December 1, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: Request for Comments on Mental Health Parity in Medicaid and CHIP,
P.O. Box 8016, Baltimore, MD 21244–8016

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

Dear Administrator Brooks-LaSure,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to provide input on the Request for Comments on Processes for Assessing Compliance with Mental Health Parity (MHP) and Addiction Equity in Medicaid and CHIP (the RFC).

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 managed care organizations (MCOs) serving more than 50 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries. Below you will find general remarks on Mental Health Parity in Medicaid and CHIP, as well as specific responses to the questions contained in the RFC.

General Remarks on Mental Health Parity in Medicaid and CHIP

We commend CMS for taking steps to solicit feedback to help improve access to mental and behavioral health services for Medicaid and CHIP enrollees. Access to mental and behavioral health services is critical to ensuring whole person health for the vulnerable populations served by the Medicaid and CHIP programs. Mental illness and substance-use disorders (SUDs) are most prevalent among nonelderly adults with Medicaid. As of 2020, an estimated 29% of Medicaid enrollees have a mental illness, compared to 21% of privately insured individuals and 20% of uninsured individuals. Medicaid enrollees have the highest overall prevalence of moderate to severe mental illness or substance use disorders. Combined, 39% of Medicaid enrollees have a mental illness and/or substance use disorder, relative to 31% of privately covered and uninsured people.[1] We applaud CMS for its transparent approach to addressing mental health parity and through the solicitation of comments from key stakeholders, which will aid in ensuring that solutions are tailored to the needs of enrollees, State Medicaid Programs, and the unique programmatic designs of each jurisdiction offering Medicaid and CHIP. MHPA and its members look forward to collaborating with CMS and State Medicaid Agencies to ensure that enrollees can access the mental and behavioral health services they need in a streamlined and accessible manner.

[1] https://www.kff.org/mental-health/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/

Value of Managed Care

Medicaid MCOs are proud to serve enrollees in Medicaid and CHIP, and services delivered through the managed care model are reflective of a successful state-health plan partnership providing the necessary infrastructure to meet the physical and behavioral health needs of Medicaid enrollees. Medicaid MCOs can coordinate care and deliver value-added services that may not always be available through a fee-for-service model. Delivering high quality of care to enrollees, Medicaid MCOs can offer whole person care, determined by the needs of the individual, that range from the provision of additional nutritional guidance to housing supports.

Variation Between State Medicaid Programs

As CMS is aware, Medicaid and CHIP differ from the Marketplace, employer-sponsored coverage, and Medicare in that each state customizes their benefit structure and approach to meet the needs of the individuals and geographies in their States, regions, and local communities. For example, states vary in whether they deliver certain Medicaid services through a fee-for-service, managed care, or hybrid model and Medicaid program design can vary by county within a state.

We encourage approaches to MHP to consider and support variation in State programmatic design for Medicaid and CHIP programs to ensure that states retain the flexibility to provide customized solutions to meet the needs of enrollees. State autonomy in the administration and programmatic design for their Medicaid and CHIP programs provides important flexibility for states to tailor approaches to meet the needs of the vulnerable populations and subpopulations receiving care through Medicaid and CHIP, based on their medical needs and geographies. In this flexibility lies the strength of the Medicaid and CHIP program, which offers solutions to meet the specific needs of enrollees including populations needing long-term services and supports, youth in foster care, individuals with serious mental illnesses (SMIs), pregnant and postpartum individuals, individuals with intellectual or developmental disabilities, aged blind and disabled populations, children, and low-income individuals, to name a few. Further, individuals in the Medicaid and CHIP program can reside in geographies such as urban, rural, suburban, and underserved areas with varying challenges including provider workforce issues, telecommunications challenges, and limited access to nutrition and housing supports.

There is no one-size-fits-all approach to ensuring MHP in Medicaid and CHIP given the significant variations between how states choose to administer the Medicaid program. For states with behavioral health carve-outs, where the state chooses to contract for behavioral health services separately from other medical benefits, we note unique challenges for conducting mental health parity analyses and would encourage CMS to continue providing State Medicaid Agencies with the flexibility to administer their programs in a way that meets the needs of their enrollees. For example, the potential lack of information on what benefits enrollees are receiving on the physical or behavioral health side in such instances may present challenges for mental health parity analyses that require the verification of benefits and non-quantitative treatment limitations (NQTLs) for enrollees. Given these wide variations in Medicaid program design and delivery, we encourage CMS to consider feedback from a broad array of stakeholders, including patient groups, providers, States, and Medicaid MCOs.

Behavioral Health Workforce Challenges

Nearly half of the US population – 47% or 158 million people – live in a behavioral health workforce shortage area. The COVID-19 pandemic exacerbated the pre-existing behavioral health workforce

shortage. Rural and underserved areas face unique challenges in recruiting and retaining health professionals. Medicaid enrollees seeking behavioral health care services are particularly impacted. On average, only 36% of psychiatrists accept new Medicaid patients – lower compared to other payers and compared to rates for physicians overall (71%). Even when providers accept Medicaid, they may only take a few patients or may not be taking new Medicaid patients at all.

MHPA supports federal and state efforts to address behavioral workforce shortages impacting Medicaid enrollees (e.g., reimbursing new provider types, changing scope of practice policies).

As CMS considers approaches to ensuring MHP in Medicaid and CHIP, we encourage the development of realistic standards which promote workforce development in advance of the imposition of new requirements which may not be tenable given existing access issues.

Behavioral Health Workforce Recommendations

States have significant flexibility to provide telehealth services, and all 50 States and the District of Columbia currently provide some Medicaid coverage of telehealth. During the COVID-19 pandemic, states took advantage of broad authority to expand Medicaid telehealth policies, resulting in increased telehealth utilization. In particular, states reported that telehealth helped maintain and expand access to behavioral health care during the pandemic.

TeleBehavioral Health (TeleBH) allows members to continue behavioral health treatment safely and in their own homes, which is particularly important in rural and underserved areas. TeleBH connects members with providers who can meet their unique cultural needs and improve access to specialists, giving all members an equal opportunity to obtain specialized care. Additionally, TeleBH removes barriers that can be present with in-person care including lack of reliable transportation, stigma, and time away from work. MHPA encourages policies that support state efforts to embrace telehealth, including continued state flexibility to determine how telehealth services are delivered and mutual recognition compacts for professional licenses that make it easier for health care providers to practice telehealth in multiple states. Medicaid enrollees lacking access to the internet or data enabled devices, including in rural and underserved areas, also present behavioral health access issues. We recommend cross-agency collaboration to promote the Affordable Connectivity Program and guidance encouraging State Medicaid Agencies to support access to these devices in order to support TeleBH.

To help address the behavioral health workforce shortage, MHPA recommends several additional policy changes at the federal level:

Integrate peer support specialists into the mental health and SUD system. Peer support specialists are individuals who use their own experience recovering from mental health and/or SUD challenges to support others. While peer support services are an evidence-based mental health model of care, varied background screening laws across states can create barriers for peer support specialists being able to provide support. We support efforts to address inconsistencies across states and work to ensure peer support specialists are integrated into the mental health and SUD system.

Allow Medicaid to be billed for services provided by a wider range of providers. This could help address workforce shortage issues and help minimize long waits for care and services. For example, Federally Qualified Health Centers (FQHCs) could be allowed to bill Medicaid for visits enrollees have with a marriage and family therapist, licensed professional counselor, or a licensed addiction counselor.

Promoting Behavioral Health Care Workforce Diversity

Medicaid serves a disproportionate number of people of color who studies have found to have worse access to mental health care and receive lower quality mental health care.[2] MHPA supports federal and state actions to build and grow a diverse behavioral health workforce as part of a broader effort to address barriers to care and promote health equity for underserved communities.

MHPA also believes that mental health literacy is the basis for prevention, stigma reduction, and increased awareness for both behavioral health issues and available treatment options. Promoting mental health literacy through education, community awareness, and outreach that incorporates an understanding of cultural norms of underserved communities can encourage greater participation in the behavioral health care workforce from traditionally underrepresented groups.

Addressing the National Opioid Crisis

Medicaid plays a critical role in addressing the national opioid crisis. We believe increased SUD and opioid use disorder (OUD) education for all appropriately licensed prescribers would increase early identification and treatment and be particularly impactful in rural areas where access to behavioral health services is limited. We recommend that CMS continue to work with treatment centers to ensure quality access with evidence-based approaches to addressing SUD and OUD. Treatment options in existing facilities vary significantly and are not always consistent with approaches recommended by SAMHSA. Moreover, only one in four residential facilities that treat adolescents in the U.S. for OUD offer buprenorphine, the sole Federal Drug Administration (FDA) approved medication for 16- to 18-year-olds.

General Approach to Ensuring Mental Health Parity in Medicaid and CHIP

We encourage CMS not to apply newly proposed commercial Mental Health Parity and Addiction Equity Act (MHPEA) rule requirements to Medicaid MCOs for parity compliance requirements. The proposed rule could impact health outcomes, and service quality for patients.

The proposed rule fundamentally restructures what parity means, shifting the focus from comparing methodologies to comparing outcome measures that do not address the care received by enrollees. This approach goes well beyond the intent of the law and any disparate outcome measure could suggest noncompliance. The proposed rule requires onerous new network adequacy data collection requirements, including in-network and out-of-network utilization rates (including data related to provider claim submissions), network adequacy metrics (including time and distance data), and provider reimbursement rates (including as compared to billed charges). Further, the proposed three-part NQTL test, particularly the Substantially All Predominant Test, would limit the ability to ensure patients receive safe, medically appropriate care. Congress specifically authorized these medical management techniques when enacting MHPEA in order to safeguard effective treatment for patients.

We believe that a redesign in how parity is measured would result in a regression in how plans measure parity given the progress in mental health parity to date. Instead, we recommend building upon previous

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8842821/#:~:text=African%20Americans%20and%20other%20ethnic,for%20depression%20are%20understudied1

work in measuring parity in the Medicaid and CHIP space, with approaches that consider the variations in State programmatic design and the unique needs of Medicaid and CHIP enrollees.

Responses to Individual Questions

Q#	Question	Response
1	What are some model formats (e.g., templates) and key questions to consider for improving efficiency and effectiveness of review of documentation of compliance with parity requirements in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?	It is important to note that each Medicaid program varies on what is considered to be a service that would be covered under a mental health/ SUD benefit. We believe it would be helpful to have a standardized Federal template on data collection requirements that will not vary significantly from State to State. Should CMS consider creating a federal template, it will be important to solicit MCO, State and other stakeholder feedback. While varying benefit packages by subregion and state, or behavioral health carve-outs may call for exceptions, we broadly recommend North Carolina's parity template as a model, as it provides a streamlined and holistic approach to measuring parity. We encourage CMS to provide North Carolina's template as an option for states to adopt as they develop parity standards. In addition, we recommend that CMS provide a completed version of this template that is compliant with federal regulations so that interpretation is kept at a minimum and states can ensure that what they submit meets CMS standards. States should retain the flexibility to modify this template and build on it in reflection of their unique programmatic designs, as discussed in our opening remarks. Additionally, we note that there is variation in how states conduct parity analyses with regards to managed care: Either the state or the MCO may complete the parity analysis depending on how benefits are provided (42 CFR § 438.920). The MCO typically must complete the analysis when it provides all Medicaid benefits—both medical and mental health and SUD benefits—and inform the state what contract changes are needed to comply (CMS 2016b). The state must complete the parity analysis if benefits are provided through multiple delivery systems (e.g., multiple MCOs, or under FFS) and provide the analysis to CMS for review (CMS 2016a). CMS should consider this variation in approaches to measuring MHP in Medicaid and CHIP.
2	What processes are states and managed care plans using to determine whether existing coverage policies are comparable for MH and SUD compared to medical and surgical benefits?	Some plans have developed a NQTL repository to serve as a crosswalk between MH/SUD coverage policies compared to medical and surgical benefits. This repository serves as a means for plans to ensure coverage policies are in alignment with Federal and State requirements. Further, plans use the NQTL library to respond to any regulatory requests that may come from the State.
3	What are some key issues to focus on in reviewing policy or	We believe that States are best positioned to understand if there are compliance issues with States, currently States audit and make sure

	coverage documents that may indicate potential parity compliance issues including regarding NQTLs in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?	that Medicaid managed care organizations are meeting mental health parity requirements.
4	Which NQTLs and/or benefit classifications should be prioritized for review?	States define the parameters around NQTLs. For example, states define which benefit to be covered, any visit limits, and any fee schedules. As such, NQTLs should be viewed differently for MCOs vs. in commercial plans. "Limitations" on benefit structures for MCO consumers are typically the result of state programmatic design. CMS should further examine what NQTL aspects are a result of state programmatic design or carve-outs and analyze those nuances before imposing similar prioritizations as in the commercial context.
6	What are some measures or datapoints or other information that could help identify potential parity violations in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?	While we share in CMS's goal of ensuring mental health parity, we note that the current requirements in contracts with States are meeting the standards that CMS is seeking feedback on. As noted in the CMS Managed Care and Access NPRM, wait time standards were proposed for certain services including MH/SUD services. We recognize that finding a remedy to ensure access to these services is a foundational access issue that needs to be addressed and support solutions that focus first on provider capacity through workforce development to serve beneficiaries with BH and SUD services before implementing wait time standards for BH providers. Further, we believe that any additional measurements should be decided between State Medicaid programs and the managed care plans that operate within the State. It is important to note that every MH/SUD does not always have a clear transition to a medical and surgical benefit. The level of the practitioner between MH/SUD and medical and surgical benefits do not always have an equivalent transition. For example, inpatient acute care for MH is not the same for medical and surgical services. In addition, a master's level therapy visit versus physician services for primary care are not equal level.
7	How should data on these or other recommended measures be collected?	We refer CMS to the comments received on the Managed Care and Access NPRM and on the proposed Medicaid and CHIP Quality Rating System (MAC QRS) to determine whether any additional measures would be necessary. Further, CMS should consult with States, MCOs and other stakeholders to determine whether any additional measurement is necessary before deciding whether any changes are necessary.
8	What are some potential follow-up protocols and corrective actions when measures indicate a potential parity violation in Medicaid	CMS should continue to give States the authority to determine follow-up protocols and corrective actions that might be needed when plans are found to be out of compliance with MH parity requirements. Deference should be given to the States to work with contracted MCOs for any corrective action.

	managed care arrangements, ABPs, and CHIP?	
9	What additional processes should be considered for assessing compliance with Medicaid and CHIP parity requirements, e.g., random audits?	States are already conducting audits of compliance with parity requirements. CMS should continue with the current processes that are in place.
10	Are there any MH conditions or SUDs that are more prevalent among enrollees in Medicaid MCOs, Medicaid ABPs, or CHIP? What are the most significant barriers to accessing treatment among enrollees with these conditions?	As noted earlier, there continues to be provider shortages in the health care industry. There are even more concerns around MH/SUD providers. CMS should work with relevant parties to improve access and come up with innovative solutions to improve the number of providers that are providing these and other types of health care services.
11	Are there any particular MH conditions or SUDs or types of treatment that are at risk of not being covered in compliance with parity requirements for Medicaid managed care arrangements, Medicaid ABPs, or CHIP?	Plans remain in compliance with various State Medicaid coverage requirements for all MH and SUDs treatments, as required by the parity requirements. Further, States audit compliance with MH parity on an ongoing basis and as such, the function, should remain with them. As CMS noted in the 2016 final rule, in part, "Since Medicaid is a state and federal partnership, we believe that the state, and not CMS, should identify which conditions are considered medical/surgical and MH/SUD conditions" (81 FR 18393).

Once again, thank you for the opportunity to provide comments on the Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP. Supporting access to behavioral and mental health care and services for Medicaid beneficiaries is of paramount importance to MHPA. We appreciate the opportunity to share our perspective to address standards for parity and access challenges and look forward to continuing to work with CMS and our state partners to make a meaningful difference in the lives of Medicaid beneficiaries.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Vice President, Government Relations and Advocacy