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Breaking Barriers. Defending Dignity.

December 4, 2023

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 Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP

Dear Deputy Administrator Tsai,

Thank you for the opportunity to submit comments on the Center for Medicare & Medicaid Services' (CMS) request for comments on measures to improve enforcement of the Mental Health Parity and Addiction Equity Act (Parity Act) in Medicaid and CHIP. I am writing on behalf of the Legal Action Center ("Center") and the 46 undersigned organizations to express our strong support for CMS's efforts to expand access to MH and SUD services in public insurance and our appreciation for your work to achieve equitable access to care through Parity Act enforcement. **We urge CMS to promptly adopt additional Parity Act compliance requirements and state oversight practices and align Medicaid/CHIP parity standards with those in the private insurance market.**

The Legal Action Center (Center) is a non-profit law and policy organization that fights discrimination, builds health equity, and restores opportunity for people with substance use disorders, arrest and conviction records, and HIV and AIDS. We worked with our national partners to secure enactment of the Parity Act, and we have done extensive work to enforce the Parity Act at the national and state levels. The Center convenes the Coalition for Whole Health, a national coalition of local, State and national organizations active in the law's enactment, and state parity coalitions in both Maryland and New York. On behalf of the Maryland Parity Coalition, we led advocacy efforts by substance use disorder (SUD) and mental health (MH) consumer and provider stakeholders to secure enactment of Parity Act compliance requirements in both Medicaid and private insurance, and we work with Medicaid officials to address parity violations in the state's program. In New York, we conduct Parity Act policy advocacy, securing enactment of a Parity Reporting Act and Parity Act compliance standards, as well as provide education and client assistance to individuals who face insurance barriers to MH and SUD care as part of the NY Consumer Health Access to Addiction and Mental Health Care Project (CHAMP) program.

Over the past year, the Center has conducted detailed research on Parity Act compliance efforts by State Medicaid authorities nationwide, including examining state Medicaid managed care contract standards for parity compliance requirements and reviewing publicly available state parity compliance reports.

We have also conducted interviews of interested providers and consumer stakeholders to determine key barriers to MH and SUD care in Medicaid, the scope of state Parity Act enforcement activities, and parity violations. **Our findings on parity contract standards and publicly available compliance reports are compiled and linked in Attachment A[1] and serve as the basis for many of our responses and recommendations.**

We also submitted comments on the recently proposed Medicaid Managed Care Rule and Medicaid Access Rule and, in addition to supporting CMS's proposals that would adopt metrics to improve access to MH and SUD care,[2] we offered recommendations on steps CMS must take to improve enforcement of the Parity Act. We appreciate your consideration of those recommendations as a starting point for agency action. Strong enforcement of the Parity Act by CMS holds the promise of expanding access to MH and SUD care through state plan reform and non-discriminatory managed care organization (MCO) practices and policies. States were required to bring MCO, CHIP and alternative benefit plan (ABP) benefits into compliance under CMS's March 2016 parity regulations,[3] yet research highlights troublesome trends in reimbursement, network composition, utilization management and scope of service coverage that are based on practices that likely violate the Parity Act. (*See infra* points 3 and 4).

Clearly, the Medicaid Parity Act regulations are not self-enforcing and state officials need far greater guidance and oversight by federal officials, which includes remedial actions and financial penalties, to ensure compliance.[4] As identified in our previous comments and reinforced below, we urge CMS to:

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[1] A previous version of our findings was submitted in the Center's comments on the Medicaid/CHIP Managed Care Access, Finance and Quality proposed rules (CMS-2439-P). Attachment A provides updated information and links. We have not conducted an exhaustive review of other state reporting requirements to determine if mandates exist separate from the MCO contracts or, as designated, state law. We have also not investigated any separate practices for CHIP.

[2] As discussed in greater detail below, the adoption of quantitative metrics for appointment wait time, secret shopper requirements to identify network participation, and reimbursement rate transparency will help improve access to MH and SUD care. At the same time, Parity Act compliance is required in all plan coverage and operational actions and must be **embedded** into every MCO/State decision before adoption to prevent adoption of non-compliant standards. It appears that most states approach Parity Act compliance as a "retrospective" reporting requirement in which they adopt MCO findings of NQTL compliance and, like NQTL analyses in private insurance, "look[ ] for ways to…characterize an NQTL as being 'comparable' and 'applied no more stringently' through careful word choice, without regard to how, in operation, the limitation burdens participants and beneficiaries by limiting access to, or by limiting the scope and duration of…mental health and substance use disorder benefits relative to medical/surgical benefits." Depts. of Treasury, Labor, and Health and Human Services, Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg, 51552, 51558 (Aug. 3, 2023).

[3] In promulgating the 2016 parity regulations, CMS allowed states 18 months to implement the requirements to ensure that all necessary coverage changes and benefit expansion, some of which could require state policy and budget action, could be adopted. CMS, "Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008," 81 Fed. Reg. 18390, 18417 (Mar. 30, 2016). Nonetheless, significant gaps in service coverage exist in many states, and some states have relied on the 1115 Waiver process to cover services that were not subject to any Medicaid policy exclusions and were likely required as of October 2017 to provide MH and SUD benefits on par with medical/surgical benefits.

[4] In 2016, CMS put state Medicaid authorities on notice that it "may decline to approve MCO contracts and defer FFP if the state cannot establish that the benefits and delivery system are compliant with these rules." We are not familiar with any such actions that have been taken by federal regulators. CMS has also suggested that states include penalties in contracts to address non-compliance by managed care plans. CMS, "Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008," 81 Fed. Reg. 18390, 18422 (Mar. 30, 2016).

- Develop updated guidance on comparative analyses of nonquantitative treatment limitations (NQTL), frequently asked questions, self-compliance tools, and standardized templates for States to gather information and document their comparative analysis and other compliance with the Parity Act, consistent with actions taken by the Departments of Labor, and Health and Human Services, and Treasury, for Parity Act enforcement in the private market.
- Develop and require the use of model contract language for state MCO contracts setting out Parity Act requirements, obligations of MCOs, state oversight requirements for prospective review of proposed MCO coverage modifications, audit requirements conducted by independent external reviewers, public posting requirements of compliance reports and materials, and remedial actions and penalties for violations, including the withholding of federal administrative funds related to violations of Parity Act enforcement.
- Ensure state enforcement of existing compliance regulatory requirements, §§ 438.920(b)(1) and (2), that documentation of compliance with the Parity Act "must be updated prior to any contract modification or other change in MCO, PHIP, PAHP or FFS State plan benefits" and that "all services are delivered" in compliance with the parity rules.
- Develop expertise and capacity in the Center for Medicaid & CHIP Services (CMCS) to conduct the above activities, respond to complaints related to MCO and/or state parity violations, and coordinate parity enforcement with sister departments and agencies.

Additionally, the Center has called upon the Department of Health and Human Services (HHS) to conform the Medicaid Parity Act regulations to those in private insurance, upon final adoption. (*See* Legal Action Center's Comments on Requirements Related to the Mental Health Parity and Addiction Equity Act). CMS has prioritized the establishment of consistent standards across health care financing systems, where possible. The Parity Act is a particularly important body of law to apply uniformly in public and private insurance to root out discriminatory insurance practices that limit access to MH and SUD care, and CMS should take full advantage of substantial enforcement work by sister agencies. Establishing uniform standards across Medicaid and private health plans would also ease administrative burdens on many entities that offer or administer health plans in both public and private markets and are subject to the same statutory non-discrimination standards.

Achieving consistent parity standards and enforcement across financing systems is essential to ensure health equity for our nation's most marginalized individuals with SUDs and MH conditions. Medicaid is the single largest payer for SUD[5] and MH[6] services in the United States, and Medicaid beneficiaries experience a higher rate of SUDs and MH conditions than individuals with other forms of insurance. An estimated 21% of Medicaid beneficiaries have a SUD compared to 16% of commercially insured individuals,[7] and 29% have a mental illness compared to 21% of privately insured individuals.[8] In 2020,

[5] GAO, "Medicaid: States' Changes to Payment Rates for Substance Use Disorder Services (Jan. 2020), https://www.gao.gov/assets/710/706790.pdf.
[6] Centers for Medicare & Medicaid Services, Behavioral Health Services, Medicaid.gov.
[7] Heather Saunders, "A Look at Substance Use Disorders (SUD) Among Medicaid Enrollees," (Feb. 17, 2023), https://www.kff.org/mental-health/issue-brief/a-look-at-substance-use-disorders-sud-among-medicaid-enrollees/#.
[8] Heather Saunders and Robin Rudowitz, Demographics and Health Insurance Coverage of Nonelderly Adults with Mental Illness and Substance Use Disorders in 2020 (June 6, 2022), https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/.

an estimated 4.6 million individuals (8%) of the 56 million Medicaid beneficiaries ages 12 and older received SUD care.[9] Yet, with fewer than one in five individuals with a SUD nationwide receiving any treatment in a specialty facility in 2020, a large majority of Medicaid beneficiaries do not receive life-saving SUD care.[10] Access to MH care is similarly limited: in 2018, half of adult Medicaid beneficiaries with a serious mental illness reported that they did not receive the MH treatment they needed.[11]

There are also notable racial and ethnic disparities in treatment access. Black Medicaid enrollees are far less likely to receive medication for opioid use disorder (OUD) than white beneficiaries.[12] For MH treatment, 52.3% of white adult Medicaid beneficiaries with any mental illness received treatment compared to 35.5% of Black beneficiaries, 35% of Hispanic beneficiaries, 27.2% of Asian American beneficiaries, and 31.9% of those who identify as two or more races.[13]

While significant efforts are needed to improve enforcement of Parity Act protections in private insurance, we are very concerned that, in most states, Medicaid members do not have access to life-saving care – whether compared to those with private health plans or based on the documented level of need. While many gaps in Medicaid coverage and access could be addressed with rigorous enforcement of the Parity Act, states seem ill-equipped or fundamentally uninterested in enforcing this critical civil rights law. **Model contract standards and transparent oversight and enforcement by CMS are needed to ensure that State Medicaid officials and MCOs embed parity requirements and assessments in all plan design and operational practices. Such actions will also support state stakeholder efforts to use the Parity Act to address care gaps and hold state Medicaid officials accountable.**

We offer the following comments on CMS's questions.

1. **Model Templates and Key Questions to Improve Review**

We fully agree that the development and use of templates as well as standardized instructions and definitions for information and data gathering will (1) facilitate MCO/CHIP compliance reporting and (2) help State officials verify and compare compliance across MCOs, and, in specific states, conduct required compliance reviews, under 42 C.F.R. §§ 438.920(b), for alternative benefit plans (ABPs) that deliver services through fee-for-service financing (42 C.F.R. § 440.395(e)). Indeed, CMS created one of the first templates for compliance review in its 2017 *Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Program*. Based on our review of state parity compliance reports, we have identified a number of states that have

[9] Dept. of Health and Human Services, Report to Congress: "T-MSIS Substance Use Disorder (SUD) Data Book: Treatment of SUD in Medicaid, 2020 at 1 (Dec. 2, 2022), https://www.medicaid.gov/sites/default/files/2022-11/2020-sud-data-book.pdf.
[10] *Id.* at 13.
[11] MACPAC, "Chapter 2: Access to Mental Health Services for Adults Covered by Medicaid" 2 (June 2021), https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf.
[12] U.S. Dept. of Health and Human Services, Office of Inspector General, "Many Medicaid Enrollees with Opioid Use Disorder Were Treated with Medication; However, Disparities Present Concerns" (Sept. 2023), https://oig.hhs.gov/oei/reports/OEI-BL-22-00260.pdf
[13] MACPAC, *supra* note 11 at 41.

adopted templates for information gathering on financial requirements (FR), quantitative treatment limitations (QTLs) and nonquantitative treatment limitations (NQTLs).[14]

Yet, based on our review, the key enforcement hurdle is not the identification or adoption of the "right" NQTL template. Instead, the essential starting point is:

- education of MCOs and State Medicaid officials about the required NQTL comparative analysis and use of data outcomes to identify compliance problems and areas for improvement;
- technical assistance and guidance on common compliance issues through FAQs and publication of CMS's guidance to states;
- CMS oversight of state compliance efforts with appropriate financial penalties for failure of MCOs/state Medicaid agencies to conduct timely, complete and accurate analyses prior to the adoption of any coverage changes;
- State engagement of independent, knowledgeable contractors to evaluate MCO and State compliance; and
- State enforcement of remedial actions, including penalties, against MCOs for parity violations.

A template will have limited value without building capacity and creating the imperative to enforce the Parity Act with fidelity. While CMS noted in both its Medicaid managed care proposed rule[15] and this Request for Comments that States are required to provide detailed information to demonstrate compliance with nonquantitative treatment limitations (NQTLs) in Medicaid, **the Legal Action Center found little evidence from public-facing documents that states adhere to federal regulatory or agency requirements.** The Center searched State Medicaid websites for compliance reports and found that, as of October 20, 2023:

- Only 8 states have issued a recent, public-facing Medicaid Parity report (dated January 2021 or later).[16]
- Eighteen (18) states have issued older reports (dated 2017-2020).[17]

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[14] **Maryland**, for example, requires MCOs and the State's Administrative Services Organization, which administers MH and SUD benefits in a carve-out, to use URAC ParityManager.™ **Georgia** requires MCOs to use a template that includes definitions, covered benefits, basic parity standards and tests for financial requirements (FR), quantitative treatment limitations (QTLs), NQTLs and reporting spreadsheets for 5 NQTLs. **Illinois and Oregon's** Medicaid authority contracted with the Health Services Advisory Group (HSAG), which developed a protocol and tools (Parity Analysis Template) in alignment with CMS's 2017 Parity Compliance Toolkit. **Ohio** requires its MCOs to use the MHPAEA Compliance Assessment Tool but has not issued a public report since 2018. **New York** created MHPAEA Testing Workbooks for NQTLs, which includes specific questions and prompts and was based on CMS's and the Department of Labor's compliance toolkits and New York statutory requirements, and provided detailed instructions and uniform definitions. **Washington** relies on CMS's Compliance Toolkit and the Kennedy Forum Six-Step Parity Compliance Guide for Non-Quantitative Treatment Limitations Requirements. **West Virginia** uses CMS's Compliance Assessment Tool to develop an MCO Request for Information and a standardized tool for quarterly data reporting on PA requests and denials, PA appeals and denials overturned, and enrollment/credentialing counts by provider type, including number of enrolled providers, terminated providers, credentialing requests and credentialing requests denied/not accepted.

[15] CMS, Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance and Quality, 88 Fed. Reg. 28092, 28109 (Mary 3, 2023).

[16] GA, IL, MD, NJ, NY, OR, WA and WV.

[17] AZ, CA, DE, HI, IN, IA, IN, LA, MA, MO, MS, NV, NH, NM, OH, TN, TX, and VA.

- Fifteen (15) states or jurisdictions with Medicaid MCOs have not issued a public-facing report.[18]

Even if state Medicaid authorities collected parity information and data from MCOs using templates, their failure to carefully review MCO data and NQTL assessments for actual compliance violates the state's obligation to enforce federal law.[19] Our review revealed that:

- Few states conducted an analysis of all NQTLs.[20]
- Many collapsed the NQTL analysis of MH and SUD benefits rather than assessing MH and SUD coverage separately, as required under the Parity Act.[21]
- Few provided sufficient information or detail to assess whether plans complied with either the "as written" or "in operation" requirement, with few providing any examination of "in operation" compliance.[22]
- Most states identified few, if any, violations, and findings of compliance were often conclusory and without detail or support.[23]

[18] DC, FL, KS, KY, MI, MN, NE, NC, ND, OK, PA, RI, SC, UT and WI.

[19] Based on our contract review, three states – Georgia, Michigan and Pennsylvania – did not even identify Parity Act compliance requirements. Georgia state law imposes parity reporting standards that are not reflected in the contract. Other states, including Massachusetts, rely on annual certifications of compliance, although Massachusetts has recently enacted a law that will require reports from managed care entities and other state-funded entities moving forward. *See infra* point 2.B

[20] For example, **Georgia's** template requires NQTL reporting on 5 NQTL (utilization management, including PA, CC and retrospective review (RR), case management, disease management, medication request and network status). **Illinois** MCOs appear to be required to submit a Parity Analysis Template, but the public facing report identifies few NQTLs other than utilization review. **Maryland** examined 5 NQTLs (concurrent review (CC), prior authorization (PA), medical necessity criteria, outlier management, fail first/step therapy and service limits) and, while identifying reimbursement rate setting as an NQTL, the State has never analyzed compliance. **West Virginia** identifies 3 NQTLs (medical necessity criteria development, utilization review standards, including PA, CC, RR, and practice guideline selection/criteria, and provider network size). In contrast, **New Jersey** assessed a wider range of NQTLs (medical management criteria, including PA, geographical limitations for providers, rate setting, practitioner types, network requirements, step therapy(ST) for prescription drugs). Similarly, **New York** assessed 19 NQTLs in three separate phases to help MCOs build their analytical capacity: Phase I – PA, CC medical necessity criteria, formulary design; Phase II – coding edits, out-of-network coverage standards, geographic restrictions, reimbursement, and provider type exclusions; and Phase III – retrospective review, outlier review, experimental/investigational determinations, fail first, provider credentialing, certification requirements, unlicensed provider, usual customary and reasonable rate determinations, exclusions for court-ordered treatment and failure to complete treatment requirements.

[21] **Georgia's** MCOs collapse MH and SUD benefits, as set out in the template; **Illinois'** report provides responses for "behavioral health," **New Jersey, Washington and West Virginia** collapse MH and SUD benefits in their reports. In contrast, **Oregon's** detailed assessment of each coordinated care organization's (CCO) operational strengths and weaknesses indicates that its independent contractor conducted separate examinations of MH and SUD benefits, although its summary data collapses MH and SUD benefits.

[22] **Georgia's** template, for example, asks for a list of supporting documentation, but does not separate out an analysis of NQTL "design" and "operation," and the MCOs provide conclusory statements of compliance in both NQTL design and operation without providing any analysis. **Oregon** conducts a comprehensive review every 3 years and relies on attestations of compliance by the coordinated care organizations (CCOs) in off-years, including the CY 2022 report year for which CCOs reported a significant number of coverage changes. No state official appears to have independently reviewed those provisions for compliance.

[23] **Oregon** concluded that no parity violations existed based on the CCOs' attestations of compliance, although the analysis of outcome data identified significant disparities by specific CCOs that the state's contractor used to recommend remedial actions. **Washington's** report provides a high-level summary of the 5 MCO's self-reported NQTL analyses, noting that all

- Some reports provided an inaccurate analysis of compliance.[24]

Apart from the New York report that summarized key deficiencies, we have also assessed the accuracy of the **Maryland Department of Health** (MDH) report, identifying incomplete and inaccurate analyses in the 3 reports filed since 2020. For its recently submitted 2023 report MDH: (1) has not evaluated compliance for reimbursement rate setting for the seventh year in a row; (2) has devised a limited set of outcome measures (claims denials and prior authorization (PA denials) that do not assess the threshold permissibility of requiring PA for virtually all MH and SUD benefits, relies on an outcome disparity metric that masks violations by individual MCOs, and requires no corrective actions, even when the denial rates for MH and SUD benefits exceed MDH's benchmark for compliance; (3) does not conduct a comparative analysis for either NQTL design or application but instead describes each factor that the MCOs and Administrative Service Organization (ASO) purportedly uses in designing an NQTL without identifying the evidentiary standards for triggering the application of the factors and bases its finding of compliance on a tally of the number of factors used by the MCOs and ASO; and (4) fails to identify the MCO standard to which the ASO standard for MH and SUD benefits will be compared, notwithstanding a commitment to address this issue following objections to the very same problematic process in 2020-2022. **MDH demonstrates no interest or urgency in complying with the Parity Act.**

Two notable states offer a compliance process and report model for CMS's further consideration.

- The New York Department of Health contracted with Milliman Group to conduct a multi-year process, beginning in 2019, to assess Parity Act compliance though education, development of NQTL compliance testing protocols, workbook templates and detailed definitions and

five reported no NQTL violations. **West Virginia's** report identifies quantitative treatment limitations for services for Children with Serious Emotional Disorders but framed those as "soft limits" and did not conduct a "substantially all" or "predominant" test or an analysis of the prior authorization requirement that members must satisfy to get additional units/hours/days of care. It also provides a chart of all NQTLs along with a list of evidentiary standards and process but offers no real comparative analysis. Based on its compliance steps, West Virginia's independent contractor found violations related to referrals for MH and SUD services and access to emergency psychiatric services. **Maryland** similarly adopts a "soft limit" interpretation for many MH and SUD QTLs that raises significant compliance concerns, and, for multiple years, the State found no NQTL violations. On at least two occasions, CMS identified violations that Maryland Medicaid officials had justified as parity compliant (e.g. data collection requirements and cost sharing for prescription drugs), and Legal Action Center identified additional violations related to service limitations, failure to assess NQTL operational compliance and repeated failure to assess all NQTLs, including reimbursement rate setting. **New York** is one of the few states that identified routine failure by MCOs to submit complete and accurate comparative analyses and multiple violations by MCOs.

[24] **New York's 2022 compliance report** identifies deficiencies that likely characterize most MCO analyses, if closely assessed, and mirror reporting problems identified by the Department of Labor in its review of employer-sponsored plans: poor quality of worksheet submissions; MCOs "not actively analyzing all their NQTLs for parity compliance;" information identified potential violations but more information required to properly evaluate compliance; submissions did not respond to prompts and did not provide substantive comparative analysis of numerous NQTLs (coding edits, reimbursement, out-of-network coverage). https://omh.ny.gov/omhweb/bho/docs/nys-mhpaea-report.pdf. The Department of Health issued citations and corrective actions against 15 MCOs. https://omh.ny.gov/omhweb/bho/mh-parity-focused-surveys.html. The New York Department of Health has most recently fined 5 MCOs a total of $2.6 million for violations of prior authorization and rate setting requirements, denials of care for services that are not subject to prior authorization, denial of reimbursement for non-network services when no network provider was available, and failure to oversee the MCO's behavioral health organization's administration of benefits. https://www.governor.ny.gov/news/governor-hochul-announces-26-million-fines-against-insurance-companies-failing-adequately#:~:text=Governor%20Kathy%20Hochul%20today%20announced,of%20behavioral%20health%20service%20claims. All violation implicate NQTLs, although Parity Act claims were not identified.

instructions, review of MCO submissions, and technical assistance based on deficient reports. It implemented NQTL submission and review in three stages and provided interim reports on deficiencies and conducted individual meetings with MCOs. The State's 2022 report concluded that MCOs did not submit sufficient information to confirm compliance with 8 of the 9 NQTLs assessed in Phase I and II and, for Phase III NQTLs, in addition to incomplete information submissions, most MCOs were found to be non-compliant for 5 of the 10 NQTLs (retrospective review, outlier review, experimental/investigational determinations, fail first and provider credentialing). **No MCO was compliant for all 19 NQTLs.** The report identified remedial steps, including amendments to MCO contracts to improve parity documentation and reporting and move beyond MCO attestations of compliance, modifications to the State's operational survey process to address in-operation parity oversight and remediation of key parity issues that impact the availability and access to MH and SUD care.

- The Oregon Health Authority contracted with Health Services Advisory Group (HSAG) to conduct a compliance review, hold meetings with diverse stakeholders, and complete an initial outcomes data analysis on authorization denials, in-network and out-of-network paid claims, and provider enrollment, consistent with State legislation (HB 3046, 2021). HSAG assessed the strengths and areas requiring improvement for each coordinated care organization (CCO), using outcomes data and other detailed information. The synthesis of findings – as opposed to a standardized chart of process steps that is commonly found in compliance reports – was the key to providing meaningful information and a roadmap for improvement. The CCO-specific information identified steps to improve access to MH and SUD care – the key purpose of the Parity Act – and identified specific "best practices" that other CCOs could adopt; *e.g.* monthly internal quality audits of utilization management data for MH and SUD service delivery to compare with physical health data. Finally, HSAG recommended future steps to ensure effective compliance review, including: file reviews targeting coverage determinations, appeals and administrative hearings; evaluations of utilization management (UM) files to ensure accurate implementation of policies and procedures; enhancement of data collection on UM and network adequacy and timely access to care; incorporation of community partners in the evaluation process to identify potential problem areas.[25]

Recommendation:

Based on the above review, we urge CMS to:

- use the DOL and HHS guidance on NQTL analysis (*See* FAQ 45) and the proposed DOL/HHS regulations (*see* proposed 45 C.F.R. 146.137; 29 C.F.R. 2590.712-1) that set out (a) standardized definitions for factors, evidentiary standards, processes and strategies, and (b) comparative

[25] It is important to note that the Oregon Health Authority, which administers the state's Medicaid program, has an Ombuds Program that serves as an advocate for Medicaid and CHIP members to improve access to care, quality of care and make recommendations for policy and program improvement based on member experience. The Ombuds Program has identified significant gaps in access to MH and SUD services for adults and children that also reflect Parity Act violations. State Medicaid officials' failure to address the underlying parity violations reflected in the findings demonstrates Parity Act enforcement deficiencies. *See* coverage and access problems identified *infra* at point 4. Oregon Health Authority, Ombuds Program 2022 Year-End Report (March 2023), https://www.oregon.gov/oha/ERD/OmbudsProgram/2022%20OmbudsYearEnd%20Report.pdf.

analysis content requirements to create standardized templates that states would be expected to use as the foundation for MCO and state compliance reporting; and

- develop templates for data outcome measures, as discussed below, that states would be required to use for in-operation analyses;
- develop standardized instructions for implementation of templates;
- require compliance reporting on an annual basis to ensure, at a minimum, that changes in the application of NQTLs are in compliance even if the NQTL design remains unchanged;[26] and
- conduct periodic audits consistent with the requirements for private health plans/issuers.

2. Processes States and Managed Care Plans are Using to Assess Coverage Policies for Parity Compliance

The 2016 Medicaid Parity regulations clearly require states to conduct on-going monitoring of parity compliance, document parity compliance prior to implementing plan changes, and post compliance information on the state's Medicaid website. Despite these requirements, our review of state parity compliance reports and managed care contracts has demonstrated that few States are meeting these obligations. We have identified several state models that we recommend CMS incorporate into its regulations, model contracts, and guidance.

A. Managed Care Contracts

Our review of state managed care contracts reveals that most States do very little to impose contractual requirements on MCOs to conduct parity compliance reviews, and the dearth of complete and up-to-date compliance reports strongly suggests that some State Medicaid authorities do not conduct accurate or continuous, real-time assessments of MCO or state compliance. A handful of states, identified below, impose contract requirements that, if vigorously enforced, would advance compliance reviews. *See* Attachment A. **CMS oversight is essential to change the status quo and the development of model parity contract provisions is needed.[27]**
First, as set out in Attachment A, State Medicaid officials are not taking rudimentary and necessary steps to place MCOs on notice that compliance analysis and reporting are part of their contractual obligations. Of the 41 state contracts, we identified:

- Twenty-one (21) state contracts require compliance information or parity analysis upon request[28] and 20 do not.[29]

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[26] While CMS permits states to attest that they have not changed benefit design or other features that affect parity compliance rather than submit annual reports, widespread deficiencies provide a strong basis for reconsidering state compliance and federal oversight processes.

[27] While CMS declined to adopt model contract provisions, as proposed by stakeholder comments on its 2016 parity regulations (81 Fed. Reg. at 18418), much has changed since then to merit this approach. The Biden Administration had appropriately prioritized the delivery of MH and SUD services in all financing systems to address our nation's unprecedented overdose and mental health crisis that disparately affect individuals in communities of colors. Federal agencies have documented poor Parity Act compliance in private insurance and have taken important steps to improve compliance and enforcement. Medicaid recipients have the right to the same level of oversight and enforcement of parity protections, which state Medicaid officials have failed to do.

[28] AZ, CO, DE, DC, HI, IL, IA, KS, LA, MD, MN, MO, NM, NY, OH, OR, TN, TX, UT, VA, WA.

[29] CA, FL, GA, IN, KY, MA, MI, MS, NE, NV, NH, NJ, NC, ND, OK, PA, RI, SC, WV, WI.

- Twenty-three (23) state contracts require proactive or periodic parity reporting[30] and 18 do not.[31]
- Three (3) state contracts require parity analysis and/or state notification when the MCO modifies or amends its contract[32] and 38 do not.
- Twenty-three (23) state contracts require specific reporting elements or format,[33] and 12 do not.[34] An additional 9 states have no clear reporting requirement in their contracts.[35]

While some states may impose such requirements through statutory requirements or other guidance, inclusion in contract provisions is critical to ensure that MCOs conduct and submit NQTL comparative analyses prior to implementation of coverage and operational modifications, engage in on-going parity assessments and track specific outcome data that are essential to flag potential parity violations. **Consistent with our recommendation that CMS develop model templates to facilitate standardized annual reporting and review by state Medicaid authorities and CMS, we recommend that CMS develop a model contract that identifies all parity compliance requirements, including required use of templates, and incentivize states to adopt the model contract.**

The starting point for key contract elements and standards can be found in existing State MCO contracts:

- <u>Substantive Parity Act Requirements</u>
    - Several states summarize the non-discrimination standards and tests for financial requirements, quantitative treatment limitations and nonquantitative treatment limitations, going beyond a summary statement of required compliance with Part 438, Subpart K.
    - Arizona, California, Colorado, District of Columbia, Louisiana, North Dakota, Oklahoma, Tennessee, Virginia, Washington, West Virginia and Wisconsin require MCOs to cover any service necessary for compliance with Parity Act, in addition to services covered under the state plan.
    - California, Delaware, Illinois, Kansas, New Jersey, Oklahoma, and Oregon explicitly require coverage of MH and SUD benefits in all classifications in which medical/surgical services are covered.
    - California, District of Columbia, Hawaii, Louisiana, Missouri, North Dakota, Oklahoma, Rhode Island, Washington, and West Virginia explicitly require parity compliance for utilization management (UM) practices and some include additional standards: submission of UM policies and description of how delegated activities are evaluated for compliance; prohibition on the use of prior authorization unless the MCO demonstrates compliance with the Parity Act and receives advance approval by the state authority.
    - Delaware and Missouri set out the NQTL requirement and list all NQTLs that must be analyzed.

- <u>Obligations of MCOs to Comply with Parity Act</u>

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[30] AZ, CA, CO, DE, FL, HI, IL, MD, MA, MN, MO, NE, NV, NH, NJ, NC, ND, OH, OK, RI, WA, WV, WI.
[31] DC, GA, IN, IA, KS, KY, LA, MI, MS, NM, NY, OR, PA, SC, TN, TX, UT, VA.
[32] AZ, OH and RI. Several other states, including DE and Missouri, require notification of changes that may affect parity compliance.
[33] AZ, CA, CO, DE, HI, IL, KS, MD, MA, MN, MO, NE, NV, NH, NY, NC, OH, OK, OR, RI, VA, WA and WV.
[34] D.C., FL, IA, LA, MN, NM, NJ, ND, TN,TX, UT, and WI.
[35] GA, IN, IA, KY, MI, MS, NM, PA, and SC.

- Louisiana requires the MCO to require all subcontractors to take actions necessary to comply with the Parity Act and parity compliance by any subcontractor to whom an MCO delegates oversight responsibilities.
- Louisiana requires MCOs to provide the state Medicaid authority access to all records and service locations for purposes of auditing or investigating parity compliance.
- Washington requires MCOs to report parity concerns and disparate applications of standards to the Medicaid authority within 14 days of discovery.

- Required Submission of NQTL Comparative Analyses and Timing of Submissions
  - Arizona requires submission of a **parity analysis in advance of implementing** any contract modification, amendment, novation or other change that may affect compliance.
  - Ohio requires the submission of an updated Parity Act Compliance Assessment Tool **30 days prior to implementation** of a new clinical coverage policy, financial requirement, change in benefits or limitations.
  - Rhode Island requires MCOs to publish their Parity Act policy and procedure on their website.
  - West Virginia requires MCOs to submit quarterly data reports on outpatient and inpatient prior authorization counts by benefit type, enrollment/credentialing counts by provider type, enrollee complaints by NCQA category, average wait time for youth to access MH services, and all approved and denied MH screenings and services.

- External Quality Review by Non-State Entity
  - Colorado requires an external quality review organization to perform an annual review of MCO policies and procedures, including utilization management practices, to ensure Parity Act compliance.

- Remedial Measures
  - Arizona requires prompt filing of corrective action plans for any parity deficiencies, designated timeline for compliance within same quarter as submission, and requirement to respond to state Medicaid or other contractor.
  - Liquidated damages
    - Missouri includes a liquidated damages assessment of $100/day for failure to submit a parity compliance report or other deliverable.
    - New Hampshire includes a liquidated damages provision for continued failure to comply with the Parity Act.
    - North Dakota imposes a liquidated damage penalty of $25,000 per violation for continuing failure to comply with the Parity Act.
  - Complaints and grievances
    - New Hampshire allows members to file complaints with the New Hampshire Dept. of Insurance if the MCO delivers a service in a way that is not consistent with the Parity Act.
    - Rhode Island requires MCOs to direct members through their grievance and appeal procedures for potential parity violations, and track parity complaints on the State's approved template.

A model contract should address additional state audit and oversight and disclosure requirements by MCOs, including:

- For a denial of any MH or SUD benefits, mandatory disclosure of relevant plan information to allow the member to assess whether the denial implicates a Parity Act violation, including information about comparable medical care.
- State audit provisions that mirror the standards under the Consolidated Appropriations Act of 2021 for private health plans/issuers, authorizing state Medicaid authorities to randomly review an MCO's comparative analysis upon request and setting the timeframe for submission of the analysis and other information required for a complete and responsive analysis and/or corrective action.
- Notification of Parity Act violations to all affected members and remedial steps to update policies and procedures within a short, designated timeframe and to reprocess coverage decisions, without requiring members to appeal benefit denials.

A second set of contract standards should set out **actions that state Medicaid authorities will take through the administration of their contracts to improve enforcement**. Specific actions should be based on findings by state authorities/external quality review organization of gaps in parity enforcement or by CMS in its review of state oversight. For example:

- New York identified contract modifications that would ensure state officials conduct compliance reviews that actually "test" an MCO's attestation of compliance and require MCO documentation and data to be available in a timely manner to conduct the review.
- State contracts should designate a specific office and/or personnel that are responsible for parity education, compliance review and technical assistance and to whom MCOs must report. This requirement would result in the development of expertise and resources with a state's Medicaid authority and facilitate continuous oversight of MCO compliance.
- In connection with audit requirements, a timeline should be established for state Medicaid authority review and specific remedial actions that the state will take for parity violations, including the submission of untimely and/or incomplete NQTL comparative analyses.

We also recommend that CMS require states to **implement a community stakeholder process that will gather information from beneficiaries and providers about barriers to MH and SUD care and MCO practices, which could be the result of policies and practices that violate the Parity Act.** Reliance on member complaints and fair hearing processes will not provide a useful assessment of MH and SUD care gaps based on the complexity of the process and lack of expertise by hearing officers on Parity Act matters. In contrast, and as demonstrated in the Oregon parity report, a regular forum for stakeholder input will provide important information to identify parity violations. CMS has proposed the implementation of a Beneficiary Advisory Group (BAG) and more robust Medical Care Advisory Committee (MAC) in its Medicaid Access rule, which, if adopted, aligns with this recommendation and could be forums for such information gathering.

Finally, **we note that standardized parity protocols that align with improved MCO contract standards must also be established for expansion states that deliver MH and SUD benefits through fee-for-service (FFS) financing.** We have seen no public-facing information that sets out state parity

oversight practices in Alaska, Arkansas, Connecticut, Idaho, Maine, Montana, South Dakota and Vermont – expansion states that do not contract with MCOs – and other states that may deliver their expansion benefits through FFS and have not aligned their parity enforcement for expansion benefits with MCO practices.

B. Additional State Processes

In addition to state managed care contract standards, Georgia and Massachusetts offer model practices that CMS can require of state Medicaid agencies to improve Parity Act compliance. In 2022, Georgia enacted legislation that requires entities providing Medicaid benefits to use standardized definitions of generally accepted standards of MH and SUD care in making medical necessity and all other coverage decisions; ensure that any subcontractor or affiliate is complying with parity; and submit an annual report with an NQTL comparative analysis that tracks the requirements imposed on private health plans/issuers under the Parity Act.[36] The law also requires the State Medicaid agency to perform parity compliance reviews of all state health care entities, with a focus on NQTLs, and establish a process for accepting, evaluating, and responding to complaints from consumers and health care providers regarding suspected parity violations.[37]

Massachusetts also enacted legislation in 2022 that requires the State Medicaid agency to perform a behavioral health parity compliance examination of each MCO or other entity that manages or administers MH and SUD benefits (including the state if it is the primary payer) at least once every four years, including a review of NQTLs, service approvals and denials, and issues identified through consumer or provider complaints.[38] The law also requires each MCO to submit an annual parity compliance report, including specific treatment authorization data, which the agency must summarize and make public. Finally, the law requires the agency to evaluate all consumer or provider complaints regarding MH and SUD coverage for possible parity violations within three months of receipt of the complaint.[39] We recommend that CMS, in addition to developing a model managed care contract, **require state Medicaid agencies to conduct regular reviews of parity compliance and develop processes to review, evaluate, and respond to consumer and provider complaints related to MH or SUD coverage for potential parity violations within a set timeframe.**

3. Key Issues to Assess that May Indicate Potential Parity Compliance Issues

CMS's review of 1115 SUD waiver demonstrations, MACPAC's review of SUD treatment in Medicaid, GAO reports on reimbursement of SUD treatment, HHS Office of Inspector General (OIG) investigations on authorization denials and other research have all identified troublesome trends that that may reflect parity violations in reimbursement rate setting, network adequacy and composition, utilization management/authorization practices, and scope of services. Additionally, CMS's 2020 SUD Data Book identifies patterns of SUD care delivery by types and settings of care and length of care that may reflect parity violations related to network composition, reimbursement rate setting, provider type

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[36] Ga. H.B. 1013 (2022), https://www.legis.ga.gov/api/legislation/document/20212022/211212.

[37] *Id.*

[38] Section 44 of Mass. Ch. 177 of the Acts of 2022, https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177 (codified in Mass. Gen. Laws. Ch. 118E Section 80(b)).

[39] *Id.*

and setting exclusions and application of medical necessity criteria. (*See infra* point 10.) We urge CMS to focus parity enforcement efforts on these NQTLs across all states.

A. Reimbursement Rate Setting

MACPAC's 2018 SUD treatment review and GAO's 2020 study of state Medicaid payment rates for SUD services found that Medicaid payment rates are low for SUD services in some states and participation of SUD providers in Medicaid is limited and variable across states, due at least in part, to low reimbursement rates.[40] Similarly, an assessment of implementation challenges across states that have Medicaid 1115 SUD demonstrations identified provider shortages of multiple types of MH and SUD professionals – psychiatrists, psychologists, alcohol and drug counselors, peer support specialists, social workers, and behavioral health counselors - and low reimbursement rates as a key impediment to expanding the number of SUD providers and expanding access to care.[41] **None of these reports examined potential Parity Act violations in reimbursement rate setting that could mitigate provider shortages**. Based on the research literature, a parity examination would likely identify parity violations in the design and/or application of MH and SUD benefits.
For example, research has found that psychiatrists in Medicaid are frequently reimbursed less than primary care physicians for providing the same treatment services to patients with MH or SUD.[42] Additionally, Medicaid reimbursement rates of psychiatry services are substantially lower (81%) than Medicare, with significant variation across States.[43] Similar disparities apply for SUD treatment, with more than 4-fold variation across States' Medicaid reimbursement for opioid treatment program services and a national average of 56% of the Medicare rate.[44] **Reimbursement rate setting practices and outcomes data must be analyzed to determine whether States are designing and applying comparable and no more restrictive factors and evidentiary standards for SUD and MH benefits.** CMS's Medicaid Access rule proposes important standards to evaluate reimbursement rates for outpatient SUD services in specialty settings, and a parity compliance review for all benefits and services will ensure a more complete assessment of state barriers to MH and SUD care. Finally, we recommend that CMS align its standards for assessing reimbursement practices with those proposed by DOL and HHS for private health plans, including an examination of reimbursement rates compared to the cost of services and/or billed rates.[45]

[40] Medicaid and CHIP Payment and Access Commission, "Access to Substance Use Disorder Treatment in Medicaid," Ch. 4 (June 2018), p. 80, 93-95 https://www.macpac.gov/publication/access-to-substance-use-disorder-treatment-in-medicaid/; GAO, "Medicaid: States' Changes to Payment Rates for Substance Use Disorder Services (Jan. 2020), https://www.gao.gov/assets/710/706790.pdf.

[41] RTI International, "Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Implementation Challenges Across States," at 4 (Nov. 2022), https://www.medicaid.gov/sites/default/files/2023-02/sud-1115-rcr-impl-chalngs.pdf.

[42] Tami L. Mark et al, "Comparison of Medicaid Reimbursements for Psychiatrists and Primary Care Physicians," Psychiatric Services (Sept. 2020), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.202000062.

[43] Jane M. Zhu et al., "Medicaid Reimbursement for Psychiatric Services: Comparisons Across States and with Medicare," Health Affairs (Apr. 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10125036/.

[44] Lisa Clemans-Cope et al., "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021," Substance Abuse Treatment, Prevention, and Policy (July 6, 2022), https://substanceabusepolicy.biomedcentral.com/articles/10.1186/s13011-022-00478-y.

[45] We note that a comparison of SUD and MH reimbursement rates to Medicare rates is highly problematic based on the well-recognized undervaluing of such services in the Medicare fee schedule, discriminatory rate setting standards for licensed social workers, and marriage and family therapists and professional counselors (as of 2024), compared to non-physician practitioners for medical services, and the lack of application of the Parity Act to Medicare. The Center's concerns regarding

B. Network Adequacy and Composition

As reflected in the proposed Medicaid managed care rule, CMS recognizes the need for standardized appointment wait time metrics for outpatient MH and SUD benefits to address the higher prevalence of these conditions among Medicaid beneficiaries and the limited availability of services due to low provider participation in Medicaid. Research has also demonstrated that, like commercial provider networks, Medicaid MCO networks include disproportionately high rates of "phantom" providers of MH services (listed providers who do not see patients). A study of Oregon's coordinated care organizations found a fivefold discrepancy in MH prescribers listed in directories compared to those who filed claims. Two-thirds of MH prescribers (67%) and 59% of MH non-prescribers listed in network directories were "phantom" providers compared to one-half of primary care providers (54%).[46] As with private health plans, a range of NQTLs contributes to limited network participation including reimbursement rate setting, network adequacy requirements, credentialing requirements and utilization management standards that, as noted below, may impose greater burdens on MH and SUD practitioners.

C. Utilization Management Standards

As noted above in item 2, a number of State MCO contracts explicitly require parity compliance in utilization management requirements (UM) to ensure equity in access to MH and SUD services and medications. Prompt access to prescribed medications for MH conditions and opioid and alcohol use disorders, including methadone, buprenorphine and naltrexone, are essential components of care, and access is often limited or delayed with the imposition of prior authorization (PA), concurrent review and step therapy requirements.[47] The HHS OIG has recently identified gaps and disparate access to medications for opioid use disorder (MOUD) among Medicaid beneficiaries, particularly for Black individuals and other individuals of color, resulting in one-third of Medicaid enrollees with OUD not receiving MOUD.[48] Access to MOUD is particularly limited for children and adolescents, raising OIG concerns about the availability of providers that specialize in pediatric MOUD care.[49] These disparities persist notwithstanding the SUPPORT Act's MOUD coverage requirement in Medicaid.

A lack of access to providers and services may be grounded in network admission and reimbursement standards that violate the Parity Act, and, as the OIG noted, UM standards may account for wide variability in MOUD access across states.[50] Burdensome UM requirements, including periodic concurrent review of medications for patients with chronic conditions who have been prescribed specific MH and SUD medications successfully, also deter MH and SUD practitioners from participating in MCO networks. While the OIG's report does not examine parity compliance for coverage and UM standards, States should be required to assess parity compliance to eliminate discriminatory coverage

a Medicare benchmark for reimbursement rate setting are set out fully in our CMS Medicaid Access Rule comments and DOL/HHS Parity Act comments and apply equally to standards that CMS adopts in the Medicaid program.

[46] Jane M. Zhu et al., "Phantom Networks: Discrepancies Between Reported and Realized Mental Health Access In Oregon Medicaid, Health Affairs (July 2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00052

[47] See Max Jordan Nguemeni Tiako, et al., Thematic Analysis of State Medicaid Buprenorphine Prior Authorization Requirements, JAMA Network (June 15, 2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806100 .

[48] HHS OIG Report, *supra* note 12.

[49] *Id*. at 6.

[50] *Id.* at 8.

and access standards in Medicaid and CHIP that can be readily addressed through design and application corrections.[51]

D. Scope of Services

Finally, in assessing the scope of covered services for SUD care, MACPAC found that few states cover the full continuum of services required by the American Society of Addiction Medicine (ASAM) criteria. The greatest gaps in coverage identified by MACPAC are early intervention services, intensive outpatient (IOP), and partial hospitalization (PHP) treatment,[52] among the services for which no federal Medicaid policy barriers exist (*e.g.* institution for mental disease (IMD) exclusion). HHS's Substance Use Disorder (SUD) Data Book[53] also examines the availability of 18 SUD services that are billed by states for SUD care, noting substantial variations across states. (*See infra* point 10 for a description of service coverage). Finally, KFF's 2022 survey of MH and SUD covered benefits for adult enrollees in state FFS programs identified the most significant service gaps and limitations for psychiatric residential treatment, case management, crisis services and integrated care services.[54]

Importantly, even if a State plan/MCO covers at least one SUD (or MH) benefit in each classification in which a medical/surgical benefit is covered, (42 C.F.R. § 438.910(b)(2)), limited service coverage in each classification may not satisfy the separate NQTL standard that requires comparable and no more stringent benefit coverage for SUD and MH services than for medical/surgical benefits, including coverage of intermediate levels of care such as IOP and PHP. [55] An examination of a state/MCO's factors and evidentiary standards for benefit exclusions across MH, SUD and medical/surgical benefits could reveal Parity Act violations, particularly for exclusions of IOP, PHP and medications for opioid use disorder. **A parity assessment of scope of services is particularly critical for SUD services, as benefit inclusion or expansion has occurred in many states through time-limited 1115 waiver authority.[56] Coverage of SUD and MH benefits on par with medical/surgical services, as required**

[51] A second recent HHS OIG report identified high rates of PA denials by some Medicaid MCOs and limited state oversight of MCO practices. While denial rates were not reported by service type, the report reinforces the need for a review of PA design and application requirements and outcomes data to identify parity violations. Dept. of Health and Human Services, "High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concern About Access to Care In Medicaid Managed Care Plans," (July 2023), https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.

[52] MACPAC, *supra* note 40 at 93-95.

[53] Dept. of Health and Human Services, Report to Congress: "T-MSIS Substance Use Disorder (SUD) Data Book: Treatment of SUD in Medicaid, 2020 (Dec. 2, 2022), https://www.medicaid.gov/sites/default/files/2022-11/2020-sud-data-book.pdf.

[54] Madeline Guth, et al., "Medicaid Coverage of Behavioral Health Services in 2022: Findings from a Survey of State Medicaid Programs" (March 17, 2023), https://www.kff.org/mental-health/issue-brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs/.

[55] In Maryland, state Medicaid officials have, in the past, asserted that they need only address the "coverage in all classifications" requirement and not address scope of services as an NQTL. The DOL/HHS proposed private insurance parity rule would address this, in part, by requiring "meaningful" coverage of SUD and MH benefits to comply with the "coverage in all classifications" requirement. This is an important standard for alignment of parity regulations across public and private insurance.

[56] Using 1115 waiver authority, 7 states added OTP services; 7 states added or expanded IOP services; 8 states added or expanded PH services; 16 states added or expanded residential services; 17 states added or expanded withdrawal management services; 16 states added or expanded coverage of recovery support services; and 8 states added or updated care coordination requirements. RTI International, "Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Features of State Approaches to Improve Medicaid SUD Treatment Delivery Systems, at 4-6, 9 (Nov. 2022), https://www.medicaid.gov/sites/default/files/2023-02/sud-1115-rcr-features.pdf.

under the Parity Act, is needed to ensure that a full continuum of care is available after waiver authority ends.

4. NQTLs and Benefit Classifications that Should be Prioritized for Review

In addition to the above research-based trends, the Legal Action Center conducted interviews with state provider and consumer stakeholders regarding on-the-ground barriers to SUD and MH care in Medicaid and state Parity Act enforcement efforts.[57] They identified specific gaps in services that may be based on discriminatory policies and practices, and state officials should have ensured that a thorough Parity Act review ruled out any violations. **The state-specific issues reinforce that key NQTLs should be prioritized: reimbursement rate setting, network composition, application of medical necessity criteria, UM standards and practices, and scope of service coverage.** Additionally, while state stakeholders identified barriers to accessing the most expensive and intensive level of care, the high priority NQTLs should be assessed in all benefit classifications, as data demonstrate substantial variability across states for outpatient and inpatient services and access to prescription medications – all of which are essential for MH and SUD care.

Stakeholders have identified the following, non-exhaustive list of barriers to care, which require an assessment of whether the underlying state/MCO standards violate the Parity Act.

- Failure to cover SUD and MH benefits and administrative barriers to MH and SUD care
    - Michigan Medicaid did not cover in-patient SUD treatment delivered by addiction physicians until September 2023.[58]
    - In Oregon, access to 1915(i) Home and Community Bases Services (HCBS) for individuals with MH and SUD benefits is inequitable compared to individuals with physical disabilities who qualify for those services: the assessment and determination
    - process for individuals with physical disabilities is more timely, provides more holistic person-centered supports, stronger supports to HCBS providers and residential treatment settings and more timely access to services.[59]
    - In Massachusetts, Medicaid does not cover Applied Behavioral Analysis (ABA) therapy for individuals with autism spectrum disorder over age 21.

[57] We interviewed provider and consumer stakeholders in 13 states including: Connecticut, Florida, Georgia, Illinois, Massachusetts, Michigan, Minnesota, Ohio, Oklahoma, Oregon, New Jersey, North Carolina, and Rhode Island. We attempted to get input from a geographical and political cross-section of states, including expansion and non-expansion states.

[58] Michigan Dept. of Health and Human Services, Project Number 2323-Hospital (Aug. 1, 2023), https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Public-Comment/2323-Hospital-P.pdf?rev=e20c27ba2e2c4b148f9d213e3943b0b4&hash=80BC72E4D48796063C217A8D20174461.

[59] Oregon Health Authority, Ombuds Program 2022 Year-End Report, *supra* note 25 at 12 (setting out significant differences in eligibility determination process for individuals with MH and SUDs, ability to identify providers of care, being informed of right to peer support specialists, scope of MH supports for individuals who qualify with a physical disability versus a mental disability).

- Medical necessity criteria
    - Minnesota hospitals will not admit patients for AUD withdrawal management, absent other co-occurring conditions, contrary to ASAM criteria.
    - West Virginia's MCOs do not use the required ASAM criteria or misapply the ASAM criteria by focusing on medical factors rather than other level of care dimensions and push patients to lower levels of care.
    - Peer-to-peer reviewers for one Rhode Island MCO could not articulate the ASAM criteria that have not been satisfied in care denials.
    - Illinois MCOs refuse authorization of 3.7 care for individuals in withdrawal from methamphetamine and have refused to identify the level of care that they would authorize.
    - In NY, some MCOs have denied coverage of continuing residential MH care as soon as a patient is deemed to be non-suicidal.

- Burdensome, restrictive and inconsistent PA and UM requirements
    - In West Virginia, UM requirements lead to frequent denials and time-consuming peer-to-peer reviews, and MCOs do not respond until after the authorization window.
    - In Illinois, length of stay (LOS) data demonstrate a "hard stop" at 28-days for residential treatment, with most residential care authorized for only 21-days, even though the ASAM criteria are the required MNC and the complexity of most patients' condition requires longer LOS. Authorizations for withdrawal management of alcohol or opioids is generally limited to 1 or 2 days.
    - In Rhode Island, peer-to-peer consults for continuing care took two-weeks to schedule for one MCO, and the MCO could not identify the ASAM criteria it relied on for denying authorization. One Rhode Island provider loses $100,000 per year fighting PA decisions and resolving UM issues with MCOs.
    - One Rhode Island MCO imposes PA for IOP, which no other MCOs requires, and also required a full clinical assessment of patients with OUD simply to ensure the program prescribes MOUD for patients with OUD. After the program objected to the burdensome process, the MCO observed the program's intake process on-site and subsequently removed the PA requirement for IOP.
    - In Rhode Island, MCOs require concurrent review after 6 sessions for IOP and providers must do extensive work to get an additional 4 sessions.
    - Rhode Island MCOs impose a cap on billing SUD care under 99214 (60-minute E&M code) to push care to a lower and less expensive service even when a patient's chronic condition requires longer counseling sessions.
    - Illinois Medicaid officials require the completion of an extensive data tool for all SUD and MH patient intakes that is not required for patient receiving medical services. (CMS instructed Maryland Medicaid to discontinue a similar patient data collection requirement for MH and SUD patients as a parity violation.)
    - One Illinois MCO requires completion of authorization forms that are more extensive than other MCOs and fails to comply with required ASAM criteria.
    - Oregon's coordinated care organizations require weekly authorization requirements for MH care even though patients with severe conditions do not get better in one week.
    - In Connecticut, restrictive UM criteria for residential SUD care limits services to 7 days for patients requiring far longer lengths of stay.

- In Massachusetts, many managed care entities contract with the same carve-out for MH and SUD providers, but the carve-out fails to assess or adjust its PA or other UM requirements to ensure they are at parity with those in the managed care plans.
- In Maryland, PA is required for virtually all MH and SUD services, which are delivered through a carve-out, while some MCOs impose PA on virtually no medical/surgical service. Maryland Medicaid has never conducted a complete and accurate comparative analysis of UM requirements.

- Prescription Drug UM requirements
  - In Rhode Island, MCOs impose a fail-first requirement for Sublocade, requiring patients with long term success on non-injectable buprenorphine to use Vivitrol, in conflict with clinical guidelines.

- Inadequate reimbursement rates
  - Low rates in Connecticut, Georgia, Minnesota, North Carolina, Oregon, and Rhode Island contribute to an insufficient number of MH and SUD providers and capacity to meet the complex care needs of Medicaid enrollees.
  - Rhode Island's SUD providers have not received a rate increase in 12 years and evaluation and management (E&M) rates for MH and SUD are $10-$12 lower than E&M rates for medical care. Rhode Island's largest MCO offered a rate for withdrawal management that is one-tenth the cost of care.
  - In Maryland, reimbursement for outpatient SUD and MH benefits are low, and Maryland Medicaid has never conducted a comparative analysis of rate setting practices.

- Reimbursement and service limitation practices
  - In Illinois, MCOs will not reimburse for the day of discharge from a residential program and some strictly enforce "date of discharge" requirements and do not consider information submitted by the provider to support reimbursement for services and extension of discharge date, resulting in programs "writing off" the cost of care.
  - In Rhode Island, MH and SUD providers are given a subset of billing codes on a fee schedule for billing and, to bill any service that is not on the fee schedule, the provider must research the rate, request approval to bill and obtain approval – a process that can take months. Billing codes for crisis counseling, alcohol withdrawal management, mental health assessment by a non-physician are not included in the fee schedule and, without specific approval for a rate, providers must bill other codes that do not cover the cost of the service or complexity. In contrast, medical service providers can use any fee schedule for billing and, as a result, do not face the same administrative burdens for billing.
  - Oregon's coordinated care organizations impose service limitation rules that exclude reimbursement for outpatient MH care delivered on the same day as residential SUD care.
  - Oregon's coordinated care organizations' network contract practices for SUD residential care do not result in sufficient networks and single-case agreement practices for out-of-network SUD residential services do not address the patient's need for care.[60]

[60] *Id*. at 13.

- Maryland imposes service limitations on billing OTP and IOP treatment on the same day and has not conducted a complete parity analysis of other service limitations on MH and SUD care that are far more extensive than those imposed by MCOs on medical/surgical services.

- Reimbursement practices
  - In Rhode Island, one MCO's behavioral health carve-out failed to pay claims to such a significant degree that providers were required to seek separate state funds to remain in business.
  - Oregon's coordinated care organizations spend a **shockingly small fraction** of their premiums on SUD and MH services: an average of 3% for SUD care, ranging from 0.6% to 4.4% and an average of 10.7% for MH services, ranging from 2.7% to 17.1%. The low rate of spending is an indicator, among others, that Medicaid members lack access to MH and SUD care.[61]
  - In Massachusetts, many managed care entities contract with the same carve-out for MH and SUD providers, but the carve-out fails to assess or adjust its reimbursement rates to ensure they are at parity with those in the respective managed care plans.

- Exclusion of provider types
  - Michigan Medicaid does not reimburse addiction psychiatrists or other allied SUD professionals for hospital-based care or recovery coaches who are not affiliated or under a contract with a treatment provider.

- Inadequate MCO networks
  - Many Oregon coordinated care organizations do not have active contracts with the limited number of providers of SUD withdrawal management care and do not contract with the majority of SUD residential programs.[62] Limited access to residential SUD treatment providers for youth and adults that accept Medicaid leads to poor care and repeated need for withdrawal management.
  - No Oregon facilities are available to treat youth with both physical and mental health needs and youth in foster care could not access meaningful MH supports due to a lack of care coordination.[63]
  - Florida's MCOs do not contract with the only SUD addiction practitioner in one country, requiring members to travel long distances, pay out-of-pocket or forego care. Efforts to contract with all MCOs have been consistently rejected.
  - Rhode Island has a limited number of practitioners in MCOs who do assessments for youth needing an individual education plan (IEP) based on mental health issues, resulting in children being excluded from school and having no appropriate treatment plan.
  - In northern Illinois, only one provider of SUD services for pregnant people accepts Medicaid.

[61] *Id.* at 9.

[62] *Id.* at 7.

[63] *Id.* at 19.

  - In Georgia, inpatient treatment for individuals with SUDs is limited based on low reimbursement rates, resulting in hospitals admitting non-resident patients with Medicaid from other states that pay higher inpatient rates.
  - Maryland's carve-out provider network has not included any providers of SUD residential services, and state officials asserted that the failure to deliver services through a non-participating provider, as required for medical/surgical services, does not constitute a parity violation because "any willing provider" was eligible to participate in the carve-out network.

- No grievance process for providers
  - Minnesota and Oregon providers have no standardized process for reporting problems to their state Medicaid authorities and do not receive responses to most inquiries.

- Inadequate parity enforcement by state Medicaid officials
  - In Oregon, the state routinely relies on the coordinated care organization's attestation of parity compliance and does not conduct a "360 review" of data. The Oregon Health Authority (OHA) Ombuds Program has identified numerous barriers to MH and SUD care in Medicaid and CHIP, some of which are based on practices that violate the Parity Act. The OHA is aware of, but does not address, these barriers through parity enforcement. The Ombuds Program 2022 year-end report prioritized their recommendations on access to MH and SUD residential capacity, hospital discharge planning to MH and SUD residential and community settings and access to OHA-administered Home and Community-Based services.[64]

- Lack of parity expertise in state Medicaid agencies and unresponsive to parity complaints
  - Oregon and Georgia providers reported that their state authorities are not tracking parity problems, do not know what problems to look for or how to assess practices that are problematic.
  - Minnesota regulators fail to respond to practitioner complaints filed through the state's parity portal.
  - One Rhode Island provider asked state Medicaid officials to participate in each UM call with one problematic MCO to understand and address systemic problems and, while some of the provider's problems were resolved, the agency's participation did not result in system-wide reform.

When state Medicaid officials fail to address barriers to MH and SUD care through Parity Act enforcement and other measures, stakeholders have pursued enforcement through other means. For example, treatment advocates in Illinois, Oregon, and Rhode Island have relied on legislative champions to achieve some oversight of MH and SUD coverage and provider reimbursement in Medicaid. **State legislators have taken advantage of federal oversight requirements to impose greater accountability in state Medicaid programs, highlighting the importance of strong federal standards and guidance.**

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[64] *Id.* at 2.

Treatment advocates in Rhode Island, Ohio and Georgia have used MCO contract renewal processes to secure additional protections.

- Rhode Island stakeholders, for example, recommended inclusion of MCO outcomes data collection and reporting requirements and Parity Act enforcement measures in a recent contract renewal process and seek to have the state Medicaid authorities conduct a market conduct examination of MCO networks to assess the rate of active billers and utilization of non-network services.

- Ohio stakeholders succeeded in getting several parity-specific contract provisions in the state's Next Generation Medicaid managed care program, including annual parity compliance reporting requirements and standardized forms (replacing previous contract requirements for parity attestation), centralized provider credentialing and Medicaid program enrollment to standardize those requirements, and centralized claims processing through the state Medicaid authority to ensure data tracking of claims submitted and paid and appropriate payment rates.

As noted above, developing a CMS model MCO contract for Parity Act enforcement would support MH and SUD providers and other stakeholders who should not bear the responsibility of forcing state officials and MCOs to comply with federal law.

Several state stakeholders also offered recommendations to improve access to MH and SUD care via rigorous Parity Act enforcement. **First, several recommended that CMS actively monitor State parity compliance, noting that, absent strong oversight of state parity enforcement activities by CMS, state Medicaid officials have no incentive to monitor MCO compliance.** Generating action at the state level is made more difficult by CMS's "silence on" or "acceptance" of state submissions, which is interpreted as parity compliance.[65] Second, stakeholders have recommended that CMS impose additional guardrails to require state Medicaid authorities to (a) establish a unit/personnel with parity expertise, (b) inform every decision in benefit design and implementation by an examination of the impact the practice/standard will have on parity and health equity, and (3) prioritize data collection and reporting.

5. Criteria for Identifying High Priority NQTLs

The NQTLs identified above in the research literature and via stakeholder input are the high priority plan design features. These align with the NQTLs that have been identified by DOL and HHS as creating the greatest burden on patient access to care in the private insurance market. While each state's Medicaid program may vary in the degree to which an NQTL burdens access to MH and SUD care, each must be fully assessed for parity compliance.

We also recommend that federal and state regulators proactively evaluate complaints from members,

[65] For example, Maryland Medicaid has imposed a significant number of service limitations on SUD and MH services, while only 2 MCOs have service limitations on medical/surgical benefits. Since the identification in 2021 of the potentially invalid MH and SUD service limits, Maryland Medicaid has retained most MH and SUD service limitations, asserting that it is awaiting guidance from CMS on how to address NCCI coding limits for medical/surgical benefits which it asserts would resolve the issue. Maryland Parity Report *supra* note 24 at 56.

providers and other stakeholders to identify NQTL violations. NQTLs are systemwide practices that will adversely affect many members if discriminatory practices persist, yet it is impossible for most members and providers to identify whether a specific barrier to care constitutes an NQTL violation.

6. Outcomes Measures and Data Points and Data Collection

A. Data Templates and Reporting Standards

As noted above, a handful of states are only now beginning to adopt outcomes data requirements to assess "in operations" parity compliance and to flag potential violations. Uniform data elements and standardized definitions and data collection and reporting methodologies are essential across all states and MCOs, CHIP and FFS systems for ABPs. Data reporting standards must require separate data analyses for MH benefits and SUD benefits to comply with the Parity Act and to fully identify variations in benefit access – a problem that has been identified by state stakeholders. Finally, these elements should be consistent across private and public health plans, to the greatest extent possible, and we urge CMS to work with DOL and CCIIO to create the necessary data tool templates, methodologies and guidance. In response to CMS's question 7, we recommend that all reporting requirements be included in MCO/CHIP contract requirements (as an element in the proposed CMS model contract), and CMS should require state Medicaid authorities to report data outcomes in annual NQTL comparative analysis documents and upon request, as a condition of receipt of federal financial participation.

Additionally, we recommend that CMS issue standards that define the degree to which disparities in outcomes data between MH, SUD and medical/surgical benefits constitute a violation or, at a minimum, trigger corrective actions.[66] As we noted in our DOL/HHS proposed regulation comments, we interpret the Parity Act's "no more restrictive" statutory standard to allow nothing more than a *de minimis* variation in outcome for parity compliance.[67] Yet, without clear guidance and benchmarks, states have interpreted the significance of similar percentage disparities differently for purposes of NQTL compliance assessments. For example, Illinois' independent contractor parity report identified "non-parity" for one MCO based on a statistically significant higher denial rate of 5 percentage points for MH/SUD services (10%) compared to medical/surgical services (5%.)[68] In contrast, the Maryland Medicaid authority found that any variation of no more than 10 percentage points to be *immaterial/de minimis* and a variation of more than 10 percentage points to be an indicator of a potential parity violation.[69] No explanation was offered for this benchmark. As with other recommendations, we recommend that CMS align its standards with those of DOL and CCIIO in private insurance.

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[66] While federal regulators interpret disparate outcomes in operational data as a "red flag" for an underlying parity violation, not dispositive evidence of a violation, we support the DOL/HHS proposed standard that a designated level of variation would constitute a violation of network composition standards. We believe the same standard should apply to all NQLs for which outcomes data are available.

[67] We have opposed the "material variation" standard in the DOL/HHS proposed regulation as inconsistent with the statutory standard of "no more restrictive" and "no more stringent" for private health plans.

[68] Dept. of Healthcare & Family Services, 2021 Mental Health Parity Analysis, Summary Report, at 12, July 2022. The same contractor's assessment of Oregon's program identified deviation rating definitions for comparing administrative data: a deviation rating of "none" would be "less than 5 percentage points in difference between MH, SUD and medical/surgical measurements; 'moderate" would be greater than 5 percentage points and less than 10 percentage points; and "substantial" would be greater than or equal to 10 percentage points. Oregon Health Authority, 2022 Mental Health Parity Analysis Summary Report, at 2-5 (Dec. 2022).

[69] Maryland Dept. of Health Report, *supra* note 24 at 52.

B. Outcomes Data Points

We agree with CMS's suggested data points for identifying possible Parity Act violations in (1) benefit denial rates, (2) factors related to network composition, including average and median appointment wait time and active billers, (3) payment rates and payment timelines, and (4) general access to care based on the prevalence of individuals with MH and SUDs and rate who receive treatment.

In addition to these data points, we recommend that data requirements include additional elements to evaluate UM practices, which some states already require, and level of access to Medicaid services across MH, SUD and medical/surgical benefits. We recommend inclusion of the following:

- Number of PA requests, number of approvals and denials, and overturn rates;
- Number of concurrent review requests, number of approvals and denials, and overturn rates;
- Frequency of concurrent review (e.g. number of days of benefit authorization at the level of care) including separate reporting for IOP and PHP and residential and inpatient care;
- Number of retrospective reviews of medical necessity, overturn rates and portion of payments recouped;
- Portion of MCO premiums that is spent on MH, SUD and medical/surgical benefits compared to the estimated portion of the capitated rate that should be allocated based on prevalence of MH and SUD among Medicaid membership and complexity of patient conditions.
- Utilization of MH, SUD and medical/surgical services per 1,000 members, by classification, based on claims data.[70]

C. Additional Measures Related to Network Composition

The Legal Action Center submitted extensive comments on network composition analyses for the DOL/HHS Technical Release. Rather than restate our recommendations, we incorporate those comments for CMS's consideration, recommend several additional metrics to evaluate network composition, and respond to CMS's questions.

First, we recommend that CMS identify the appropriate benchmark for comparing MCO/CHIP and FFS reimbursement rate setting. State Medicaid programs often benchmark reimbursement to Medicare rates, paying a percentage of the CPT code rate. As discussed extensively in our DOL/HHS parity comments, a Medicare benchmark is inherently discriminatory for SUD and MH benefits and should not be used as the basis for establishing payment rates. Medicare is not subject to the Parity Act, and research demonstrates that psychiatrists are paid less than other physicians when billing the same E&M codes. Licensed clinical social workers (and, as of January 2024, counselors and marriage and family therapists) are paid at a lower rate than other non-physician practitioners based on a larger percentage discount of the base rate, which the Departments have recognized is a parity violation in and of itself. CMS has long recognized that the relative value unit (RVU) methodology for establishing Medicare rates results in a "systemic undervaluation of work estimates for behavioral health services"[71]

[70] Oregon Health Authority, Ombuds Program 2022 Year-End Report, *supra* note 25 at 9.

[71] Centers for Medicare & Medicaid Services, Medicare and Medicaid Programs: CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 88 Fed. Reg. 52262, 52320, 52366 (Aug. 7, 2023); *see also*, Marua Calsyn and Madeline Twomey, "Rethinking the RUC: Reforming How Medicare Pays for

and that counseling services for MH and SUDs are among the services most affected by their existing methodology.[72] Finally, Medicare also does not cover most community-based programs that deliver SUD treatment, a number of SUD practitioners who deliver care to Medicaid members and services for children and youth.

In the private insurance context, we support a comparison of health plan/issuer reimbursement payment rates to billed charges, as proposed in the DOL/HHS parity rule. The very low rate of Medicaid participation by MH and SUD providers in many states, as a result of low reimbursement rates, calls for the identification of a benchmark that is sufficient to increase provider participation and a requirement to compare MCO, CHIP and FFS payment rates to that benchmark, consistent with 42 U.S.C. § 1396a(a)(30).[73] **The cost of service delivery may be the appropriate benchmark.**

Second, as an analogue to the active biller proposal, we recommend that CMS require states to assess the accuracy of provider directories across MH, SUD and medical/surgical providers, which can build upon the proposed secret shopper requirements in CMS's pending Medicaid MCO/CHIP rule. Finally, in addition to the appointment wait time data, data on network adequacy should include satisfaction of travel distance standards and inclusion of essential community providers (calculated separately for MH and SUD providers). We also recommend that CMS ensure that the list of provider types that are tracked for travel distance standards are sufficiently granular to capture community-based MH and SUD services, including OTPs, programs that deliver IOP and PHP care, and residential services. Community-based programs are frequently the setting at which members receive SUD and MH care and must be tracked to gain a complete understanding of the provider network.[74]

D. Terminology Definitions

We urge CMS to work with DOL and CCIIO to identify terminology that must be defined to ensure uniform data gathering and meaningful outcome assessments. Among the terms that we identified in our DOL Technical Release comments, we recommend that the following terms be defined:

- the setting(s) of care and services that are to be included in each benefit classification;
- the method of counting a "claim" when multiple billed services or codes are covered in a single claim;
- the terms "paid in full," paid in part," "denied," and "denied in part;"
- the term "unique" patient for purposes of calculating active billing; and
- the method for identifying the numerator and denominator for all percentage calculations.

7. Means of Collecting Data

Doctors' Services" (July 13, 2018), https://www.americanprogress.org/article/rethinking-the-ruc/ (identifying the undervaluing of cognitive services, such as those involved in MH and SUD counseling patients, compared to procedure-based services, and the underlying flaws in the process for establishing RVUs).

[72] CMS 2024 Payment Policies, 88 Fed. Reg. at 52367.

[73] Requiring State Medicaid plans to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area".

[74] We note that Maryland has adopted network adequacy regulations that track travel distance for a wide range of MH and SUD providers and serves as a good model for such metrics. COMAR § 31.10.44.05.

We recommend that CMS require uniform data collection on the above outcomes by developing templates with standardized data definitions and methodologies. These elements should be consistent across private and public health plans, and we urge CMS to work with DOL and CCIIO to create those data tools. State Medicaid authorities should require MCOs, CHIP and entities administering FFS benefits in ABPs to conduct required data analyses through contract requirements.

8. Follow-Up Protocols and Corrective Actions

A six-year track record of deficient parity compliance in Medicaid calls for prompt[75] corrective action by: (1) CMS when a state cannot present accurate and complete parity compliance documentation or implements non-compliant NQTLs; and (2) state Medicaid officials when MCOs, CHIP and ABPs fail to submit complete comparative analyses in advance of coverage changes and at required intervals, and/or violate parity standards. The burden of proof for parity compliance falls squarely on the state and MCOs/CHIP and a range of corrective actions should be taken promptly to incentivize compliance.

We recommend that CMS adopt a range of corrective measures including technical assistance to state Medicaid officials, withholding contract and rate approval until evidence of compliance is submitted, "deferring claims for FFP in expenditures for capitation rates based on unapproved MCO contracts"[76] and withholding administrative costs and non-benefit costs associated with non-compliance. To improve transparency and facilitate future compliance, we also recommend that CMS issue regular guidance to state Medicaid officials on common parity questions, violations CMS has identified via contract review and other audits, and any penalties.

For state enforcement, we recommend that state Medicaid officials:

- Include contract provisions that impose a range of penalties, including withholding a portion of a capitation rate for non-compliance and imposing liquidated damages for failure to submit complete and accurate compliance reports and continuing failure to comply with federal and state standards;
- Require MCOs to notify members and providers of NQTL violations that have system-wide effect; and
- require MCOs to review and correct all benefit denials or other adverse decisions for all affected members, even if a member has not challenged a determination.

9. Additional Processes to Assess Compliance with Parity Requirements

As noted above, we recommend that CMS establish a designated unit with expertise in the Parity Act that would work with CCIIO and DOL to develop guidance, templates and enforcement capacity and work with state Medicaid authorities to improve compliance and enforcement. As part of that unit's

[75] Maryland Medicaid, for example, has not implemented corrective action for a prescription drug cost sharing violation that CMS identified in 2020, asserting that implementation will occur in May 2024. The state's report also identifies comparative analyses that it has failed to conduct – in operation analyses based on outcomes data – and simply states that it plans to conduct such analyses "in the coming years." Maryland Dept. of Health Report, *supra* note 24 at 6 and 15. CMS should take action to ensure that corrective measures are implemented no later than the following plan year and impose penalties for on-going failure to conduct a complete comparative analysis.

[76] Medicaid Parity Regulation, 81 Fed. Reg. at 18419.

activities, it would conduct compliance audits consistent with the 2021 Consolidated Appropriations Act amendments to the Parity Act for private health plans/issuers. *See* 42 U.S.C 300gg-26(a)(8). Based on those standards and existing regulatory authority, CMS should require all states to prepare an NQTL comparative analysis and make it available upon request for CMS's review. CMS could address deficiencies through a range of actions identified above in point 8.

States may adopt a number of oversight practices, including several already adopted by some state Medicaid programs:

- Review all member and provider complaints related to MH and SUD benefits for underlying parity violations;
- Establish a point of contact with parity expertise in the Medicaid office or a patient advocate/ombud office to directly assist members and providers who face barriers in accessing or delivering MH and SUD services and serve as an active intermediary with MCOs to address those and parity-related problems.
- Require the MCOs external quality review organization to assess parity compliance annually as part of its external quality review (42 C.F.R. § 438.350) and/or engage external experts to conduct compliance tests and offer technical assistance to address deficiencies;
- Require state departments of insurance or other appropriate non-Medicaid entity to conduct market conduct examinations of parity compliance, with the cost of the examination borne by the MCO; and
- Include metrics related to an MCO's quality of Parity Act assessment, documentation and compliance, and other external assessments of compliance in all MCO contract renewal determinations.

10. Most Prevalent Mental Health Conditions and Substance Use Disorders Among Enrollees and Most Significant Barriers

HHS's most recent Substance Use Disorder (SUD) Data Book provides data on the number of Medicaid beneficiaries with a SUD who received treatment services, SUD prevalence data, and the types of services and settings in which beneficiaries received treatment in 2020.[77] Significant variations in prevalence and treatment services exist for Medicaid beneficiaries across all states. In brief:

- Of the approximately 56 million Medicaid beneficiaries ages 12 and older with full or comprehensive benefits in states included in the analysis, 4.6 million individuals (8%) were treated for an SUD.
- Approximately 1.6 million beneficiaries (3%) were treated for opioid use disorder (OUD); 1.5 million (3%) were treated for polysubstance use disorder; and 1 million (2%) were treated for alcohol use disorder (AUD).
- Of those receiving treatment, 35% of beneficiaries were treated for an OUD; 23% for an AUD; 15% for a stimulant use disorder; 14% for a cannabis use disorder; and 10% for all other SUDs.

The types of SUD services that beneficiaries received and settings of care varied widely across states [78] – reflecting the need to evaluate whether states/MCOs apply scope of services rules, provider

[77] SUD Data Book, *supra* note 9 at 17-21.

reimbursement, provider type and credentialing practices that create barriers to care, which could be addressed, in part, through Parity Act enforcement. For example:

- Acute care services, which includes inpatient care and emergency services, were the most common SUD services received by approximately 40% of beneficiaries, with wide variations across states (62% to 8% of beneficiaries for emergency services and 63% to 22% of beneficiaries for inpatient services).
- One-third of beneficiaries (33%) received medication assisted treatment and, for individuals with OUD, over 75% received medication for opioid use disorder (MOUD) with approximately 50% of beneficiaries receiving MOUD in all states and territories.
- One-third of beneficiaries received physician services (35%) and one-fifth received screening and assessment (20%).
- Over one-fourth of beneficiaries received counseling with significant variations in the states.[79]

These data suggest that acute care treatment is more readily available than chronic care services, which may reflect state/MCO barriers to treatment across the full continuum of services and the restrictive and incorrect application of medical necessity criteria such that a member's acute episode of substance use is address but not the underlying chronic condition that requires services of varying intensity, as addressed in the ASAM criteria.

The settings of care also reveal potential limitations on provider types and settings of SUD care. Approximately three-quarters (78%) of Medicaid beneficiaries received at least one service in an outpatient setting and 42% received at least one service in an inpatient setting. A much smaller portion of treatment was received in a residential setting (6%), home-based (4%) or community-based setting (2%).[80] These data suggest that states/MCOs may have network inclusion, network adequacy and reimbursement rate setting that could limit access to SUD care on par with medical/surgical benefits. Finally, the Data Book reports the length of services that beneficiaries received, which may also be related to state/MCOs UM practices and the application of medical necessity criteria (MNC). With significant variation across states, beneficiaries received an average of 10 days of inpatient care; 16 days of partial hospitalization care; 34 days in a treatment program; 130 days of medication assisted treatment; and 10 counseling sessions.[81] The extremely short treatment durations for a chronic health condition suggest that beneficiaries are not receiving the scope and length of care needed to regain health and sustain recovery. Given the substantial variation of length of stay across states and the chronic nature of SUDs, a close examination of policies and practices for authorizing continuing care, the selection and application of MNC, and outcome data related to these NQTLs is critically important.

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[78] States/MCOs billed for 18 SUD services, 10 of which were billed for at least one patient by all states: counseling, detoxification, emergency services, inpatient care, intervention services, medication assisted treatment, observation care, physician services, pharmacotherapy, and screening and assessment. The 8 remaining services – case management, community support, consultation, medication management, partial hospitalization, peer support, treatment programs (defined as residential or IOP) and other services – were not billed by at least one state or territory. *Id.* at 48-50, Tables B1 and B2.

[79] *Id.* at 51.
[80] *Id.* at 52.
[81] *Id.* at 62.

11. Mental Health Conditions and Substance Use Disorders or Types of Treatment Most Likely to Not Be Covered In Compliance with the Parity Act

While variations exist across states, stakeholder feedback and other research suggest that, for SUD care, inpatient withdrawal management services, IOP, PHP and residential services are the least likely types of treatment to be covered in compliance with the Parity Act. For MH and SUD care, the continuum of services for youth is not covered in compliance with the law, notwithstanding EPSDT requirements. Additionally, individuals with complex and chronic SUDs – a significant portion of Medicaid members with SUDs – and those with co-occurring MH and SUD conditions or co-occurring physical conditions face the greatest barriers to accessing the full continuum of care and recovery support.

The failure to provide parity compliant MH and SUD benefits also imposes unique burdens on specific groups of Medicaid beneficiaries. Parity compliance is essential to reduce health disparities, consistent with CMS's Behavioral Health Strategy goal of strengthening equity and quality in behavioral health care. About 6 in 10 Medicaid beneficiaries are Black, Indigenous, or people of color, and yet, as previously noted, Black, Hispanic, American Indian or Alaska Native, Asian-American, and multi-racial individuals in Medicaid have more limited access to MH and SUD treatment than white beneficiaries. Limited access to MH and SUD care leads to higher rates of inpatient treatment and involvement with the criminal legal system; individuals with mental illness in Medicaid are more likely to be involved in the criminal legal system than those in private insurance.[82]

Many barriers to treatment for racial and ethnic minorities can be tied to NQTLs. For example, counties with higher percentages of Black, rural, or uninsured individuals are less likely to have at least one SUD facility accepting Medicaid,[83] which suggests inadequate networks. Black beneficiaries with OUD are far less likely than white beneficiaries to receive MOUD (53% compared to 71%) and similar disparities exist for American Indian or Alaska Native (66%), Native Hawaiian or Other Pacific Islander (64%), and Asian (61%) beneficiaries. Racially disparate access to MOUD is especially problematic because overdose death rates have increased at greater rates among Black people.[84] Barriers to MOUD – such as inadequate networks of prescribers, utilization management practices, and same-day treatment limitations – could be ameliorated through greater attention to and enforcement of parity requirement for these NQTLs.

The lack of parity compliance in Medicaid is also a serious concern for individuals who are dually eligible for both Medicaid and Medicare, more than half of whom are from communities of color and virtually all of whom live on annual incomes below $20,000.[85] Almost half of dual-eligible individuals (47%) have a MH condition and almost one in ten have a SUD.[86] As previously identified, Medicare is not subject to the Parity Act and does not cover the full scope of benefits, settings, and providers for MH and SUD care. As a result, these individuals must rely on their Medicaid coverage to get the treatment they need and face greater barriers related to navigating multiple financing systems with inconsistent

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[82] MACPAC report, *supra* note 11 at 32.
[83] Janet R. Cummings, Hefei Wen, & Michelle Ko, "Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Facilities in the United States," JAMA Psychiatry (Feb. 2014), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1792142
[84] HHS OIG, *supra* note 12.
[85] Maria T. Pena et al., "A Profile of Medicare-Medicaid Enrollees (Dual Eligibles), KFF (Jan. 31, 2023), https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/.
[86] *Id.*

standards. Dual eligible individuals must contend with two delivery systems both of which present inadequate networks, prior authorization and other utilization management requirements, and the failure to adhere to standardized medical necessity criteria. Providers and facilities are disincentivized from treating dual eligible individuals – further reducing network access – because the providers that are not authorized as covered providers under Medicare cannot get the denials they need to bill Medicaid, and those that are authorized under Medicare often get reimbursed at a lower rate due to the "lesser of" payment policy.[87]

As CMS considers strengthening parity enforcement in Medicaid, we recommend a specific emphasis on assessing how treatment limitations impact racial and ethnic minorities, beneficiaries in rural areas, beneficiaries with a history of involvement in the criminal legal system, and beneficiaries who are dually eligible for Medicare.

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Thank you for considering our views. We look forward to working with CMS to improve access to MH and SUD care for Medicaid beneficiaries through robust Parity Act enforcement.

Sincerely,

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ANA Massachusetts
Community Catalyst
Community Behavioral Health Association of Maryland
Disability Rights Maryland
Eating Disorders Coalition for Research, Policy, & Action
Faces & Voices of Recovery
Friends of Recovery - New York
Haymarket Center
Health Law Advocates, Inc.
Illinois Association for Behavioral Health
Inseparable

[87] CMS, "Access to Care Issues Among Qualified Medicare Beneficiaries" (July 2015), https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/access_to_care_issues_among_qualified_medicare_beneficiaries.pdf.

James' Place Inc.
Justice in Aging
Lakeshore Foundation
Maryland Addiction Directors Council
Maryland Family Network
Maryland Psychiatric Society, Inc.
Massachusetts Association for Mental Health
Medicare Rights Center
Michigan Society of Addiction Medicine
NAMI-Maryland
National Association for Behavioral Healthcare
National Association of Addiction Treatment Providers
National Council on Alcoholism and Drug Dependence- Maryland Chapter
National Disability Rights Network (NDRN)
New Jersey Association of Mental Health and Addiction Agencies Inc.
New York State Coalition for Children's Behavioral Health
New York State Council of Community Behavioral Healthcare
North Shore Child and Family Guidance Center
Parent/Professional Advocacy League, Inc.
Partnership to End Addiction
Policy Center for Maternal Mental Health
Psychotherapy Action Network
REDC Consortium
START Treatment & Recovery Centers, Inc.
TASC, Inc. (Treatment Alternatives for Safe Communities)
The Ohio Council of Behavioral Health and Family Services Providers
Treatment Communities of America
Trilogy Behavioral Health
VICTA
West Virginia Association of Addiction and Prevention Professionals (WVAAPP)
West Virginia University Department of Behavioral Medicine and Psychiatry
WVU Medicine & West Virginia Society of Addiction Medicine (WVSAM)
Where There's A Will Fund

Attachment A:Parity Report Status and MCO Contract Parity Reporting Provision by State

State (link to contract or RFP)	Parity Report Status as of October 2022 (including links)[1]	Contract Requires Reporting on Request[2]	Contract Requires Periodic Reporting[2]	Contract Requires Reporting on Amendment[2]	Contract Requires Specific Elements[3]
Alabama	N/A	State contracts with MCOs for integrated care (link) not general services			
Alaska	N/A	State does not contract with MCOs (link)			
Arizona	2017 report	Yes	Yes	Yes	Yes
Arkansas	None found	State does not contract with MCOs (link)			
California	2019 rev. report	No	Yes	No	Yes
Colorado	None found	Yes	Yes	No	Yes
Connecticut	N/A	State does not contract with MCOs (link)			
Delaware	2017 report	Yes	Yes	No	Yes
D.C.	None found	Yes	No	No	No
Florida	None found	No	Yes	No	No
Georgia	2022 report	No	No	No	N/A
Hawaii	2018 rev. report	Yes	Yes	No	Yes
Idaho	N/A	State does not contract with MCOs (link)			
Illinois	2022 report	Yes	Yes	No	Yes
Indiana	2017 report	No	No	No	No
Iowa	2019 report	Yes	No	No	No
Kansas	None found	Yes	No	No	Yes
Kentucky	None found	No	No	No	N/A
Louisiana	2017 report	Yes	No	No	No
Maine	N/A	State does not contract with MCOs (link)			
Maryland	2023 report	Yes	Yes	No	Yes
Massachusetts	2017 report	No	Yes	No	Yes
Michigan	None found	No	No	No	N/A
Minnesota	None found	Yes	Yes	No	Yes
Mississippi	2020 report	No	No	No	N/A
Missouri	2017 report	Yes	Yes	No	Yes
Montana	N/A	State does not contract with MCOs (link)			
Nebraska	None found	No	Yes	No	Yes
Nevada	2017 report	No	Yes	No	Yes
New Hampshire	2018 report	No	Yes	No	Yes
New Jersey	2021 report	No	Yes	No	No
New Mexico	2018 report	Yes	No	No	No
New York	2022 report	Yes	No	No	Yes
N. Carolina	None found	No	Yes	No	Yes
N. Dakota	None found	No	Yes	No	No
Ohio	2018 report	Yes	Yes	Yes	Yes
Oklahoma	None found	No	Yes	No	Yes
Oregon	2022 report	Yes	No	No	Yes
Pennsylvania	None found	No	No	No	N/A

State (link to contract or RFP)	Parity Report Status as of October 2022 (including links)[1]	Contract Requires Reporting on Request[2]	Contract Requires Periodic Reporting[2]	Contract Requires Reporting on Amendment[2]	Contract Requires Specific Elements[3]
Rhode Island	None found	No	Yes	Yes	Yes
S. Carolina	None found	No	No	No	N/A
S. Dakota	N/A	State does not contract with MCOs (link)			
Tennessee	2019 rev. report	Yes	No	No	No
Texas	2017 report	Yes	No	No	No
Utah	None found	Yes	No	No	No
Vermont	N/A	State does not contract with MCOs (link)			
Virginia	2020 report and NQTL addendum	Yes	No	No	Yes
Washington	2023 report	Yes	Yes	No	Yes
W. Virginia	2023 report	No	Yes	No	Yes
Wisconsin	None found	No	Yes	No	No
Wyoming	N/A	State does not contract with MCOs (link)			

[1] For reports, yellow signifies "older" reports and green signifies "recent" reports, which are those released before and after January 2021, respectively. Red signifies that no report was found for a State that contracts with managed care organizations. Grey indicates that no report was found and the state does not contract with managed care organizations.

[2] Examples of reporting requirements. Illinois requires reporting on request ("Contractor shall provide the necessary documentation, reporting, and analyses in the format and frequency required by the [State]"). Florida requires periodic reporting ("[t]he Managed Care Plan shall conduct an annual review of its administrative, clinical, and utilization management practices to assess its compliance with the MHPAEA under this Contract"). Arizona requires reporting on amendment ("[t]he Contractor shall certify compliance with mental health parity requirements before contract changes become effective").

[3] "Yes" signifies contracts that either include a template (such as Nevada), identify specific items that must be reported to demonstrate compliance (such as Hawaii), or specify that the State will provide the format for reporting compliance (such as Illinois).