NYS Council for Community Behavioral Healthcare

December 1, 2023

The Honorable Daniel Tsai
Deputy Administrator and Director, Center for Medicaid and CHIP Services
Centers for Medicare and 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,

On behalf of the New York State Council for Community Behavioral Healthcare (NYS Council), we appreciate the opportunity to comment on the Center for Medicaid and CHIP Services' (CMCS) request for comments on processes for assessing compliance with mental health parity and addiction equity in Medicaid and the Children's Health Insurance Program (CHIP).

The NYS Council is a statewide membership organization composed of 130 community-based organizations that provide recovery-focused mental health and/or substance abuse/chemical dependence and addiction treatment programs and services for New Yorkers in need. NYS Council members offer a broad array of behavioral health services designed to meet the unique needs of children and adolescents, individuals and families seeking our assistance. Our services are available in a variety of community settings including freestanding agencies, behavioral health divisions of general hospitals, and county mental hygiene programs.

We appreciate the opportunity to comment on this critically important issue. Unfortunately, we believe there is widespread noncompliance with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) in Medicaid managed care, CHIP, and Medicaid Alternative Benefit Plans (ABPs). With millions of individuals across the country enrolled in these plans, the lack of parity compliance is an urgent public health issue.

While parity compliance is inadequate across public and private payers subject to MHPAEA, as we describe below, ensuring the sustainability of safety net systems is vital to providing lifesaving mental health and substance use disorder (MH/SUD) services. Therefore, we are grateful for CMCS's request for comment to begin addressing parity noncompliance in Medicaid managed care, CHIP, and ABPs.

To address parity noncompliance in Medicaid managed care, CHIP and ABPs, we urge CMCS to prioritize the following:

- Develop guidance and provide resources to state Medicaid agencies to develop MHPAEA expertise and support compliance oversight efforts; hold agencies accountable for non-enforcement.
- Require Medicaid managed care, CHIP, and ABPs to conduct regular parity compliance analyses that mirror the requirements for private plans set forth in Consolidated Appropriations Act, 2021 (CAA 2021) for all current and future MH/SUD benefits and submit their analyses to the state Medicaid program and CHIP as appropriate.
- Provide states with frequently asked questions, self-compliance tools, and a standardized template of the questions and information that must be covered in an adequate parity compliance analysis by the state Medicaid agency, as well as by individual MCEs;
- Require state Medicaid programs and CHIP to review and compile the analyses from all managed care, CHIP, and ABPs to ensure compliance, and address any non-compliance, and submit a compliance report to CMS at least every three years.
- Develop and require the use of model contract language for state MCE contracts setting out MHPAEA requirements, obligations of MCEs, state oversight requirements for prospective review of proposed MCE coverage modifications, audit requirements conducted by independent external reviewers, public posting requirements of compliance reports and materials, and remedial actions and penalties for violations.
- Publicly post state Medicaid program and CHIP parity compliance reports on a single website;
- Perform additional monitoring and enforcement to ensure that Medicaid programs and CHIPs have addressed any findings of non-compliance.
- Work with state Medicaid programs and CHIPs to ensure each has established a process to rigorously monitor whether contracted managed care plans are disclosing information consistent with their parity obligations.
- Work with state Medicaid programs to ensure that they provide children and youth under age 21 with the full range of MH/SUD services required by law.
- Develop a standardized process for receiving and investigating parity complaints in Medicaid and communicating that process publicly.
- Develop expertise and capacity in 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.

Our full comments are as follows.

Issues Found in Current Parity Approach

Broad Parity Noncompliance

State Medicaid programs and CHIPs were required to provide CMS with "documentation of compliance" with the parity requirements by October 2017.[1] Documentation of compliance with parity requirements submitted by states varied widely in quality and completeness across states and many submitted documentation that was inconsistent with CMS guidance. However, CMS did not put states on notice when the submitted documentation of compliance was inconsistent with their guidance and did not

[1] 42 C.F.R. § 438.930 (states using MCOs); id. § 440.395(e)(4) (ABPs); id. § 457.496(g) (CHIPs).

insist that states submit revised plans consistent with their guidance. Since plans initially reported on their compliance with these requirements over six years ago – a process that does not meet current best practices – many state Medicaid agencies have not conducted adequate reviews to evaluate ongoing compliance with MHPAEA. Unlike with individual marketplace and employer-sponsored plans, where many state insurance departments and all federal regulators are prioritizing reviews of health plans' parity compliance analyses for NQTLs, state Medicaid agencies rarely require or review such analyses.

Examining NQTL comparative analyses is an effective way to test whether plans are meeting the requirements of the federal NQTL rule, helping to support state Medicaid agencies identify and correct critical parity issues. As noted above, state insurance departments and federal regulators are regularly finding noncompliance in commercial plans.[2] Many of the same companies operate both public and commercial plans, meaning that violations being discovered in companies' commercial plans are very likely to also be occurring in their public plans. But without parity compliance reviews by the states, we are operating in the dark without the full scope of the problem.

Lack of Accountability and Transparency

The widespread MHPAEA noncompliance in Medicaid managed care, CHIP, and ABPs described above is the result of inadequate accountability and transparency across systems. We are grateful that CMCS is seeking to address this urgent problem. The more safety net systems can improve resources and expertise devoted to the complex coverage barriers, the better we can improve access to MH/SUD care.

We recognize that, in 2017, CMCS required the completion of parity compliance reviews, and we appreciate this step. However, there have been issues found with this approach. The analyses performed by most states to collect information relating to parity solicited inadequate information and data. One way to address this issue is for CMCS to identify the areas in which the parity analyses were inadequate and inconsistent with CMCS guidelines and require that they be amended and resubmitted until found to have adequate and responsive information consistent with CMCS guidance. Such reviews are also now incompatible with parity compliance best practices. Most importantly, the 2017 reviews did not test all aspects of the federal NQTL rule and, thus, do not align with the requirements for individual marketplace and employer-sponsored plans that were passed as part of the Consolidated Appropriations Act, 2021 (CAA 2021). Additionally, many states have failed to conduct any parity analyses since then, despite benefit and reimbursement rate changes that would affect plan compliance with the law.

While we wish Congress had extended the CAA 2021 requirements to Medicaid managed care, CHIP, and ABPs, we do believe that state Medicaid agencies and CMCS have the inherent authority to require that detailed parity compliance analyses be conducted, even if federal law does not mandate that they do so, as demonstrated by CMCS's 2017 requirements. Therefore, we strongly urge CMCS to require states to ensure that Medicaid managed care, CHIP, and ABPs conduct such analyses in a manner that aligns with the CAA, 2021's parity analysis requirements, which test the foundational NQTL rule that

[2] A range of states are regularly collecting and reviewing private plans' MHPAEA compliance analysis. States including Illinois, Maryland, and Washington have recently issues MHPAEA fines. The National Association of Insurance Commissioners has a MHPAEA Working Group to improve oversight that members from 31 states and Washington DC. In 2022 and again in 2023, the Departments of Labor, Treasury, and Health and Human Services have issued damning reports to Congress on private plans' MHPAEA violations and failure to demonstrate compliance across a range of NQTLs.

applied to both Medicaid and commercial plans, and to do so on at least an annual basis and before any plan changes are implemented. Accordingly, we recommend that CMCS require states to train staff on MHPAEA's requirements and have the MHPAEA expertise necessary (either on staff or through independent external organizations) to do a full parity compliance review. Doing so will help build capacity, expertise, and accountability for compliance.

In order to prioritize parity and mitigate existing barriers to coverage, it is vital to have the resources and processes in place to investigate and take responsive action where necessary. We seek clarification on if there are formal processes or mechanisms that states must utilize in accepting complaints about MH/SUD coverage problems and potential parity violations. Clear clarification and steps to file a complaint with CMCS, and understanding of CMCS' role in enforcement when a state identifies a parity violation will go a long way in resolution.

An additional problem includes the current ability of states to assert parity compliance for youth simply by attesting to the state's compliance with Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate. While we recognize that EPSDT "deeming" with respect to MHPAEA is a statutory provision, simply allowing such a self-serving attestation to occur allows states to avoid parity scrutiny. CMS must ensure that state Medicaid programs provide children and youth under age 21 with the full range of MH/SUD services required by law. State Medicaid services out of compliance with parity are also out of compliance with EPSDT. Therefore, demonstrations of compliance with parity must be necessary for states to demonstrate compliance with EPSDT. The EPSDT provisions of the Medicaid Act are designed to ensure that youth in Medicaid have access to the services they need to prevent, ameliorate, and treat MH/SUDs. The EPSDT mandate is extremely broad and requires Medicaid programs to cover health services for youth under age 21 when they are necessary to correct or ameliorate a MH/SUD. For youth under age 21, compliance with EPSDT would likely mean no parity issues because EPSDT requires access to all services needed to correct or ameliorate a youth's MH/SUD. Because, unlike other health coverage programs, in Medicaid, EPSDT already provides a strong foundation that requires states to provide youth with a broad range of MH/SUD services and applies the same medical necessity standard to both MH/SUD and physical health services, parity compliance in Medicaid is readily met when Medicaid programs comply with EPSDT.

Unfortunately, CMS has provided little oversight of states' compliance with the EPSDT requirement. Instead, it has allowed states to merely attest that their Medicaid programs comply–taking states at their word that they are providing critical MH/SUD services when necessary to correct or ameliorate the behavioral health conditions of children and youth in their Medicaid programs. Too often, families and their advocates have had to resort to litigation to ensure that youth in Medicaid programs receive the MH/SUD services to which they are entitled. CMS must hold states to a higher standard than an assurance and independently analyze whether Medicaid programs are providing their beneficiaries under age 21 with all the MH/SUD services they need.

Finally, there is little consistency across states on what their contracts with Medicaid and CHIP managed care plans contain. Nor has CMS instructed states on the kind of contract language necessary to ensure managed care plans comply with parity requirements. These binding legal contracts between states and plans are ideal places to put in place detailed parity requirements.

Equal Parity Protections Across Public and Private Insurance

Consistent Rules, Enforcement Tools, and Guidance

Medicaid managed care, CHIP, and ABP beneficiaries deserve the same MHPAEA protections as individuals with private health insurance, which aligns with CMS's goal of consistency across delivery systems. Regulators of individual marketplace and employer-based plans have expended significant efforts to strengthen MHPAEA rules, improve enforcement tools, and issue guidance to increase access to care and to clarify plans' MHPAEA obligations. Similar efforts have been notably absent until this request for comment, despite Medicaid's greater complexity, which makes clarity on obligations, public transparency, and accountability essential. MHPAEA 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/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.

The lack of parity in MHPAEA enforcement between public and private insurance cannot be justified, and the likelihood that the Administration will soon finalize stronger MHPAEA rules for individual marketplace and employer-based plans threaten to create even bigger gaps in Medicaid MHPAEA compliance. It is imperative that CMS move quickly to propose and finalize rules for Medicaid managed care, CHIP, and ABPs without delay after the finalization of this proposed rule. The Administration must not allow a strong set of MHPAEA rules for those in individual and group plans, but a weaker set of rules for individuals in Medicaid managed care, CHIP, and ABPs. This is particularly critical given that these plans serve lower-income individuals and families who are disproportionately Black, Latino, Native American, and from other marginalized and underserved communities.[3] We strongly believe that all Medicaid managed care, CHIP and ABPs must be required to conduct detailed MHPAEA compliance reviews for all NQTLs in each classification of care, meeting the same requirements – and using the same tools – as have been proposed for private-sector plans.

As noted above, MHPAEA is critical in structuring Medicaid, CHIP, and ABP benefits and can no longer be relegated as an afterthought by state Medicaid agencies and CMCS. Given that parity compliance can be affected by *anything* – whether as written or as applied – affecting the scope or duration of MH, SUD, or Medical/Surgical (M/S) treatment, CMCS must build robust MHPAEA reviews into everything relating to states' coverage of MH, SUD, or M/S benefits. Examining changes to M/S benefits and treatment limitations are also critical because any steps to increase access to M/S treatment likely necessitate changes to MH and SUD benefits as well. Such reviews should not be limited to future changes. There should be a top-to-bottom review of states' coverage of MH, SUD, and M/S services and imposition of treatment limitations to ensure full parity compliance.

Ensuring Transparency and Accountability

We strongly believe that, not only should CMCS mandate completion of NQTL parity compliance analyses that align with the requirements for private insurance, but it should also mandate that states ensure the availability of these analyses to both beneficiaries and the general public. In its recent proposed rule on Medicaid Managed Care Access, CMS proposed to require states to post their

[3] https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/

documentation of compliance with parity on their state websites, while reiterating that states were already required to do so. Without the availability of NQTL analyses, it is impossible for advocates or the general public to assess MHPAEA compliance. ERISA beneficiaries are entitled to receive NQTL analyses upon request, and Medicaid and CHIP beneficiaries deserve no less. Indeed, even greater public transparency is warranted to ensure the proper use of taxpayer dollars to administer Medicaid and CHIP benefits. Required public disclosure should also extend to NQTL data collection and analysis requirements that should be imposed as currently proposed for private-sector plans. It is particularly important to have public transparency on network composition and reimbursement rates, including whether Medicare rates are a basis for reimbursement. We strongly support the proposed MHPAEA rule's provision prohibiting discriminatory factors and evidentiary standards and believe that use of the Medicare Fee Schedule to demonstrate compliance falls within the proposed scope of this provision. Plans and states should not be allowed to establish that their reimbursement rates are MHPAEA compliant by citing the Medicare Fee Schedule, particularly when CMS recently recognized the Schedule undervalues MH/SUD services in the recently proposed updates to the reimbursement rate for psychotherapy.

To further ensure transparency and accountability, we recommend CMS require state Medicaid programs and CHIPs to include language in their managed care contracts that requires the MCEs to comply with MHPAEA and to conduct parity analyses whenever changes/amendments are made to their plans. Putting an affirmative obligation on MCEs to comply with parity and to conduct and report on their analyses will ensure that the entities who are developing policies are doing so in a way that ensures equitable access to MH and SUD care.

As noted previously, we oppose allowing states to attest that they are in compliance with EPSDT as a way to assert MHPAEA compliance with respect to CHIP. Regardless of a beneficiaries' age, MHPAEA compliance should have to be *demonstrated* – not merely attested to – especially given the nation's ongoing youth mental health crisis. As noted above, the converse is equally true; state Medicaid services out of compliance with parity are of necessity out of compliance with EPSDT. Therefore, demonstrations of compliance with parity must be necessary for states to demonstrate compliance with EPSDT.

Feedback on Specific CMCS Questions

Question 1 – What are some model formats (e.g., templates) and key questions to consider for improving efficiency and effectiveness of review of documentation of compliance with parity requirements in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?

We strongly urge CMCS to develop model reporting templates that align with robust tools such as The Kennedy Forum's "Six Step" Parity Compliance Tool, which tests each of the components of the federal NQTL rule. Many states (e.g., Texas) have adopted this basic structure in reporting templates. We strongly believe that any reporting template should explicitly integrate the Departments of Labor, Treasury, and Health and Human Services' (the "Departments") FAQ Part 45, dated April 2, 2021, which provides clear guidance on what an NQTL analysis must contain in order to demonstrate compliance as well as common practices that plans should avoid (e.g., conclusory or generalized statement without specific supporting evidence and detailed explanations). We also believe it is critical to collect robust data measuring in-operation MHPAEA compliance. The Appendix to the recent MHPAEA Technical Release lists data templates already in use, including the Bowman Family Foundation's Model Data Request Form. We support the use of such templates.

We also believe CMCS should provide states with a standardized template of the questions and information that must be covered in an adequate parity compliance analysis by individual MCEs. CMCS should provide states with a standardized template of the questions and information that must be covered in an adequate parity compliance analysis by the state Medicaid agency and should formally review and determine if the state submitted parity analysis is responsive to and compliant with the requirements of the standardized template.

Most importantly, it is essential that the MHPAEA compliance tools and requirements for Medicaid managed care, CHIP, and ABPs align fully with forthcoming final MHPAEA rules for private plans, including guidance that will specify required data reporting and formats. In attempting to advance MHPAEA compliance for public plans, it is critical that CMS utilize all the important work that the Departments are doing for private plans.

Question 2 – What processes are states and managed care plans using to determine whether existing coverage policies are comparable for MH and SUD compared to medical and surgical benefits?

As explained above, we believe that many state Medicaid agencies are not doing enough to examine MHPAEA compliance. Fundamentally, MHPAEA compliance cannot be determined with respect to NQTLs (where most compliance issues lie) if the state Medicaid agency is not collecting and thoroughly reviewing a plan's NQTL parity compliance analysis for each NQTL imposed on MH or SUD benefits in each classification of care in which that NQTL is imposed. The analysis must test all components of the federal NQTL rule (which is exactly what the CAA, 2021 provisions do) and must be fully consistent with the Departments' FAQ 45 guidance. As demonstrated by the Departments' 2022 and 2023 MHPAEA reports to Congress, initial reviews will likely necessitate sustained back-and-forths with each plan to request needed information and clarification for a plan to demonstrate MHPAEA compliance. And, in many instances, plans will be unable to demonstrate compliance and state Medicaid agencies (and ultimately CMCS) will need to demand changes to ensure such compliance.

Question 3 – What are some key issues to focus on in reviewing policy or coverage documents that may indicate potential parity compliance issues including regarding NQTLs in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?

Reviews of policy and coverage documents are insufficient to determine MHPAEA compliance, though there may well be indications of noncompliance contained therein. Key places to examine within such documents are coverage exclusions, prior authorization requirements, prescription drug formularies, or other requirements relating to MH/SUD coverage that may not exist (or may be less stringent) for M/S coverage. In reviewing plans' policy and coverage documents, we believe it is important that state Medicaid agencies also examine requirements relating to MH and/or SUD coverage that that state may be imposing upon plans. We have seen instances where such state-mandated requirements cause violations of MHPAEA, with plans not being the actor responsible for causing the violation. By reviewing data and state regulations, as well as policy and coverage documents, states and CMS can gain a more comprehensive understanding of parity issues, both as written and in operation.

Question 4 – Which NQTLs and/or benefit classifications should be prioritized for review?

We believe that parity compliance issues for Medicaid managed care, CHIP, and ABPs are broadly similar to private plans. In the recent proposed MHPAEA rules, the Departments put a strong focus on NQTLs relating to "network composition." Because many Medicaid managed care and CHIP plans have deeply inadequate MH/SUD networks, we strongly urge CMCS to similarly prioritize "network composition" NQTLs. Reimbursement rate setting and application of medical necessity criteria should also be considered.

We also recommend CMS review the scope of services NQTL and ensure that all states are providing meaningful coverage of MH and SUD services in Medicaid across all benefit classifications. Several states lack coverage for SUD care in inpatient settings, and a number of states are not covering the full continuum of medically necessary care in the community (including intensive outpatient and partial hospitalization programs, or opioid treatment programs), despite doing so for M/S benefits. As the Departments consider expanding on this requirement for commercial plans, we urge similar consideration for Medicaid MCOs, ABPs, and CHIP. We also note that there is inconsistent coverage of mobile crisis and crisis response services in Medicaid programs, and CMS should ensure that such coverage is meaningfully available across the country for Medicaid enrollees to enable a person-centered approach to MH/SUD crises, rather than a law enforcement or punitive one.

Question 5 – What should be the criteria for identifying high priority NQTLs for review?

In the recent proposed MHPAEA rules, the Departments have proposed requiring plans to collect, analyze, and report data showing the effect of their NQTLs on access to MH/SUD and M/S care in order to demonstrate equitable access to care. We believe state Medicaid agencies and CMCS should be guided by similar data. Our organization believes that low reimbursement rates and inadequate MH/SUD networks are a critical barrier to access, but that all "network composition" NQTLs should be priorities. We also have seen how any barriers to care that effectively require Medicaid / CHIP beneficiaries to jump through hoops before obtaining needed treatment can severely hinder access. For example, prior authorization and step therapy ("fail first") requirements are deeply problematic for Medicaid / CHIP beneficiaries, who often lack the time or resources necessary for navigating these complex policies. This is particularly true for individuals with an MH or SUD, which may further inhibit their ability to navigate complex systems. These barriers often compound for individuals who are dually eligible for Medicare, where they may be forced to jump through hoops in multiple insurance systems, further delaying care or resulting in the individual foregoing necessary treatment altogether.

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

Question 6 – What are some measures or datapoints or other information that could help identify potential parity violations in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?

Measures and data are critically important to identifying potential violations. As referenced above, there are a number of data collection tools that already exist such as the Model Data Request Form.

Additionally, several organizations recently submitted detailed responses to the request for comment to the Departments' MHPAEA Technical Release.[4] 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 to ease the burden on both carriers and regulators, we urge CMCS to review these comments on data measures.

Question 7 – How should data on these or other recommended measures be collected?

We believe that data collection methods and formats should align to the maximum extent possible with new final MHPAEA rules for private plans and guidance relating to data collection requirements and formats. We urge CMCS not to have differing requirements.

Question 8 – What are some potential follow-up protocols and corrective actions when measures indicate a potential parity violation in Medicaid managed care arrangements, ABPs, and CHIP?

When MHPAEA compliance information and data is collected, we have seen instances where regulators accept grossly inadequate responses. To ensure MHPAEA compliance, state Medicaid agencies must not accept plan responses until plans have demonstrated compliance as laid out in FAQ 45. Particularly where state Medicaid agencies have put in place strong contractual requirements, they have the clear authority to demand that plans provide further information until a plan fully demonstrates compliance (including making any needed changes). Corrective actions for noncompliance must include changes to make the NQTL in question fully compliant, reprocessing of claims for coverage subject to noncompliant NQTLs, and administrative penalties against the plan.

Question 9 – What additional processes should be considered for assessing compliance with Medicaid and CHIP parity requirements, e.g., random audits?

As referenced above, MHPAEA compliance should be built into all aspects of Medicaid managed care, CHIP, and ABP coverage – for MH, SUD, and M/S care. This includes reviewing initial plan policies and coverage documents, plans' NQTL analyses, and through audits of plans' practices. State Medicaid agencies should conduct parity 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.

Question 10 – Are there any MH conditions or SUDs that are more prevalent among enrollees in Medicaid MCOs, Medicaid ABPs, or CHIP? What are the most significant barriers to accessing treatment among enrollees with these conditions?

We believe that coverage barriers to specialized or more intensive treatment are particularly urgent to address. For example, for individuals experiencing early psychosis, Coordinated Specialty Care often is

[4] For example, The National Council for Mental Wellbeing, Kennedy Forum, and more than a dozen other groups submitted these comments on the Technical Release.

not properly covered. At the same time, data suggests that there is insufficient access to community-based and less intensive services for SUD treatment (including intensive outpatient and partial hospitalization programs, as well as medications for alcohol and opioid use disorders) that could prevent beneficiaries from needing emergency department or inpatient services. This is particularly important since substance use disorders, including opioid, alcohol, and stimulant use disorders, disproportionately affect low-income people. Additionally, there is an urgent need to improve treatment and supports for co-occurring MH/SUD or any MH/SUD with a co-occurring chronic/acute medical condition. Core services for borderline personality disorder such as DBT are often not appropriately covered nor are services to treat trauma in both youth and adults.

Question 11 – Are there any particular MH conditions or SUDs or types of treatment that are at risk of not being covered in compliance with parity requirements for Medicaid managed care arrangements, Medicaid ABPs, or CHIP?

While variations exist across states, SUD care, inpatient withdrawal management services, IOP, PHP and residential services are among the least likely types of treatment to be covered in compliance with MHPAEA. 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.

We encourage additional reporting on a range of services, including coordinated 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 MH/SUD or co-occurring chronic or acute medical conditions.

Further, there are still widespread parity violations when it comes to imposing prior authorization, quantity limits, and preferred drug list status on all medications for opioid use disorder and naloxone. There are also significant issues with lack of coverage of opioid treatment programs (OTP), which means people have significant barriers to accessing coverage for methadone. Plans may be in violation of parity if they're imposing more onerous requirements on OTP coverage than similar M/S facilities. We encourage CMS to require states to ensure equal access to services for both MH and SUD.

Lastly, we are concerned that SUD benefits continue to have differential coverage than MH benefits. Thus, the failure of some states to review MH and SUD benefits separately and compare them to M/S benefits makes it difficult to establish if even the most common MH conditions and SUDs are covered in compliance with parity. We have often seen significant differences in parity compliance between the same entity's MH and SUD programs. Thus, aggregation of MH and SUD benefits information may mask significant problems. CMS should ensure that regulations and guidance clarify this requirement and ensure that appropriate and comprehensive parity compliance analyses are conducted, for both MH and SUD, in all MCO, ABP, and CHIP plans.

The NYS Council appreciates the opportunity to provide these comments. We welcome any questions or further discussion about the recommendations described here. Please contact Lauri Cole at lauri@nyscouncil.org. Thank you for your time and consideration.

Sincerely,

Lauri Cole
Executive Director
NYS Council for Community Behavioral Healthcare