ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

December 2, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016, Baltimore, MD 21244–8016

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

Re: 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 and Deputy Administrator Tsai,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments on the Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and CHIP Services (CMCS) Request for Comments (RFC) on Templates for Documenting Compliance with Mental Health Parity and Addiction Equity Act Requirements in Medicaid and CHIP (Compliance Tools or Templates).

ABHW is the national voice for payers managing behavioral health (BH) insurance benefits. Our member companies provide coverage to approximately 200 million people in the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness. Since its inception, ABHW has been at the forefront of and an advocate for MH and SUD parity. ABHW was instrumental in drafting the legislation for the initial Mental Health Parity and Addition Equity Act (MHPAEA) of 2008, and our members have worked tirelessly over the past 16 years to implement parity for behavioral health services. We believe that access to comprehensive, evidence-based MH and SUD services is critical to enhance patients' health and overall well-being, whether covered by a commercial, Medicare, Medicaid, or another health benefit program.

ABHW thanks CMS for the opportunity to comment on these templates. There is significant variation in states' management of Medicaid MH and SUD benefits. Some states have specialty MH or SUD benefits carved out of Medicaid Managed Care Organization (MCO) contracts provided by the state. Notably, MCOs in carve-out states generally do not have the requisite information to verify benefits and NQTLs on the medical/surgical (M/S) side. MCOs must abide by each state's contract terms. For example, the MCO contract dictates certain limits, such as Quantitative Treatment Limits (QTLs) and Non-Quantitative Treatment Limitations (NQTLs). Some contracts mandate the exact QTL levels, such as visit limits and copays, and these contracts ensure that benefits and offers are aligned. Therefore, states are responsible and should be accountable for broad aspects of MH and SUD parity compliance, such as reporting and analysis within Medicaid-managed care.

CMS must propose and finalize parity regulations that are operationally feasible and efficient for states to implement. Given the different state requirements already in existence, a substantial administrative burden and increased costs will come with imposing additional requirements on Medicaid and CHIP programs. Moreover, Medicaid services delivered through the Medicaid MCO model reflect a successful and specific state-health plan partnership that provides the necessary infrastructure to meet that variation in states and their Medicaid enrollees' physical and behavioral health needs.

Guidance around NQTLs has lacked the specificity necessary for health plans to implement parity for NQTLs successfully. Health plans are still awaiting clarifying information and illustrative de-identified examples regarding the development and application of NQTLs, which were required in the 21st Century CURES Act of 2016 and the Consolidated Appropriations Act of 2021 (CAA 2021) and have yet to be produced.

We appreciate CMS's efforts to develop these tools and recognize that the proposed templates are a good start for a uniform MHPAEA template for managed care programs. Overridingly, ABHW recommends that the next step to this RFC is the development of an advisory committee comprised of diverse stakeholders who can work together to improve upon the proposals that CMS has put forward.

Below, we have responded to CMS's specific questions.

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

ABHW supports a uniform template with consistent definitions that will reduce variation in reporting requirements among states. CMS should provide a platform that includes core, standardized questions, and definitions but allows for state programs' nuances.

These templates capture financial requirements, QTLs, and NQTLs for Medicaid managed care across states. However, not all NQTLs exist in every state. As discussed above, states dictate NQTLs in their MCO contracts, so they vary by state, and the questions may not fit each case. NQTLs sometimes need to be left blank if the state does not allow them.

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?

While our members feel that these templates are a starting place to provide clarity for health plans to report to states, we want to emphasize that, more often than not, Medicaid-managed care plans have incomplete information from states about mental health parity compliance for reporting. Therefore, ABHW urges CMS to encourage states to respond to questions directly when the state already has the information needed for a response. Often, the state has already collected data from Medicaid MCOs that are sufficient to support a response, given that the parity reporting relates to contractual requirements the state applies to managed care plans or the state directly provides behavioral health services.

The templates should be focused solely on requesting the necessary QTL and NQTL (current five-step approach) information that usually applies to Medicaid MCOs, ABPs, and CHIP programs.

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)?

The Excel format is hard to follow as character limitations constrain the spreadsheets. Health plans use the document to draft their narrative response, and Excel is a difficult format for cross-collaboration and to provide a narrative response. As a result of the restrictions of Excel, our members suggest CMS use a combination of Excel and supplemental documentation in Word and PDF. CMS should allow for attachments or references to additional documents, in addition to a feature within or outside of the template that provides space to add clarification or notes. While not as streamlined as including the information in the template itself, this could help address the limitations of the Excel templates.

ABHW also urges CMS to allow Medicaid agencies to provide one response if it applies to multiple programs (for instance, CHIP and managed care) instead of repeating responses numerous times across the templates.

We also encourage CMS to hold training and question sessions to identify and create solutions to problems identified during this process and periodically update the templates as needed. Furthermore, having a point of contact who can respond to Medicaid MCOs would be helpful. Many of our members have highlighted the importance of specific guidance for states with MH/SUD benefits carved out of managed care.

Lastly, we recommend that CMS include more examples for each NQTL element to help Medicaid MCOs and Medicaid agencies understand what is expected, including an NQTL example for various benefit limitations.

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?

CMS appears to have captured the most common NQTLs while leaving some room for Medicaid agencies to report on additional NQTLs as applicable. ABHW urges consistency in the NQTLs examined for commercial and Medicaid, allowing plans to streamline processes. Additionally, Medicaid parity review should focus on NQTLs over which plans have control rather than NQTLs required to align with state requirements.

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

Our members prefer splitting the financial requirements and quantitative limitations data into two worksheets rather than one, as they have different definitions and are illustrated differently (e.g., copayments v. number of visits). Furthermore, other teams often deal with these forms, and combining them could cause confusion and version control issues.

ABHW encourages CMS to require Medicaid agencies to complete the template before sending it to a Medicaid managed care plan to allow these plans to provide a more complete analysis. As discussed above, Medicaid MCOs often lack the information needed to complete either the QTL or FR sections of the template when all or a portion of MH or SUD are carved out from the managed care plans.

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

ABHW appreciates CMS's effort to create a foundational list of NQTLs and feels the appropriate NQTLs have been captured. However, once the finalized templates are deployed

and put into practice, stakeholders may discover missing elements, and we encourage CMS to continue to iterate as needed.

As described above, where MH or SUD services are carved out, Medicaid managed care plans do not have complete information about FRs, QTLs, and NQTLs depending on the carve-out model. As a result, these plans can only provide information and data relevant to the services they provide, and their mental health parity analyses may be incomplete.

7. Has experience shown that managed care plans apply NQTLs identically across Medicaid managed care, CHIP, and 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?

While individual Medicaid managed care, CHIP, and ABPs vary across programs, the benefit packages are comparable. A Medicaid agency should be able to collapse responses when able rather than provide the same language/information multiple times.

Carve-outs are as varied across MH/SUD benefits as plans are for M/S benefits. As discussed above, MCOs in carve-out states generally do not have the requisite information to verify benefits and NQTLs on the M/S side.

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?

As mentioned above, a Medicaid agency should have the option to collapse its responses when it has the capability rather than providing the same language and information multiple times.

ABHW recommends leaving the fields unlocked so the data/narrative can be formatted and wrapped for ease of review.

Additionally, CMS should clarify that Medicaid agencies must conduct parity analyses rather than individual Medicaid-managed care plans when the states are contracted to provide any MH/SUD benefits. The results of the state's full mental health parity analysis should be shared with stakeholders such as Medicaid MCOs, who will have an opportunity to make adjustments/corrections. If CMS audits a Medicaid agency, Medicaid MCOs should receive whatever feedback is provided to the agency.

States should prepopulate reporting documents based on their already-established data, including services included in the managed care contract. Moreover, while pre-population of

fields will be helpful for simpler responses (such as simple yes/no), they are not always appropriate. ABHW recommends a feature within or outside of the template that provides space for clarification or notes. Additionally, providing examples of what information should be included in each field would help clarify expectations.

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?

This depends on the market and Medicaid agency. Some Medicaid agencies report once for the entire program, while others provide one report for each managed care partner.

> 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?

There is much variation in the size and complexity by the state. As an example, in 2021, there were 26 Medicaid MCOs in California[1], while some states had 4-5 MCOs.

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

Again, it depends on the state, Medicaid agency, and Medicaid population and 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?

ABHW recommends a start date of at least one year from the time of the finalized templates. We believe it will be easier to require standardized templates.

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[1] https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22california%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

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?

ABHW recommends that the effective date be at least one year after the templates have been finalized.

b. Should CMS's transition timeline vary based on the type of program? For example, if CMS uses 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?

No, there should be one uniform timeline.

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

Given the extensive data requested for financial requirements and QTLs, along with the complexity of the format for NQTLs, completing these templates will require the attention of multiple representatives for both Medicaid agencies and Medicaid managed care entities. We anticipate that each state agency and managed care entity will need to hire a Full-Time Employee (FTE) (if not already in existence) to complete these parity templates.

Thank you for the opportunity to provide feedback on these proposed templates. We are committed to engaging with CMS and other partners on opportunities to improve access to mental health and substance abuse services. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,

Debbie Witchey
President and CEO