



4 December 2023

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

Submitted Electronically

Dear Deputy Administrator Tsai:

The National Association for Behavioral Healthcare (NABH) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) [request for information](#) (RFI) on better enforcement of the *Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA). In addition to this letter, NABH also co-signed coalition letters from the [Legal Action Center](#) as well as a [collective response](#) by NABH in conjunction with greater than 25 national stakeholders.

NABH members provide the full continuum of behavioral healthcare services, including treating children, adolescents, adults, and older adults with mental health and substance use disorders (SUD) in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs (IOP), medication-assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C.

CMS and Key Agencies Should Implement Robust Parity Protections for All Managed Care Organizations (MCOs)

To help mitigate the nation's ongoing behavioral healthcare crisis, we urge CMS, key federal partners, and every state to implement robust oversight and enforcement of MHPAEA. A multi-agency letter released this summer outlines a parity framework of national standards and requirements for the individual insurance marketplace and employer-based plans. Although NABH [recommended](#) modifications to enhance this proposed rule, we and our members are very pleased with its overall direction to meaningfully improve parity protections for Americans. We're also encouraged by this RFI about parity for state-contracted plans.

The current level of parity noncompliance among state-contracted managed care organizations (MCOs) shows persistent disregard for both the letter and spirit of MHPAEA. Consequently, this negligence too often leaves patients with intensive mental health and SUD treatment needs to face life-threatening conditions without the benefit of the insurance they rely upon for coverage.

To counter this extreme neglect, it is essential that the relevant agencies establish – and enforce – the same parity protections to state-contracted health plans that they are about to finalize for individual and employer-based plans. Any gap in protection between these two groups would lead to preventable and harmful disparities—which directly opposes MHPAEA's objectives. Not only would parity safeguards lag for those in state-based plans, but given the Medicaid population's greater mental health needs, as we note below, such disparity would lead to disproportionate patient harm. To avert this scenario, it is imperative that CMS move quickly through formal rulemaking to similarly implement robust parity guardrails for Medicaid managed care, the Children's Health Insurance Program (CHIP), and Medicaid alternative benefit plans, following this RFI about state-level parity.



The Current Level of Parity Non-compliance is Unacceptable:

Today, behavioral healthcare stakeholders remain in the dark about the actual level of parity compliance for state-contracted MCOs due to the absence of meaningful compliance reporting. Unfortunately, the states' ongoing lack of parity enforcement continues to disincentivize the achievement of parity for patients covered in these health plans. Yet, available indicators demonstrate the nationwide lack of behavioral healthcare coverage parity, including CMS' 2017 call for compliance reviews by states, which resulted in mostly flawed and incomplete assessments of parity compliance status. Unfortunately, despite the more recent parity compliance assessment mandate outlined in the *Consolidated Appropriations Act of 2021 (CAA of 2021)* for individual marketplace and employer-sponsored plans, most states still have not conducted meaningful parity analyses, much less enforcement. While this 2021 mandate did not specifically apply to state-level MCOs, states and CMS have the inherent authority to implement standards consistent with the 2021 law, as CMS' 2017 requirements demonstrate. **And yet, the vast majority of states continue to neglect, and often completely ignore, their fundamental duty to implement MHPAEA.**

Impact of Non-compliance on Patients and Families:

From the vantage point of behavioral healthcare patients seeking care from health plans that lack behavioral healthcare parity, meaningful parity protections are long overdue, especially given that MHPAEA passed 15 years ago. In particular, the lack of parity by these state programs causes alarm because they are designed specifically to serve more vulnerable patients. For example, about six in 10 Medicaid beneficiaries are people of color, a group with greater incidence of untreated mental health and SUDs. As such, widespread parity noncompliance by MCOs contributes to the well-documented and glaring equity gap in behavioral healthcare coverage parity.

Meanwhile, as the country transitions beyond the COVID-19 pandemic, the overall behavioral healthcare crisis continues to debilitate too many individuals, families, and communities:

- **Overdoses:** There has been an upward trend in annual overdose frequency since before the COVID-19 pandemic, which continues on a steady upward trajectory. For 2022, the Centers for Disease Control and Prevention (CDC) [estimates](#) than 110,000 deaths from drug overdose and toxins in the supply of banned drugs, a 2.8% increase from 2021 levels.
 - This pattern of increase aligns with the rise in US overdose deaths involving both fentanyl and stimulants increased from 0.6% in 2010 to 32.3% in 2021.
- **Youth and Adolescents:** For U.S. teenagers, overdose deaths doubled in 2020 and rose another 20% in the first half of 2021, relative to the 10 years preceding the COVID-19 pandemic. UCLA [research](#) found that this exponential rise in the teen drug death rate, the first in US history, was "almost entirely due to illicit fentanyls, which are increasingly found in counterfeit pills."
- **Maternal Health:** Recent [research](#) from the National Institutes of Health that overdose mortality more than tripled among those aged 35 to 44 during the study period, from 4.9 deaths per 100,000 mothers with a live birth in the 2018 period to 15.8 in 2021.
- **Suicides:** Based on near-final data for the year, the CDC reports that 49,449 people died by suicide in 2022, a 3% increase from 2021 and the highest number of annual suicides since 1941.¹

Clearly, only strong and consistent action by CMS and its partnering federal and state agencies can counteract these profound and worsening disparities and, too often, fatal outcomes.

¹ According to a [report](#) published last week by the Centers for Disease Control and Prevention's National Center for Health Statistics.



NABH Recommendations

Implementing meaningful behavioral healthcare parity protections is a complex process that involves multiple stakeholders and policymaking entities. With regard to this RFI's questions, we raise distinct parity actions in direct response to the RFI, as well as discuss related concerns and recommendations below and in our coalition letters. **Note that our specific responses to the RFI's 11 questions are attached as Appendix A.**

Implement Consistent Parity Standards Across all Health Plans:

NABH fully supports CMS' long-term goal of consistent parity execution and enforcement across public and private payers, and this RFI is a concrete step in that direction. Following this RFI, we also support formal rulemaking to mandate that all state-contracted behavioral healthcare coverage comply with MHPAEA. To achieve more standardized implementation with MHPAEA across payers and for both public and private plans, we call on CMS to lead the effort by first reviewing and comparing state coverage of mental health and SUD coverage relative to physical health coverage. CMS also should apply consistent non-quantitative treatment limitations (NQTLs) to future behavioral healthcare coverage changes. As discussed, CMS' clarification of MHPAEA requirements also is needed by states and MCOs that have not been enforcing parity standards.

States and MCOs Need Technical Support from CMS:

A fundamental ingredient for prioritizing parity compliance and enforcement across all states is for CMS to systematically address the lack of parity expertise at the state level, including:

- *Expert Training:* Experts are needed to train state personnel on the statutory parity mandate, regulatory requirements, and best practices from other states on parity implementation and enforcement.
- *Parity Complaints:* Create a federal portal to receive complaints about behavioral coverage problems and potential parity violations. Use these incoming reports to:
 - Identify parity protocols requiring process improvements and oversee the implementation and compliant operation of such changes.
 - Report parity complaint trends to the state's parity enforcement team so it can monitor the types and MCOs involved with frequent parity complaints and follow-up with any needed parity remediation.
 - When a parity violation is identified, report the finding to the affected state and monitor its remediation on an individual basis and, when warranted, remediate a state parity protocol that needs broader process improvement.
 - Education is needed on restrictions that protect federal coverage standards from being unilaterally narrowed by a state or MCO. Our members report that such narrowing is occurring for IOP and partial hospitalization program (PHP) services, which may involve opioid treatment programs. Ultimately, providers need a channel to file a complaint on these possible parity and coverage violations.

Increase Transparency and Accountability for Parity Compliance:

Greater stakeholder access to state and MCO parity compliance status will materially raise accountability to MHPAEA and, ultimately, progress toward parity. One recent step toward this level of transparency is the 2024 Medicaid Managed Care Access rulemaking that restates the requirement of states to post parity compliance levels on state websites. Today, NABH partners investigated and found that only 26 states are currently publishing accessible parity reports, 15 of which were posted before 2020. Not only should CMS implement ramifications for non-reporting, the agency also should require public sharing of NQTL compliance, behavioral healthcare payment rates, and network composition per MCO.



Compare Payments and Parity Levels Across States:

Ensuring parity will require payment levels that can attract and retain behavioral healthcare practitioners from other settings – otherwise, behavioral healthcare settings will continue to suffer from workforce shortages that cripple our efforts to achieve parity and reverse the national crisis. A national parity effort should include state-to-state comparisons of the current level of MHPAEA compliance, to identify any best practices that could be replicated by states with inadequate parity levels. We also encourage a cross-state review of payment rates for different settings and provider types, as reimbursement for MH and SUD services are reported as low relative to services by the same practitioner categories who work in other healthcare settings, which potentially could exacerbate parity violations.

Investigate Unwarranted MCO Denials Resulting in Uncompensated Care:

To fully understand the impact of MHPAEA noncompliance, additional reporting by MCOs should be required to capture the quantity of care that is being provided following a complete or partial coverage denial by the health plan. In such scenarios, the MCO denies all or a portion of the days of treatment requested by the treating physician. Despite these frequent denials that second guess and counter the expert medical opinion of the treating physician, providers very often continue to provide care to:

- Continue the course of treatment prescribed by the physician; or
- Hold a patient who otherwise has been deemed ready for discharge by the physician because a safe discharge option is unavailable.

Quantifying the scope and impact of this practice is relevant under MHPAEA because these non-medically justified denials are another form of reducing coverage of behavioral healthcare services.

Mandate Reporting of Clinical and Administrative Denials:

While access to care continues to be a challenge with restrictive interpretation of medical necessity criteria, administrative and clinical denials account for the majority of claims that are only partially paid or completely denied. In most instances, Medicare Advantage Plans, managed Medicaid Plans, and Commercial Plans are not required to provide data on care provided versus care actually paid for.

Protect Youth and Adolescents:

More oversight by CMS is needed to ensure parity in coverage for youth behavioral healthcare services. While we support the statutorily granted option that allows MCOs to use their compliance with Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) to be deemed as compliant with MHPAEA, the deeming process currently is being applied to non-compliant behavioral healthcare coverage for youth under age 21 relative to all legally guaranteed MH/SUD services. The broad coverage provisions under EPSDT are designed to ensure that youth under 21 years have access to the services they need to prevent, ameliorate, and treat behavioral healthcare conditions, including both mental health and SUD—regardless of whether such services are covered under a state plan. Moreover, at least on paper, “medical necessity” under EPSDT, defined as “necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan,” applies identically to both behavioral and physical healthcare services.

In practice, MCOs that achieve EPSDT compliance should also be fully compliant with MHPAEA, as it applies to parity in mental health and SUD coverage for youth. As such, we greatly appreciate CMS’ recent informational bulletin on state implementation of the EPSDT benefit, emphasizing MCOs’ explicit obligation to provide all medically necessary care under EPSDT extends to prevention, screening, assessment, and treatment for both mental health and SUD services. Unfortunately, many state Medicaid



programs do not provide the range of behavioral healthcare services guaranteed by EPSDT, which has led to litigation by families trying to secure access to these services.

We call on CMS to step in to protect these young people through a prompt and comprehensive gap analysis to quantify the actual availability of guaranteed, essential mental health and SUD services. Such findings should be shared with stakeholders as part of a comprehensive intervention to demand and oversee remediation by the states. This need is particularly urgent for youth needing SUD treatment, because few states ensure access to SUD treatment, in part due to a lack of understanding about the standard of care for youth with SUD or at-risk of SUD. **We strongly encourage CMS and SAMHSA to partner in the near future to support states in order to begin providing the full scope of EPSDT-guaranteed SUD care for youth.**

Advance Parity through Managed Care Contracts:

There is little consistency across states contracts with Medicaid and CHIP MCOs. To advance a standardized approach to advance parity, we urge CMS to provide specific guidance on key contract elements that will help implement and enforce MHPAEA to protect behavioral healthcare patients. To move beyond the long-standing negligence of parity objectives, it is necessary to now use legally binding contract terms on NQTL standards, analysis and reporting specifications, remediation protocols and ramifications for noncompliance. Further, we urge the consistent application of these contract elements for private plans, as well. To fill a critical enforcement gap, we also urge that third-party beneficiaries, including patients and providers, be allowed to pursue private litigation to enforce state-required parity obligations that have been established through these contracts.

Apply Certain Penalties for Noncompliance

While NABH calls upon CMS to take concrete enforcement steps through this letter and other advocacy, we also note that the immediate urgency to secure additional access to BH services, especially for those with higher intensity needs, requires the pursuit of state plan amendments (SPA). In many areas, an SPA can be the only tool to increase access for patients with urgent mental health and SUD needs. Until BH parity becomes commonplace across the country, we support the use of SPAs to increase access to care – despite SPAs being an imperfect and sluggish alternative – because the lack of alternative remedies. In particular, SPAs are essential to counter the severe barriers to access caused by the federal Institutions for Mental Diseases exclusion policy.

In addition to SPAs, we join our coalition members in endorsing material consequences for parity non-reporting and/or noncompliance, including those listed below. These penalties align with CMS statements in 2016² that put state Medicaid authorities on notice that in the future the agency “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.” While we are unaware of any such actions by CMS thus far, we appreciate this policy rationale and urge the agency to promptly implement these steps. In addition, we support action by CMS to implement its 2016 recommendation for states to include penalties in contracts to address non-compliance by managed care plans.

Federal and State Enforcement Measures:

NABH calls on a range of corrective interventions to address parity noncompliance by states and MCOs, including withholding contract and rate approval until evidence of compliance is submitted, deferring federal compensation for capitation rates based on unapproved MCO contracts and withholding

² “Medicaid and Children’s Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008,” 81 Fed. Reg. 18390, 18422 (Mar. 30, 2016).



administrative costs and non-benefit costs associated with non-compliance. 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.

We also note that a few states already are assessing penalties for parity noncompliance. These experiences, including the effectiveness of such penalties to boost actual parity, may provide useful insights for CMS and other parity policy policymakers. For example:

- In Missouri, \$100/day penalties are assessed for overdue parity compliance reports;
- In New Hampshire, “liquidated damages” are assessed for parity noncompliance;
- North Dakota implements a \$25,000 liquidated damages penalty for parity noncompliance;
- New Hampshire allows patients to file parity complaints with the state department of insurance; and
- Rhode Island requires MCOs to provide guidance on their grievance and appeal processes for potential parity violations and to track parity complaints using a state-approved template.

Finally, rather than focusing on maintaining relationships with MCOs, we call on states to switch their focus to their legal duty to protect patients.

Apply Commercial NQTL Auditing Methods:

Parity compliance review of state-contracted MCOs must include comparative analyses of non-quantitative treatment limits (NQTL), which include network adequacy standards, timely and geographic access standards, medical necessity criteria, prior authorization requirements, and fail-first / step-therapy protocols. Today, nearly all states fail to meaningfully review NQTLs imposed by MCOs. Moving forward, the protocols used to evaluate NQTL compliance should mirror those used by federal regulators and leading state agencies, such as the New York State Office of Mental Health, as its auditing methods regularly identify parity noncompliance by commercial plans. Many MCOs provide both commercial and public health plan coverage; therefore, common oversight approaches are likely to also be effective with public plans.

- Suggest MH/OTP network adequacy requirements and network inclusion criteria be reviewed to check for parity in network design/geographic coverage/access to care (Question 2).
- Explore inconsistencies across state Medicaid programs that create barriers to access care, and, therefore, create disparities for beneficiaries in different states.
 - E.g., prior authorization requirements to begin/continue treatment for Opioid Use Disorder (Question 10).

Standardize the Frequency of MCO Reporting and State Audits:

States should assess MCO parity compliance at least annually and prior to implementing plan changes. Perhaps in the future—should some states or some MCOs achieve meaningful parity—this frequency could be reduced.

**National
Association
for Behavioral
Healthcare**



Access. Care. Recovery.

Thank you for considering NABH's recommendations for these important rules. We look forward to supporting and working with you and your staff to address this critical issue. Please contact me at 202-393-6700, ext. 100 or shawn@nabh.org if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Shawn Coughlin'.

Shawn Coughlin
President and CEO



CMS Request for Information

NABH Response to 11 Questions on State-level Parity

In addition to the overriding recommendations shared in our main letter, the following responses address CMS' specific RFI questions. These are followed below by an overview of additional NABH feedback to CMS on how to meaningfully improve parity.

Response to Question 1: NABH supports the use of common templates for parity-related documents and reports that CMS and states mandate.

Consistent reporting templates will advance the nationwide standardization needed to help ensure actual parity. As such, we support the alignment of national parity-related templates with these existing policies and tools:

- the Kennedy Forum's "Six Step" Parity Compliance Tool, which tests each of the components of the federal NQTL rule and is already being used by some states, such as New York and Texas;
- the joint [FAQ Part 45](#) from the U.S. Health and Human Services Department, U.S. Labor Department, and U.S. Treasury Department in April 2021, which provides clear guidance on what an NQTL analysis must contain in order to comprehensively demonstrate a plan's level of parity compliance, as well as common practices that plans should avoid (e.g., conclusory or generalized statement without specific supporting evidence and detailed explanations); and
- the pending final rule on parity or individual and employer-sponsored coverage.

Response to Question 2: NABH strongly urges a reengineering of parity oversight and enforcement protocols to achieve meaningful and consistent parity compliance nationwide to align with the overall objectives of the July 2023 multi-agency proposed parity rule. In addition, we support using penalties to disincentivize noncompliance.

We urge CMS to partner with the New York State Office of Mental Health (New York is one of very few states taking firm steps to secure meaningful parity) to identify key elements of a viable oversight and enforcement program. For each MCO, such a program will require a reliable compliance assessment for each NQTL, which should be reported and assessed separately for mental health and SUD compliance. Under the *CAA of 2021*, full parity requires compliance with multi-agency FAQ 45 guidance mentioned above. Unfortunately, based on health plans' MHPAEA compliance self-assessments in 2022 and 2023, policymakers and other stakeholders should expect that some MCOs will lack the ability to demonstrate compliance, which will necessitate corrective action plans and substantial back-and-forth communications with affected health plans.

Managed Care Contracts as Vehicles to Advance Parity:

Contracts between states and MCOs provide an opportunity to advance standardization to facilitate actual gains in parity. Specifically, CMS should use its authority to require contract terms on parity standards, analysis and reporting specifications, remediation protocols and standards for noncompliance, penalties for non-compliance, and private enforcement through litigation by third-party beneficiaries. Such contract elements should be required for both public and private plans, to the extent possible, and should be based on CMS-developed, model contract language that states can customize, as needed to facilitate parity compliance.



Response to Question 3: Thorough Investigation Needed of Potential Causes of Coverage Disparities.

To help identify possible sources of parity noncompliance, standardized parity templates and related protocols and guidance from CMS and states should closely evaluate:

- Coverage exclusions,
- Prior authorization requirements,
- Prescription drug formularies,
- Behavioral healthcare coverage requirements that might depart from the comparable standards for medical coverage, including behavioral healthcare coverage that may be more stringent or inconsistent with generally accepted standards of care,
- Medicaid fee schedules and claims to assess parity in payment rate-setting practices,
- Network adequacy, including timely and geographic access standards; and
- State-established behavioral healthcare coverage requirements that may violate MHPAEA.

Response to Question 4: Key NQTLs to Identify Disparities for Behavioral Healthcare Coverage.

NABH agrees with the multi-agency finding in the 2022 MHPAEA Report to Congress that the priority NQTLs to advance actual parity should be:

- Utilization management, including prior authorization, concurrent review, and retrospective review,
- Medical necessity,
- Network adequacy, including timely and geographic access standards, and parity in the design of key network clinician and non-clinician categories to ensure that actual network composition is capable of achieving MHPAEA objectives, and
- Reimbursement rates.

Appropriately, these priorities also were prominent in the June 2023 rulemaking on parity for individual and employer-sponsored coverage. That said, MHPAEA requires and we support full reporting and compliance with all NQTLs in each classification of care, including using the same tools recently proposed for private-sector plans.

NQTLs on Network Adequacy:

In addition, in alignment with feedback from our members and the June proposed rule, we urge CMS to prioritize “network composition” NQTLs to address the weak presence of actually available behavioral healthcare providers in most current networks. A recent [study](#) in *Health Affairs* about the Oregon Medicaid program found that 67% of mental health prescribers and 59% of other mental health professionals listed in the directories were phantoms. This issue is worse for behavioral healthcare providers than for other practitioners listed in networks. As such, specific and separate network adequacy requirements for mental health and SUD practitioners are needed to accurately assess these distinct shortages and, ultimately, to begin to identify any targeted increases in compensation that would be needed to attract providers to join an incomplete network.

Scope of Services NQTL:

This NQTL also warrants prioritization to identify any gaps in coverage for mental health and/or SUD services in some states. In particular, we encourage that this NQTL be updated to specify the measurement of these critical services to ensure consistent coverage across the country:

- SUD care in inpatient settings;
- IOPs and PHPs
- Opioid treatment programs; and



- Mobile crisis and crisis response services.³

These NQTL findings will be useful to policymakers considering the degree of actual parity in coverage among state-contracted MCOs and across payers, as well as the interventions needed to secure parity where it lags.

Response to Question 5: Criteria for Identifying High Priority NQTLs

Data collected through NQTL analysis on behavioral healthcare coverage relative to physical health coverage should guide CMS and the states in identifying priority areas for intervention, per our comments on Question 4.

Response to Question 6: Identifying Potential Parity Data Errors

Strategic data collection and sound quality measure design are needed to identify potential violations. As referenced above, there are a number of data collection tools that already exist. Additionally, many of our organizations submitted detailed responses to the request for comment to the Departments' MHPAEA Technical Release. Because we believe common MHPAEA compliance problems exist across private and public plans, and in an effort to establish greater consistency across health plan types, we urge the Center for Medicaid and CHIP Services to review these comments on data measures and adopt robust data requirements as appropriate for government programs.

Network Adequacy

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

Feedback on Question 7: Align Reporting Specifications

To advance policymaking effectiveness and efficiency and to mitigate avoidable administrative burden for all stakeholders, we urge CMS and the states to implement consistent data reporting metrics and submission protocols. That said, we encourage policymakers to solicit feedback from a cross-section of behavioral healthcare providers to assess any technical limits on data and other reporting due to outdated technology, which is widespread across behavioral healthcare provider settings.

Response to Question 8: MCO Reporting and Enforcement Require Greater Oversight

When MCOs collect MHPAEA compliance information and data, regulators too often accept grossly inadequate responses with no assessment of the quality of the submission. Instead, state Medicaid agencies must:

- Reject incomplete compliance reports and data and demand the missing information in accordance with FAQ 45 noted above; and

³ NABH urges CMS in its assessment of parity by state-contracted and all other MCOs, to go beyond assessing the *availability* of mobile and other crisis response services. Rather, as is currently under consideration by the courts in *Wit v. United Behavioral Health*, the outcomes metric used for parity compliance should be for "*crisis recovery*" using [SAMHSA's recovery definition](#): a process over time that leads to the capacity to live a self-directed life.



- Ensure that corrective actions for noncompliance include changes to bring any NQTL noncompliance into fully compliance, reprocess claims that were denied under noncompliant NQTLs, and issue administrative and perhaps other penalties against the plan.

In particular, strong contractual arrangements between states and MCOs must be used to demand fully compliant reporting, as well as NQTL compliance.

Response to Question 9: Additional Processes

As referenced above, MHPAEA compliance should be built into all aspects of Medicaid managed care, CHIP, and ABP coverage – for MH, SUD, and medical-surgical care. This includes:

- reviewing initial plan policies and coverage documents, plans' NQTL analyses, and through audits of plans' practices, including standard operating procedures and training materials for utilization manuals, systems configuration for behavioral healthcare Claims Adjudication, behavioral healthcare data associated with plan's Medical Loss Ratio, clinical & administrative denial data;
- conducting compliance investigations that are similar in nature to state departments of insurance market conduct examinations. Such investigations, which should include robust audits of claims, should occur at least every few years and should be unannounced; and
- CMS and states developing common processes to review and address all complaints and grievances potential parity violations.

Response to Questions 10 and 11: Certain Conditions Face Greater Parity Noncompliance

While the entire behavioral healthcare patient population feels the effects of behavioral healthcare coverage disparities, the two patient subgroups described below face even greater disparities in coverage, relative to coverage for physical health services.

Higher-intensity Patients:

Higher-intensity patients, including those who require wrap-around services for non-clinical but essential needs, face greater parity noncompliance. These more-complex patients need earlier and more comprehensive coordination of clinical and non-clinical services. Collecting more data from MCOs about this vulnerable population would provide the policy foundation needed to more accurately assess needs and care delivery strategies related to services such as specialty care for early psychosis, intensive outpatient or partial hospitalization services for eating disorders, applied behavior analysis for autism spectrum disorders, dialectical behavior therapy for a range of serious mental illness including bipolar disorder and bipolar disorder with psychotic features, treatment-resistant depression, and post-traumatic stress disorder, and services for co-occurring behavioral healthcare and/or chronic or acute medical conditions. We also note that treatments for borderline personality disorder and trauma often are not covered at parity-compliant levels.

Further, we note that higher-intensity patients often have one or more serious mental illnesses. Given the daily impact of these and other complications and MCOs current focus on data related to access and outcomes for SMI patients and those with significant social determinants of health, NABH urges the states and CMS to specifically investigate compliance for such patients in all levels of their parity and NQTL assessments.

SUD Patients:

In addition, our members report widespread parity violations for SUD patients regarding aggressive prior authorization, tighter service quantity limits, and limited preferred-drug list options on medications for opioid use disorder and naloxone. Immediate access to methadone, buprenorphine and naltrexone must be allowed, as any delays through preauthorization, concurrent review, and step-therapy barriers could



stimulate the cycle of withdrawal, drug use, and potential overdose and death. These [data](#) also suggest insufficient coverage of SUD treatment in IOP and PHPs, as well as reduced coverage of medications for alcohol and opioid use disorders. This is particularly important because SUDs, including opioid, alcohol, and stimulant use disorders, disproportionately affect low-income patients. Additionally, there is an urgent need to improve treatments and supports for co-occurring MH/SUD or any MH/SUD with a co-occurring chronic/acute medical condition.

As noted, to advance stakeholder knowledge of the extent of SUD coverage disparities, NABH strongly urges CMS to require that all parity data collection break out SUD and mental health data, including for compliance assessments on NQTLs. Our concern is that the current aggregation of these data can mask distinct SUD obstacles to parity in coverage that result in specific gaps in access. Moving forward, MCO accountability for both MH and SUD parity can only be improved if we first distinctly assess these respective parity levels.

Overview of Key NABH Recommendations

Recommended Parity Actions for HHS:

- *Nationwide Approach:* Apply consistent and statutorily compliant parity standards and enforcement procedures across all payers to the greatest extent possible.
- *Use Templates:* Increase policy guidance and support to the states and their contracted MCOs, including through the use of template policies and documents.
- *Youth and Adolescents:* Work with state Medicaid programs to ensure that children and youth under age 21 have access and parity protections for the full range of behavioral healthcare services required by law.
- *Develop State Expertise:* Allocate resources to state Medicaid programs to help develop expertise on MHPAEA requirements, health plan accountability strategies, and compliance oversight approaches for these contracts.

Recommended Parity Actions for States:

- *Standardize Channels for Collecting Information:*
 - Develop a standardized process for receiving and monitoring parity complaints.
 - Implement a community stakeholder engagement process to identify systemic issues which may be the result of parity violations, as CMS implemented in its 2024 Medicaid rule to collect feedback on service access issues.
 - The vehicle for reporting parity violations should be user-friendly, easy to access, and broadcasted widely.
 - Multi-state MCOs with larger noncompliance findings should face larger penalties and enhanced oversight to determine the pervasive extent of noncompliance across all state contracts.
- *Clarify Compliance Requirements:* Require regular parity compliance self-assessment and reporting by MCOs.
- *Raise Accountability:*
 - Post MCO parity compliance status on a single, public website; and
 - Submit a national compliance report to CMS at least every three years.
- *Address Noncompliance:*
 - Implement clear monitoring and enforcement protocols for corrective action execution for all findings of non-compliance.
 - *Penalties:* Hold agencies accountable for non-enforcement through financial and other penalties.



Recommended MCO Accountability Requirements:

- *Transparent Clinical Standards for Coverage for MCOs:* Adopt generally accepted clinical standards that align with standards set by national medical societies, as noted.
- *Standardize Frequency.* Frequency of MCO parity compliance self-assessments should occur at least when contract changes/amendments are made.
- *Coverage:* At a minimum demonstrate compliance with behavioral healthcare coverage standards set for private plans by the *CAA of 2021*.

Again, thank you for considering our comments. If you have questions, please contact me at 202.393.6700, ext. 100 or shawn@nabh.org.

Sincerely,

Shawn Coughlin
President and CEO