AMA
AMERICAN MEDICAL ASSOCIATION

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December 4, 2023

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

Re: Implementation of Mental Health Parity and Addiction Equity in Medicaid and CHIP

Dear Deputy Administrator and Director Tsai:

On behalf of our physician and medical student members, the American Medical Association (AMA), we thank the Center for Medicaid and CHIP Services (CMCS) for the opportunity to provide comments[1] on the importance of extending mental health and substance use disorder (MH/SUD) parity requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid and the Childrens Health Insurance Program (CHIP). As an overarching and fundamental principle, the AMA strongly agrees with CMCS that "ensuring compliance with federal parity requirements in Medicaid and CHIP is fundamental to improving access to care for enrollees who need MH and/or SUD treatment."

The AMA supports the efforts that the Centers for Medicare & Medicaid Services (CMS) has undertaken to increase understanding of MHPAEA, including development of multiple resources such as the CMS Parity Compliance Toolkit, Parity Implementation Roadmap, Frequently Asked Questions, and other resources and technical assistance. Similar efforts have also been undertaken by the U.S. Department of Labor (DOL) and other agencies. Unfortunately, despite the excellent resources and outreach by the federal government, health insurers continue to violate MHPAEA, and they continue to complain[2] that they do not understand the law. The AMA commends the Administration for the increased emphasis on helping to ensure that all individuals can access the care they need, regardless of whether it is paid for with premium dollars or public benefits. **However, even the best resources will not make compliance a reality without greater enforcement.**

The nation's payers and issuers have had more than 15 years to demonstrate a willingness to comply with MHPAEA. In this time, payers and issuers have consistently failed to comply with both federal and state

[1] Center for Medicaid & CHIP Services Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP. Available at https://www.medicaid.gov/sites/default/files/2023-09/cmcs-mental-health-parity-092023.pdf
[2] Insurers bash Biden's mental health parity proposal. Axios. October 18, 2023. Available at https://www.axios.com/2023/10/18/mental-health-parity-insurers

regulations,[3] and state-level enforcement continues to be highly varied. **Without adoption of policies and procedures to require compliance for Medicaid and CHIP enrollees, payers will continue to flout the law.** Also, the result of payers' failures to comply with MHPAEA will have a multitude of negative impacts,[4] including reduced access to MH and SUD care for marginalized and minoritized populations as well as continued increases in overdose-related morbidity and mortality.

Accordingly, the AMA strongly urges consideration of the recommendations below to help ensure that the millions of individuals with MH or SUD are able to access the care they need without continued payer barriers to care.

Extending Parity Protections to Medicaid and CHIP Plans

Establishing consistent expectations for payers is an important place to begin. Specifically, recent statutory amendments to MHPAEA enacted as part of the Consolidated Appropriations Act require private sector group health plans and health insurance issuers that provide both medical and surgical benefits and MH or SUD benefits to perform and document comparative analyses of the design and application of any non-quantitative treatment limitation (NQTL) applied to MH/SUD benefits—and to make these analyses available to applicable federal and state regulators upon request. However, as CMCS notes in this request for comment, "[t]hese most recent amendments to MHPAEA do not directly apply to Medicaid and CHIP." **The AMA encourages CMS to ensure that the most recent amendments to MHPAEA apply directly to both Medicaid and CHIP.**

Questions 1-3

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?*
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?*
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?*

AMA comment: The AMA urges CMCS to consult closely with leading state departments of insurance on the specific templates, processes and key issues that will best help with oversight, analysis, and enforcement of MH/SUD parity laws. These issues—as described in the first three questions—all have been addressed by multiple states, including Colorado, Illinois, Pennsylvania, and Washington, to name a few. The technical expertise developed by these states can serve as invaluable resources to help CMS in their efforts to expand these critical protections to Medicaid and CHIP beneficiaries with MH and SUD.

[3] See, for example, State Parity Regulatory Enforcement Actions. The Kennedy Forum. Available at https://www.paritytrack.org/resources/state-parity-enforcement-actions/

[4] See, for example, Parity laws haven't solved access to mental health care in Minnesota. Minneapolis Star Tribune. April 28, 2023. Available at https://www.startribune.com/minnesota-mental-health-care-access-parity-laws/600258574/

Questions 4-5

4. *Which NQTLs and/or benefit classifications should be prioritized for review?*
5. *What should be the criteria for identifying high priority NQTLs for review?*

AMA Comment: The AMA does not believe ranking certain benefit classifications or NQTLs is an effective way to ensure that parity requirements are appropriately enforced, and patients effectively protected. At their core, NQTLs are designed to limit treatment for mental health and substance use disorders. Individuals in every community in the United States face restricted access to mental health and substance use disorder care. Among the chief reasons for this are treatment restrictions and other limitations imposed by health plans that go unenforced by regulators. The AMA understands that regulators face an overwhelming challenge to keep up with health plans' continued violations, but that does not make the need to enforce MHPAEA any less necessary. The recent MHPAEA Comparative Analysis Report to Congress highlighted that for every federal regulator, there are thousands of plans to review.[5]

Accordingly, we urge CMCS to consult with state regulators where successful enforcement actions have been undertaken to develop the appropriate regulatory and investigatory strategies and tactics. When violations are found, the AMA urges swift action to prohibit the payers from imposing the NQTL until the health plan can affirmatively demonstrate compliance with the law, including—if necessary—the corrective measures the plan has taken to comply. This approach is one the AMA believes is necessary to increase compliance with the law and patients' access to care.

Question 6

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?*

AMA Comment: The AMA agrees with CMS' proposals to identify potential parity violations through comparisons of different measures and data points. At its heart, effective parity compliance and MHPAEA requires payers and issuers to compare whether the MH and SUD benefits, coverage, and other areas are on par with medical surgical benefits. Thus, the AMA supports comparison of:

- Rates of coverage being denied for MH and SUD benefits compared to rates of coverage being denied for medical and surgical benefits.
- Average and median appointment wait times for MH and SUD providers compared to medical and surgical providers.
- Payment rates for MH and SUD providers compared to payment rates for medical/surgical providers.
- Prevalence rates of MH conditions or SUDs among certain groups of enrollees compared to the percentage of enrollees from those groups who are receiving treatment for MH conditions or SUDs.
- Average time from receipt of a claim to payment of that claim for MH and SUD benefits compared to medical and surgical benefits.

[5] MHPAEA Comparative Analysis Report to Congress. U.S. Department of Labor, U.S. Department of Health and Human Services, U.S. Department of the Treasury. July 2023. Available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf

- The percentage of MH and SUD network providers actively submitting claims compared to the percentage of medical and surgical providers actively submitting claims.

The AMA encourages CMS to consider additional data collection and reporting requirements and disclosures for issuers, including:

- Require plans/issuers to disclose the specific criteria/guidelines for MHPAEA review to allow CMS to more easily determine if payers impermissibly diverge from using medically established peer reviewed criteria from non-profit professional medical associations with clinical expertise in MH and SUD, such as the American Society of Addiction Medicine (ASAM) and American Psychiatric Association (APA). The MHPAEA Comparative Analysis Report to Congress[6] detailed numerous examples of regulators being unable to review the criteria, guidelines or other information related to an NQTL because plans and issuers either did not provide information, or they were not using ASAM or APA guidelines. Using standards relied upon by the nation's physicians would promote consistency and integrity in the standards and process. For this reason, an increasing number of states require using these criteria. **The AMA strongly recommends that the Administration require plans and issuers to disclose what information they use to determine divergences from ASAM, APA, and similar criteria and national practice guidelines**.
- Require specific data reporting for medical necessity/appropriateness. Such data should include the number of authorizations and denials issued for participants/beneficiaries by each of the levels (and sub-levels) of care described in the ASAM Criteria and the age-specific Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) family of criteria. Having a clear picture of the numbers and types of authorizations and denials can help regulators understand whether a plan or issuer is discriminating against and restricting access to specific levels of care recommended by the enrollee's physician. For example, it is important to understand that when a plan or issuer denies a certain level of care, that does not mean that a lower level of care was approved—and moreover, it also does not mean that a lower level of care is appropriate.
- Require payers to report the number of SUD providers that are in-network, accepting new patients, and who prescribe FDA-approved medications to treat SUDs. It is important to ensure sufficient access to these critical medications, which are considered the gold standard of care by addiction medicine physicians. This is particularly important with regard to opioid use disorder (OUD) because methadone is only available in federally regulated Opioid Treatment Programs, and buprenorphine generally is only offered in office-based settings in the community. Given that these medications are part of chronic disease management for OUD, an adequate network to treat OUD must have an adequate network of physicians who can prescribe these critical medications—and are actively accepting new patients. If a plan or issuer does not know whether a provider offers medications for opioid use disorder—and is actively accepting new patients—there is almost no way for the plan or issuer to confirm whether a network is adequate. Therefore, the AMA recommends that these data be specifically reported.

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[6] MHPAEA Comparative Analysis Report to Congress. U.S. Department of Labor, U.S. Department of Health and Human Services, U.S. Department of the Treasury. July 2023. Available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf

Question 7

7. *How should data on these or other recommended measures be collected?*

AMA Comment: The AMA encourages CMS to coordinate with its partners at DOL and HHS as well as state regulatory experts to identify the most successful data collection strategies. The July 2023 MHPAEA Comparative Analysis Report to Congress provided numerous examples of plans and issues providing insufficient, incomplete, or non-responsive information to regulators. The levels of insufficiency and failure to provide full comparative analyses demonstrate the need for a strong, coordinated effort by the Administration to require immediate corrective action and other penalties, including monetary fines when applicable.[7]

Questions 8-9

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

AMA Comment: The AMA encourages CMS to use all tools at its disposal, including but not limited to randomized audits, corrective action plans, civil monetary penalties, and possible termination of contracts for repeated bad actors. Given plans' and issuers' failures in complying with the law, **the AMA urges that CMS prohibit plans and issuers from continuing the use of NQTLs for MH or SUD services if the plan or issuer cannot provide the documentation and other information to demonstrate that the NQTL is compliant with MHPAEA.**

The AMA further recommends that the plan or issuer be barred from re-instituting the NQTL until it has put a corrective action plan into place. In addition, the AMA also recommends that CMS levy monetary penalties upon the plan or issuer for the duration of time between a finding of insufficiency or non-compliance and the time it takes for the corrective action plan to be put into effect.

As explained above, multiple federal agencies, including CMS, have bent over backwards in trying to help plans comply with MHPAEA. Plans already are required to perform comparative analyses, so they should not have any difficulty in providing the documentation to regulators to demonstrate compliance. The years of failures, however, prove that plans are not actually performing any sort of due diligence, and the AMA urges they be held accountable because when plans and issuers fail to comply with parity, patients bear the brunt of that failure. As a direct result of plans withholding care, however, plans and issuers earn increased revenue. The AMA believes it is far past time to restore balance for patients' health and well-being. Thus, when considering "additional processes," the AMA again encourages CMS to identify processes that have demonstrated success at the federal and state levels, including those offered

[7] See, for example, AMA letter to Xavier Becerra Secretary U.S. Department of Health and Human Services, Lisa M. Gomez Assistant Secretary Employee Benefits Security Administration U.S. Department of Labor, Douglas W. O'Donnell Deputy Commissioner for Services and Enforcement Internal Revenue Service U.S. Department of the Treasury. October 17, 2023. Available at https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcts.zip%2F2023-10-17-Letter-to-Becerra-Gomez-O%27Donnell-re-Parity-Proposed-Rule-v3.pdf

in response to this request for comment, and to take the additional steps to prohibit use of non-compliant NQTLs.

Questions 10-11

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?*
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?*

AMA Comment: The AMA emphasizes that, because parity violations are so widespread and enforcement is so thin, it is difficult to zero-in on the most pressing MH or SUD conditions that may be affected. The main point is that when an individual with an MH or SUD condition is not able to access timely, affordable treatment, that patient suffers and, in many cases, is at increased risk of significant harm, including death. This should no longer be tolerated.

Up to this point, parity enforcement has been more a question of effort and resources than novel investigatory tools. The AMA commends the Administration for developing additional resources, but we stress the fundamental principle that MHPAEA should be meaningfully enforced for all Americans. Specifically extending these protections to Medicaid and CHIP plans and enforcing these protections is critical to ensuring that patients with this coverage do not suffer needlessly because of plans' and issuers' failure to comply with a law focused on improving mental health and substance use disorder care.

Impact on Physicians

Parity violations by plans and issuers also deeply affect physicians. Utilization management tactics for MH and SUD services including but not limited to prior authorizations force physician offices to spend inordinate amounts of staff time and resources submitting paperwork to justify to health plan bureaucrats medically necessary care for their patients. Physicians train for at least 8-10 years to ensure that they provide their patients with the standard of care, which is why **the AMA recommended using a definition for the generally accepted standard of care as put forward by professional medical associations to be used as the standard by health plans—and for parity analyses**.

When health plans devise their own varying standards, the inevitable result is to force physicians to justify their reasoning for providing broadly accepted, evidence-based standards of care—typically so the health plan can delay treatment and possibly avoid payment. This pernicious use of NQTLs to delay and deny care is devastating to patients' health and well-being—as well as to physician practices. For a child with a treatable mental health condition, prior authorization causes unnecessary—and preventable—harm and trauma,[8] and for a patient with OUD, the consequences of delayed and denied care can be deadly.[9] In addition, 33 percent of physicians report that prior authorization has led to a serious adverse event for a patient in their care including hospitalization, permanent impairment or death, and 89 percent of

[8] In D.C., a fight over 'Kafkaesque absurdity' of insurance delays, denials. The Washington Post. May 28, 2023. Available at https://www.washingtonpost.com/dc-md-va/2023/05/28/dc-prior-authorization-reform/

[9] Kentucky Bill To Remove Prior Authorization Aims To Help Opioid Users Get Treatment. WKU. February 19, 2019. Available at https://www.wkyufm.org/health/2019-02-19/kentucky-bill-to-remove-prior-authorization-aimsto-help-opioid-users-get-treatment

physicians report that prior authorization has a negative impact on clinical outcomes. These reckless intrusions into the patient-physician decision making process mean that despite knowing what is best for their patients, physicians are unable to provide that care. Accordingly, these inevitable consequences to patients because of NQTLs have a corresponding traumatic effect on the mental health and well-being of physicians, who are invested in the health and safety of their patients.

NQTLs and other utilization management tactics also disrupt the efficient functioning of the practice, diverting clinician and staff time to jumping through administrative hoops rather than delivering direct patient care. Currently, physician practices must spend a significant amount of time and resources navigating complex insurance regulations and negotiating with insurance companies to ensure that their patients receive the care they need. A 2022 survey from the Physicians Foundation[10] found that 85 percent of the physicians who reported staff shortages rated administrative burdens as impactful. AMA survey data[11] show that, on average, physician practices complete 45 prior authorizations per physician per week. This adds up to nearly two business days, or 14 hours, each week dedicated to just completing prior authorizations. A very real cost of these burdens is their contribution to physician burnout. Physicians are struggling to hire staff for their practices, get back on their feet following the pandemic, and focus on what they were trained to do—provide care to patients. But rather than focusing on patient care, physicians are being forced to accommodate endless health insurer requirements and devote their time, their staff's time, and extensive resources to helping patients access the care they need.

Over time, this continued and constant exposure to these barriers, and the ongoing negative impact on the patients they have been trusted to care for is extremely demoralizing and draining to physicians. This problem is particularly acute for referring and authorizing care for mental health issues and substance use disorders. As a result, as the country is facing a mental health and substance use epidemic, we are facing a looming physician workforce shortage. Physicians and other health care professionals are simply burnt out. Data suggest that one in every five physicians is planning to leave practice within two years. Administrative burdens, especially prior authorization, play a major role in that burnout, as 88 percent of physicians describe the burden associated with prior authorization as high or extremely high.[12]

Moreover, physician shortages are particularly acute in certain areas of the country, such as rural and underserved areas, as well as for small, independent and safety net practices, thereby exacerbating existing inequities. Shortages are also particularly acute for MH and SUD providers, and these effects can be cumulative. Data from the AMA's 2022 Physician Practice Benchmark Survey for example shows that many more psychiatrists work in smaller practices compared with other medical specialties: 45 percent of psychiatrists work in practices that include between one and four physicians, compared with 33 percent for all specialties combined.[13] Importantly, when Medicaid and CHIP plans feature these burdensome delay tactics, a disproportionate burden falls on safety net providers who treat larger populations of Medicaid and CHIP patients.

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[10] 2022 Survey of America's Physicians. The Physicians Foundation. Part Three of Three: Assessing the State of Physician Practice and the Strategies to Improve It Survey completed October 2022. https://physiciansfoundation.org/wp-content/uploads/PF22_Brochure-Report_Americas-Physicians-Part-3_V2b-1.pdf

[11] 2022 AMA prior authorization (PA) physician survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

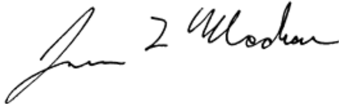
[12] ibid.

[13] AMA Physician Practice Benchmark Survey. https://www.ama-assn.org/about/research/physician-practice-benchmark-survey

Conclusion

CMS' effort to enforce parity is a win-win for both patients and physicians by improving access to care while reducing bureaucratic administrative burdens. The AMA urges CMCS to take all necessary steps to increase compliance with MHPAEA, including ensuring that all applicable federal laws apply to Medicaid and CHIP. If you have further questions, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely,



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