December 2, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Submitted via: MedicaidandCHIP-Parity@cms.hhs.gov

Re: Centers for Medicaid & CHIP Services: Request for Comments on Templates for Documenting Compliance with Mental Health Parity and Addiction Equity Act Requirements 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 (RFC) on Templates for Documenting Compliance with Mental Health Parity and Addiction Equity Act Requirements in Medicaid and CHIP. Supporting access to behavioral and mental health care and services for Medicaid beneficiaries is of paramount importance to our health plan members. We believe that 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.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 150 managed care organizations (MCOs) serving more than 47 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 comments on the proposed templates for documenting compliance with Mental Health Parity and Addiction Equity Act requirements in Medicaid and CHIP as well as specific responses to the questions contained in the RFC.

General Comments on the Templates for Documenting Compliance with Mental Health Parity in Medicaid and CHIP

MHPA applauds CMS' transparent approach to support compliance with mental health/substance use disorder (MH/SUD) parity requirements across health care delivery

systems, including Medicaid managed care. In our [December 1, 2023 letter] in response to the Center for Medicaid & CHIP Services (CMCS) Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP, MHPA shared that "[i]t 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." We appreciate CMS' acknowledgement and responsiveness to our feedback noting in the current RFC that "there was broad agreement that a more standardized and simplified approach to documentation of parity compliance would be helpful." We applaud CMS for moving in the direction of using uniform tools to measure compliance and support the agency in adopting measures aimed at promoting consistency among states.

While the proposed templates are intended to reduce the amount of time spent by states and health plans collecting information to document compliance and to improve the efficiency and effectiveness of CMCS' review and analysis of submitted information, we have concerns with the complexity of the proposed format. While we recognize that the templates may be useful for collecting information – particularly in states where MH/SUD and medical/surgical (M/S) coverage is provided by the same MCO, the real work of parity compliance lies in the comparative analysis. This is because – often for historical and contingent reasons – operational processes for coverage of MH/SUD services under Medicaid are often different from the processes for M/S coverage. However, different does *not* mean non-compliant, as long as the MH/SUD processes are not more *stringent*; this underscores the complexities inherent in developing comparative analyses related to mental health parity compliance.

Given the expansive breadth of information required in the proposed templates, we believe the Excel spreadsheet format is not well-suited for capture and review of the required information for assessing mental health parity compliance. For example, each Excel cell has a character limitation that can easily be exceeded when attempting to include clinically complex information. Both the design and application of non-quantitative treatment limits (NQTLs) are complicated subjects that do not lend themselves well to a one-cell summary in a spreadsheet. This is particularly true for states that carve out subsets of populations that receive mental health services or that carve out subsets of mental health services as well as for state Medicaid programs that include carve-outs from capitation payments.[1] For example, in Pennsylvania, the MH/SUD Medicaid coverage is carved out from physical health coverage and provided through separate behavioral health (BH)-MCOs that contract with individual counties. In such instances, we recommend that CMS clarify that states are responsible for conducting parity analyses rather than Medicaid managed care plans, and

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[1] For an overview of behavioral health care delivery in state Medicaid programs, please refer to the KFF Issue Brief: *How do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs* (May 2023) at: https://www.kff.org/medicaid/issue-brief/how-do-states-deliver-administer-and-integrate-behavioral-health-care-findings-from-a-survey-of-state-medicaid-programs/

share the results of the analysis with stakeholders to provide opportunity to adjust. To the extent states are being audited by CMS and given feedback, plans should also receive that information. We also recommend CMS consider alternative formats such as the development of pre-set Tables in a Microsoft Word template to minimize burden and provide greater flexibility and refer to North Carolina's parity template as a model (https://www.ncdoi.gov/documents/life-and-health/healthcare-law/mental-health-parity-and-addiction-equity-act-mhpaea-compliance-checklist/open).

In addition, we recommend the format allow for a narrative discussion for each point of comparison. This information would provide critical details and insights for whether differences in policies or processes actually are more restrictive. For example, the paradigm of utilization management and care management is different for inpatient admissions for MH/SUD compared to M/S. For physical health hospital admissions, there is a stringent front-end assessment because payment is diagnostically-related group (DRG)-based with continued stay review primarily focused on discharge planning purposes rather than cost-avoidance. For mental health hospitalization - that are typically auto-authorized upon notification from the hospital and where facilities are usually paid a per diem amount – continued stay reviews are set after admission to determine the necessity of continued stay to ensure that patients with acute psychiatric needs do not face barriers to treatment and that patients are discharged to less restrictive, community-based levels of care as soon as appropriate. This example demonstrates why a side-by-side comparison of processes is unlikely to be useful in the absence of narrative discussion of the issues for each type of admission.

The proposed templates could also be streamlined. To decrease burden and enhance efficiency, we recommend CMS revise the proposed templates to allow information to be input once, and thereby reviewed once, if it applies across multiple programs (e.g., CHIP and managed care) instead of requiring the same responses multiple times across the templates under a separate tab for each program.

Specific comments related to worksheets (i.e., Tabs) within the ***Parity State Summary Template*** are included in the following table:

Parity State Summary Template	
Tab C	CMS should clarify whether states or MCOs fill out this section. We recommend that the header "Entity Providing Benefits" be changed to "Entity who owns the Policy and Procedures for BH".
Tab D	We recommend that the header "Entity Providing Benefits" be changed to "Entity who owns the Policy and Procedures for BH".

Tab G	We recommend more explicit instructions, with examples, on how to handle and document cross-over benefits (claims and authorizations for “cross-over services” that are delivered to treat both MH/SUD and M/S conditions—including speech and occupational therapy, urgent care, surgeries (e.g., for gender dysphoria), and a wide range of other services—which must be treated as MH/SUD benefits if the primary diagnosis is a MH or SUD condition.) We recommend that for cross-over services, CMS ensure the form allows for the testing used by the Tri-Agencies for commercial coverage as well, where the percentage of annual claims for a treatment or service stemming from a M/S diagnosis or a MH/SUD diagnosis can help to determine categorization (see October 2017 FAQ).
Tab H	We recommend CMS clarify if a state must classify each benefit per state contract and the role for MCOs.
Tab N and O	We recommend CMS clarify how the states will ask MCOs to memorialize this information going forward.

For additional guidance, we encourage CMS to provide examples of successfully completed templates using deidentified NQTL as well as a few examples of data that are input incorrectly. Also, when the proposed templates are finalized and as they are updated over time, CMS should consider offering voluntary training sessions such as webinars.

Further, MHPA recommends that CMS consider the convening of an Advisory Committee comprised of stakeholders - including representatives from state Medicaid programs, health plans, and patient advocacy organizations - to help inform further improvements to the proposed templates. While we appreciate the opportunity to provide feedback through this RFC, we believe an Advisory Committee would support the exchange of ideas to further improve the proposed templates and could help further refine the templates as needed even after they are finalized.

Considering our concerns and recommendations expressed in this letter, MHPA recommends CMS consider January 1, 2026 as the “go live” date for the proposed templates. MHPA appreciates the development of these proposed templates to ensure compliance with mental health parity requirements. However, we believe there is additional work to be done for the proposed templates to support greater efficiencies and effectiveness. Furthermore, recent regulatory enhancements to access and quality will require states, plans, and providers to make significant investments in areas such as network adequacy and technology to remain compliant with new requirements, with plans likely to spend their administrative funds to ensure compliance. Although requirements from recent rulemaking are too numerous to list here, some of the more significant policy changes include:

- Requiring wait time standards for primary care, OB/GYN, BH, and one state selected service with secret shoppers to verify compliance.
- Requiring managed care plans to submit an annual payment analysis to states.
- State directed payments (SDPs): Average commercial rate provision and requirement that SDPs to be incorporated into Medicaid managed care capitation rates.
- Establishing a Medicaid and CHIP quality rating website.
- Requiring that states ensure that 80% of Medicaid payments be spent on compensation for direct care workers.
- Requiring minimum nurse staffing levels at long-term care facilities.

Responses for Specific Questions for Comment

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

The proposed templates adequately incorporate the MH/SUD parity requirements for Medicaid managed care including the documentation for financial requirements, quantitative treatment limitations (QTLs), and NQTLs for Medicaid state agencies. However, we note that many NQTLs are designed or mandated by the state such as out of network providers and step therapy application. This variation means that not all NQTLs exist in every state and some of the cells in the proposed templates would be left blank if the state does not allow them. Further, there is no guidance indicating how a MCO would respond to how they were designed other than "as required by the state."

We recommend that CMS remove the financial requirement fields from the template since there is generally no cost-sharing in Medicaid plans.

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

We appreciate that the templates and instructional guides are intended to clarify and standardize information that demonstrates compliance, or failure to comply, with MH/SUD parity requirements. We fully support instructional guides as helpful companion documents with explicit instructions on how to successfully complete the parity templates.

While the proposed templates would standardize the submission of data, we believe the templates are overly complex and could be simplified to minimize burden. For example, the proposed templates could be truncated to request only the necessary QTL and NQTL information that usually applies to Medicaid managed care, ABPs, and CHIP programs.

Additionally, Excel spreadsheets are constrained by cell character limitations that can easily be exceeded when attempting to include clinically complex information. An example of this can be found under "Tab G – NQTL Prior Auth – IP", Line 13, which asks for Evidentiary Standards, but its cell size restrictions will likely prevent the input of enough detail to demonstrate compliance with MH/SUD Parity. We also note a lack of clarity on whether or how a state should request data metrics from MCOs (i.e., denial rates, reimbursement rates.) Instructional guidance in this area would be helpful.

While varying benefit packages and behavioral health carve-outs may call for exceptions, we recommend North Carolina's parity template as a model of a streamlined and holistic approach to measuring parity (https://www.ncdoi.gov/documents/life-and-health/healthcare-law/mental-health-parity-and-addiction-equity-act-mhpaea-compliance-checklist/open). The North Carolina parity template uses a pre-populated Word table that provides boxes to be checked (or not). CMS could consider this approach for its federal template, or, alternatively, provide North Carolina's template as an option for states to adopt as they develop parity standards.

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

We believe the proposed templates are complicated to follow even with the instruction guides. The Excel format is not user-friendly and may be overly complicated for many Medicaid agencies to complete. Adding to the complexity is the requirement that the same information is required to be input multiple times across the templates under a separate tab for each program.

For additional guidance, we would recommend that CMS include more examples for each element to support a better understanding of what exactly is expected in the proposed templates. We encourage CMS to provide examples of successfully completed templates that are compliant with federal regulations using deidentified NQTL. We also believe that states should retain the flexibility to modify this template and build on it in reflection of their unique programmatic designs.

Additionally, we believe that issues are likely to emerge with the proposed template that only become evident after they are finalized and used broadly. To address these issues, we encourage CMS to hold training and question sessions to identify and create solutions during this process and periodically update the templates as needed. Emerging issues could also be addressed by a standing Advisory committee as referred to in our general comments.

4. Are the NQTLs highlighted in the templates (i.e., prior authorization, concurrent review, step therapy/fail first, standards for provider network admission, and

standards for access to out-of-network providers) the most common and critical NQTLs? Are there others we should consider including or some on this list that are not as critical?

We believe the proposed templates include the most common NQTLs and would allow Medicaid agencies to report on additional NQTLs as applicable.

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

While minimizing duplicative efforts would help minimize burden, we would not recommend combining the financial requirements (FR) and quantitative limitations (QTL) data worksheets into a single worksheet. The FR and QTL worksheets have different definitions and are illustrated in different ways (e.g., copays, number of visits). Additionally, these forms are often managed by different groups within health plans and combining them could cause confusion and version control issues.

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

We believe the appropriate NQTLs are captured and appreciate CMS' effort to create a foundational list of appropriate NQTLs. We encourage CMS to continue to iterate over the required information to identify any missing elements once the finalized templates are in use over time.

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

Contract type can lead to variances in how NQTLs are applied across programs. However, NQTLs are generally applied in a similar fashion across various programs.

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

To streamline data entry, minimize burden, and enhance efficiency, we recommend CMS revise the proposed templates to allow information to be input once if it applies to multiple programs (e.g., CHIP and managed care) instead of requiring the same responses multiple times across the templates under a separate tab for each program.

Further, the guidance requires states to provide MCOs with their benefit classifications. We recommend CMS develop uniform classifications and specificity that all classifications on the template should be aligned with ICD-10.

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9. As we consider how best to structure and format these templates and the number of worksheets that may be needed, it would be helpful to have information in response to the following questions:

    a. What is the maximum number of benefit packages that could be expected to be subject to parity requirements in a state?

    The maximum number of benefit packages depends on the market and Medicaid agency.

    b. What is a maximum number of entities (i.e., managed care plans and State FFS programs) that could be expected to deliver benefits for a given benefit package in a state?

    The number of Medicaid managed care plans administering the Medicaid program varies between states and can vary from year to year. Currently, there are state Medicaid programs that have nine or more managed care entities administering the Medicaid program in that state. It would be helpful for CMS to clarify whether the state Medicaid agency is expected to report once for the state Medicaid program as a whole or would need to provide one report for each of its managed care partners.

    c. What is the average number of entities that deliver benefits for a given benefit package?

    The average number of benefit packages depends on the state, Medicaid agency, Medicaid population, and approved waivers.

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

We believe that it will be easier to require standardized templates particularly in light of the Medicaid Managed Care Rule. We also recommend a start date of at least one year (e.g., January 1, 2026) from the time of the finalized templates that would apply to all state

Medicaid programs. We have concerns that establishing a "triggering event" may lead to some Medicaid agencies having to complete these new templates as early as January 1, 2025, if, for example, a "triggering event" is defined as when a new managed care plan joins the program.

11. Once these templates are finalized in accordance with the Paperwork Reduction Act, CMS intends to require states to use them to document their compliance with the parity requirements.

    a. What is a reasonable transition period that CMS should consider allowing before requiring the use of these templates?

    We recommend a start date of at least one year (e.g., January 1, 2026) from the time of the finalized templates that would apply to all state Medicaid programs

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

    MHPA recommends CMS establish one uniform timeline across all program types. We recommend CMS clarify how often the templates should be completed and submitted.

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

    We defer to states to provide the initial estimates of dedicated staff time. However, given the extensive data requested for financial requirements and QTLs, in addition to the complexity of the format for NQTLs, we expect that completing these templates will require the attention of multiple representatives for both state agencies and managed care entities.

Once again, thank you for the opportunity to provide comments on the Request for Comments on Templates for Documenting Compliance with Mental Health Parity and Addiction Equity Act Requirements in Medicaid and CHIP. We commend CMS for soliciting feedback to ensure compliance with mental health parity requirements and to help improve access to mental and behavioral health services for 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
Senior Vice President, Government Relations, Policy, and Advocacy