and plans will not take the steps necessary to ensure equitable access to MH/SUD care. For too long, regulators across the country have prioritized maintaining friendly relationships with health plans and other stakeholders, while deprioritizing the interests of beneficiaries and enrollees the regulators are charged with protecting. The result has been widespread MHPAEA noncompliance and the inability of individuals to access MH/SUD services in an equitable manner.

Through the proposed MHPAEA rule and this request for comment, the Biden Administration is rightly seeking to correct these imbalances and protect individuals’ rights under MHPAEA. We urge the Administration to push forward to ensure equitable rules, transparency, and accountability to realize the promise of parity, regardless of whether an individual has public or private insurance coverage.

Feedback on Specific CMCS Questions

Question 1 – Model Formats / Key Questions

We strongly urge CMCS to develop model reporting templates that align with robust tools such as The Kennedy Forum’s “Six Step” Parity Compliance Tool, which tests each of the components of the federal NQTL rule. Many states (e.g., [Texas](#) and [New York](#)) have adopted this basic structure in reporting templates. We strongly believe that any reporting template should explicitly integrate the Departments of Labor, Treasury, and Health and Human Services’ (the “Departments”) [FAQ Part 45](#), dated April 2, 2021, which provides clear guidance on what an NQTL analysis must contain in order to demonstrate compliance as well as common practices that plans should avoid (e.g., conclusory or generalized statement without specific supporting evidence and detailed explanations). We also believe it is critical to collect robust data measuring in-operation MHPAEA compliance. The Appendix to the recent [MHPAEA Technical Release](#) lists data templates already in use, including the Bowman Family Foundation’s [Model Data Request Form](#). We support the use of such templates.

Most importantly, it is essential that the MHPAEA compliance tools and requirements for Medicaid managed care, CHIP, and ABPs align fully with forthcoming final MHPAEA rules for private plans, including guidance that will specify required data reporting and formats. In attempting to advance MHPAEA compliance for public plans, it is critical that CMS utilize all the important work that the Departments are moving forward for private plans.

Question 2 – Processes Currently Being Used

As explained above, we believe that the vast majority of state Medicaid agencies are doing very little to examine MHPAEA compliance. The exception is New York State. We urge CMCS to work closely with New York State's Office of Mental Health within its Department of Health to identify key aspects of its oversight. Fundamentally, MHPAEA compliance cannot be determined with respect to NQTLs (where most compliance issues lie) if the state Medicaid agency is not collecting and thoroughly reviewing a plan's NQTL parity compliance analysis for each NQTL imposed on MH or SUD benefits in each classification of care in which that NQTL is imposed. The analysis must test all components of the federal NQTL rule (which is exactly what the CAA, 2021 provisions do) and must be fully consistent with the Departments' FAQ 45 guidance. As demonstrated by the Departments' 2022 and 2023 MHPAEA reports to Congress, initial reviews will likely necessitate sustained back-and-forth with each plan to request needed information and clarification in order for a plan to demonstrate MHPAEA compliance. And, in many instances, plans will be unable to demonstrate compliance and state Medicaid agencies (and ultimately CMCS) will need to demand changes to ensure such compliance.

As previously noted, managed care contracts are an ideal place to incorporate ongoing parity analysis, compliance and reporting requirements, and we recommend CMS develop model contract language which states can adopt to facilitate parity compliance. Standardized parity protocols must also be established and implemented in expansion states that use fee-for-service financing for their expansion populations. We also recommend CMS require States to implement a community stakeholder engagement process to identify systemic issues which may be the result of parity violations, consistent with the proposed Beneficiary Advisory Group in the recent Medicaid Access proposed rule.

Question 3 – Key Issues to Focus on In Policy / Coverage Documents

Reviews of policy and coverage documents are *insufficient* to determine MHPAEA compliance, though there may well be indications of noncompliance contained therein. Key places to examine within such documents are coverage exclusions, prior authorization requirements, prescription drug formularies, or other requirements relating to MH/SUD coverage that may not exist (or may be less stringent) for M/S coverage. We also urge CMS and States to review Medicaid fee schedules and claims to ensure parity in reimbursement rate setting practices. In reviewing plans' policy and coverage documents, we believe it is important that state Medicaid agencies also examine requirements relating to MH and/or SUD coverage that that state may be imposing upon plans. We have seen instances where such state-mandated requirements cause violations of MHPAEA, with plans not being the actor responsible for causing the violation. By reviewing data and state regulations, as well as policy and coverage documents, states and CMS can gain a more comprehensive understanding of parity issues, both as written and in operation.

Question 4 – Priority NQTLs / Benefits Classifications

We believe that parity compliance issues for Medicaid managed care, CHIP, and ABPs are broadly similar to private plans. The Departments previously indicated in their 2022 MHPAEA Report to Congress that they are prioritizing prior authorization, concurrent review, and reimbursement rates. We believe this is appropriate. In the recently proposed MHPAEA rules, the Departments put a strong focus on NQTLs relating to “network composition.” Because many Medicaid managed care and CHIP plans have deeply inadequate MH/SUD networks, we strongly urge CMCS to similarly prioritize “network composition” NQTLs.

We also recommend CMS review the scope of services NQTL and ensure that all states are providing meaningful coverage of MH and SUD services in Medicaid across all benefit classifications. Several states lack coverage for SUD care in inpatient settings, and a number of states are not covering the full continuum of medically necessary care in the community (particularly intensive outpatient and partial hospitalization programs, or opioid treatment programs), despite doing so for M/S benefits. While we acknowledge that many states have lifted up the IMD exclusion as a barrier to ensuring coverage of the whole continuum of care, we believe states are overlooking their ability under current law to strengthen and expand community-based services while reserving non-IMD residential facilities for individuals in need of a higher level of care. As the Departments consider expanding on this requirement for commercial plans, we urge similar consideration for Medicaid MCOs, ABPs, and CHIP. We also note that there is inconsistent coverage of mobile crisis and crisis response services in Medicaid programs, and CMS should ensure that such coverage is meaningfully available across the country for Medicaid enrollees to enable a person-centered approach to MH/SUD crises, rather than a law enforcement or punitive one.

Ghost networks are another NQTL that is particularly problematic in the Medicaid program. A recent [study](#) in Health Affairs of the Oregon Medicaid program found that **67.4%** (more than 2/3) of mental health prescribers and **59%** of other mental health professionals listed in the directories were phantoms. This issue is worse in MH/SUD than in other areas of healthcare. Network adequacy is another issue that disproportionately affects MH/SUD and plans do not adjust rates to address workforce shortages in MH/SUD as they do in other areas of healthcare.

Question 5 – Criteria for Identifying High Priority NQTLs

In the recent proposed MHPAEA rules, the Departments have proposed requiring plans to collect, analyze, and report data showing the effect of their NQTLs on access to MH/SUD and M/S care in order to demonstrate equitable access to care. We believe state Medicaid agencies and CMCS should be guided by similar data. Our organizations believe that low reimbursement rates and inadequate MH/SUD networks are a critical barrier to access, but that all “network composition” NQTLs should be priorities. We also have seen how any barriers to care that effectively require Medicaid / CHIP beneficiaries to jump through hoops before obtaining needed treatment can severely hinder access. For example, prior authorization and step therapy (“fail first”) requirements are deeply problematic for Medicaid / CHIP beneficiaries, who often lack

the time or resources necessary for navigating these complex policies. This is particularly true for individuals with an MH or SUD, which may further inhibit their ability to navigate complex systems. These barriers often compound for individuals who are dually eligible for Medicare, where they may be forced to jump through hoops in multiple insurance systems, further delaying care or resulting in the individual foregoing necessary treatment altogether.

Question 6 – Measures / Datapoints for Identifying Potential Violations

Measures and data are critically important to identifying potential violations. As referenced above, there are a number of data collection tools that already exist such as the Model Data Request Form. Additionally, many of our organizations submitted detailed responses to the request for comment to the Departments' MHPAEA Technical Release.⁶ Because we believe common MHPAEA compliance problems exist across private and public plans, and in an effort to establish greater consistency across health plan types to ease the burden on both carriers and regulators, we urge CMCS to review these comments on data measures and adopt robust data requirements as appropriate for government programs.

For example, given the prevalence of ghost networks in Medicaid, MCOs should be required to report on network composition data identified in those comments,⁷ such as how many of their MH/SUD providers have not billed at least some minimum amount last year compared to their Med/surg providers. They should also have to report on provider directory accuracy in a manner that compares MH/SUD to med/surg on key data points such as phone numbers, what providers are accepting new patients, and linguistic capabilities. Our detailed responses to the request for comment to the Departments' MHPAEA Technical Release further outline relevant data we believe should be considered for network composition.

Question 7 – Collecting Data / Measures

We believe that data collection methods and formats should align to the maximum extent possible with new final MHPAEA rules for private plans and guidance relating to data collection requirements and formats. We urge CMCS not to have differing requirements.

Question 8 – Follow-Up Protocols / Corrective Actions

When MHPAEA compliance information and data is collected, we have seen too many regulators simply accept grossly inadequate responses. To ensure MHPAEA compliance, state Medicaid agencies must not accept plan responses until plans have demonstrated compliance as laid out in FAQ 45. Particularly where state Medicaid agencies have put in place strong contractual requirements, they have the clear

⁶ For example, The Kennedy Forum and more than a dozen other groups submitted [these comments](#) on the Technical Release.

⁷ See, e.g., pp. 3-7 of the comments cited in the prior footnote.

authority to demand that plans provide further information until a plan fully demonstrates compliance (including making any needed changes). Corrective actions for noncompliance must include changes to make the NQTL in question fully compliant, reprocessing of claims for coverage subject to noncompliant NQTLs, and administrative penalties against the plan.

Question 9 – Additional Processes (E.g., Random Audits)

As referenced above, MHPAEA compliance should be built into all aspects of Medicaid managed care, CHIP, and ABP coverage – for MH, SUD, and M/S care. This includes reviewing initial plan policies and coverage documents, plans' NQTL analyses, and through audits of plans' practices. State Medicaid agencies should conduct parity compliance investigations that are similar in nature to state departments of insurance market conduct examinations. Such investigations, which should include robust audits of claims, should occur at least every few years and should be unannounced. We also recommend both CMS and State Medicaid agencies develop processes to review and address all complaints and grievances related to MH and SUD benefits for potential parity violations.

Question 10 – MH/SUDs that Are More Prevalent / Barriers to Treatment

We believe that coverage barriers to specialized or more intensive treatment are particularly urgent to address. For example, for individuals experiencing early psychosis, Coordinated Specialty Care often is not properly covered. At the same time, [data](#) suggests that there is insufficient access to community-based and less intensive services for SUD treatment (including intensive outpatient and partial hospitalization programs, as well as medications for alcohol and opioid use disorders) that could prevent beneficiaries from needing emergency department or inpatient services. This is particularly important since substance use disorders, including opioid, alcohol, and stimulant use disorders, disproportionately affect low-income people. Additionally, there is an urgent need to improve treatment and supports for co-occurring MH/SUD or any MH/SUD with a co-occurring chronic/acute medical condition. Core services for borderline personality disorder such as DBT are often not appropriately covered nor are services to treat trauma in both youth and adults.

Question 11 – Particular MH/SUDs or Type of Treatment with Greater Parity Noncompliance

MH/SUDs that require specialized, complex, or intensive treatment, including wrap-around and coordinated services, are at higher risk of parity noncompliance and should be examined more closely. We encourage additional reporting on a range of services, including coordinated specialty care for early psychosis, intensive outpatient or partial hospitalization services for eating disorders, applied behavior analysis for autism spectrum disorders, dialectical behavior therapy for a range of serious mental illness including bipolar disorder and bipolar disorder with psychotic features, treatment-

resistant depression, and post-traumatic stress disorder, and services for co-occurring MH/SUD or co-occurring chronic or acute medical conditions.

Further, there are still widespread parity violations when it comes to imposing prior authorization, quantity limits, and preferred drug list status on all medications for opioid use disorder and naloxone.⁸ There are also significant issues with lack of coverage of opioid treatment programs (OTP), which means people have significant barriers to accessing coverage for methadone. Plans may be in violation of parity if they're imposing more onerous requirements on OTP coverage than similar M/S facilities. We encourage CMS to require states to ensure equal access to services for both MH and SUD.

Lastly, we are concerned that SUD benefits continue to have differential coverage than MH benefits. Thus, the failure of most states to review MH and SUD benefits separately and compare them to M/S benefits makes it difficult to establish if even the most common MH conditions and SUDs are covered in compliance with parity. We have often seen significant differences in parity compliance between the same entity's MH and SUD programs. Thus, aggregation of MH and SUD benefits information may mask significant problems. CMS should ensure that regulations and guidance clarify this requirement and ensure that appropriate and comprehensive parity compliance analyses are conducted, for both MH and SUD, in all MCO, ABP, and CHIP plans.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Lauren Finke at The Kennedy Forum (lauren@thekennedyforum.org).

Sincerely,

The Kennedy Forum
American Association for Psychoanalysis in Clinical Social Work
American Association of Psychiatric Pharmacists (AAPP)
American Association on Health and Disability
American Mental Health Counselors Association
American Psychiatric Association
American Psychological Association
American Society of Addiction Medicine
Anxiety and Depression Association of America
Anxiety and Depression Association of America
Eating Disorders Coalition for Research, Policy, & Action
Inseparable
International OCD Foundation
Lakeshore Foundation
Mental Health America

⁸ Substance Abuse & Mental Health Serv. Admin., *Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose* (2018), https://store.samhsa.gov/sites/default/files/d7/priv/medicaidfinancingmatreport_0.pdf.

National Alliance on Mental Illness (NAMI)
National Association for Behavioral Healthcare
National Association for Children's Behavioral Health
National Council for Mental Wellbeing
National Federation of Families
National Health Law Program
Partnership to End Addiction
Psychotherapy Action Network
REDC
RI International
The National Alliance to Advance Adolescent Health
Treatment Advocacy Center