December 4, 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

Submitted via email to MedicaidandCHIP-Parity@cms.hhs.gov

Dear Director Tsai,

NAMI appreciates the opportunity to submit comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP. NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to improving lives for people affected by mental illness. Throughout our 40-year history, NAMI has fought for dignity, fairness, and equity for people with mental illness. We know that access to mental health care is essential for people to successfully manage their mental health condition, get on a path of recovery, and live healthy, fulfilling lives.

Many of the people we represent receive critical health care through Medicaid, the nation's largest payer of mental health services. NAMI appreciates the work of the Center for Medicaid and CHIP Services (CMCS) to address a range of mental health parity and access-related challenges that impact how beneficiaries are served by Medicaid across its delivery systems. However, we believe there are still unaddressed challenges that prevent CMS from achieving mental health parity within the Medicaid program. As detailed below, in order to achieve CMS's stated goal of "improving access to high quality MH and SUD treatment" NAMI urges CMS to finalize the outstanding proposed rules, *Ensuring Access to Medicaid Services* and *Managed Care Access, Finance, and Quality* and to the take information collected here and issue a new set of proposed rules to improve accountability, transparency and enforcement of mental health parity in Medicaid and CHIP.

Background on Medicaid, Mental Illness, and Mental Health Parity

Medicaid plays an important role for people with mental health conditions as the single largest payer of mental health and substance use disorder (MH/SUD) services in the country[i]. These critical prevention, treatment, and recovery services include therapy, inpatient treatment, crisis

services, and prescription medications. MH/SUDs are common amongst the Medicaid population with approximately 39 percent of Medicaid beneficiaries reporting mild, moderate, or severe mental health or substance use disorder (MH/SUD) conditions[ii]. Medicaid also provides coverage to those with the most serious mental illness, as approximately two-thirds of Americans with schizophrenia are enrolled in Medicaid[iii]. While Medicaid is a lifeline for many people with MH/SUD conditions, many beneficiaries have challenges accessing these services. For instance, in 2018, 50 percent of beneficiaries with serious mental illness reported they did not receive the treatment they needed. One of the largest barriers to care is limited Medicaid coverage across states for the full continuum of mental health services, which includes crisis services, outpatient treatment, supported employment and peer support[iv]. Lack of access to mental health care can have serious consequences for people with mental health conditions.

As a major funder of mental health services, serving a diverse demographic, Medicaid has an opportunity to advance health equity for populations who have historically faced significant barriers to accessing MH/SUD care. Medicaid disproportionately serves Black, Hispanic, American Indian and Alaska Native, and Native Hawaiian or Pacific Islander populations[v,vi]. In 2022, 56 percent of white adults with mental illness received treatment compared to approximately 40 percent of Black, 39 percent of Hispanic, and 36 percent of Asian adults with mental illness. Moreover, Black and Hispanic Medicaid beneficiaries are less likely to receive treatment in a private therapist's office and take medication for a mental health condition [vii]. Diverse racial and ethnic populations often face unique barriers to mental health care, such as the lack of a diverse behavioral health workforce, language barriers, and provider bias.

Mental health federal laws and regulations have sought to close the access gap between mental health and physical health care by addressing some of the largest barriers to mental health care, such as excessive out of pocket costs, limited coverage of critical services, and difficulty obtaining mental health medication. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that insurers cover mental health and substance use disorder services in a manner that is no more restrictive than other medical services. In 2016, CMS finalized federal regulation to clarify that the MHPAEA parity requirements applied to the Medicaid program and the Children's Health Insurance program (CHIP). The regulation also required states and Medicaid Managed Care Organizations (MCOs) to conduct parity analyses in four categories (outpatient, inpatient, emergency services and prescription drugs) to assess parity compliance.

Unfortunately, there is evidence of noncompliance with the requirements of MHPAEA in Medicaid and CHIP. This is particularly concerning given that mental health issues are on the rise across the country and research consistently shows that that many individuals with MH/SUD conditions struggle to access treatment and support. NAMI agrees 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 and appreciates the opportunity to

provide comments on questions related to how CMCS can improve mental health parity implementation and oversight.

NAMI Responses to CMCS Questions

The barriers to MH/SUD care access in Medicaid are concerning and underscore what NAMI hears regularly from our 49 State NAMI Organizations and more than 600 NAMI Affiliates across the country. In response to CMCS' request for comments, NAMI conducted a survey in November 2023 to collect input from our field regarding mental health parity and access barriers for people on Medicaid. NAMI surveyed a geographically diverse sample of our NAMI state organizations, hearing from our leaders across the country. Their responses were consistent with feedback we have previously received from the field.

Key barriers to Mental Health Care Access [Questions 3 and 10]

In our recent Medicaid parity survey, NAMI state leaders reported the following top three barriers to receiving mental health care for people on Medicaid: 1) lack of mental health care professionals and services, 2) travel time/distance to provider, and 3) social stigma of mental health treatment and conditions. One NAMI leader said the lack of providers was "dire." A few NAMI leaders noted that in their state, travel time/distance to an appointment could be under an hour in cities and multiple hours for rural areas. Racial/ethnic barriers to mental health care access and treatment were also cited as a common barrier, along with overall difficulties navigating the mental health care system. One NAMI leader noted that:

> "*There are far too many experiencing mental health and/or substance use disorder co-occurring symptoms that are unfamiliar with how to maneuver the system, unfamiliar with what sort of benefits may be covered or not covered leading them down a rabbit hole of phone calls... and in the end going without the treatment they need or want...*"

Currently, an individual experiencing a mental health condition or crisis must not only overcome the social stigma surrounding mental health treatment, but also navigate a complex health care system and insurance provider networks. NAMI believes that promulgating rules to improve mental health parity compliance in the Medicaid program would reduce the onus on individuals seeking care and facilitate timely access to critical services.

NAMI state leaders reported the following top three reasons people on Medicaid have trouble securing mental health appointments: 1) providers contacted had long wait lists, 2) providers contacted no longer accepted Medicaid, and 3) providers contacted no longer accepted patients. Most of the NAMI leaders surveyed said that it can take from a few weeks to a few months to secure an initial appointment, and approximately half of the respondents said they heard from people on Medicaid who are unable to find a provider at least weekly. Importantly one NAMI leader noted that, "The issue beyond getting the appointment is that after the screening, getting an actual therapy or med appointment can take weeks," illustrating the

ongoing challenges people on Medicaid face to access the full continuum of mental health care services.

Mental health providers, such as psychologists and psychiatrists, who do not accept Medicaid cite low reimbursement rates as a main reason[viii,ix]. In fact, psychiatrists are much less likely than most other medical specialists to accept Medicaid[x]. This was reflected in the survey responses from NAMI state leaders noting low reimbursement rates in their states as a barrier to provider network participation. NAMI urges CMCS to promulgate regulation that would address ghost networks, low reimbursement rates, and other factors that lead to inadequate provider networks, to ensure that people have the same access to mental health providers as they do to other medical providers.

Uncovered Mental Health Treatments and Services [Question 11]

Despite the promise of MHPAEA, disparities in mental health coverage remain, particularly related to the coverage of specific mental health treatments and services. In our recent survey, NAMI state leaders indicated that Medicaid beneficiaries in their state have trouble accessing the following services:

- Collaborative care model
- Mobile crisis services
- Full continuum of mental health services, including care coordination and wrap around services
- Coordinated specialty care
- In-patient treatment for substance use disorders, especially for juveniles
- Housing support

As of 2022, only nineteen states reported Medicaid coverage of the collaborative care model (CoCM), which integrates behavioral health services into primary care[xi]. The uptake of this model has been low, despite many studies showing that it improves anxiety and depression outcomes[xii]. Importantly, the collaborative care model reduces stigma by offering mental health services in primary care settings, and maximizes the current workforce by providing mental health expertise to primary care providers. NAMI believes that working with states to increase coverage of CoCM, and other integrated care models, will improve mental health parity as it will increase access to important mental health services.

Now that the 988 Suicide and Crisis Lifeline is available nationwide, there is an urgent need to bolster the behavioral health crisis system. A key element in improving the crisis continuum of care is to build up community-based mobile crisis response services so that people in a mental health crisis can receive a mental health response. Currently, fourteen states have received approval for enhanced Medicaid funding for mobile crisis response[xiii]. Moving forward, it will be important to incorporate crisis services in parity review and compliance to ensure that these services are covered at the same level as emergency services for physical health.

Coordinated specialty care (CSC) is the standard of care for treatment of first episode psychosis (FEP). It is an evidence-based, recovery-focused, team-based model that promotes access to

care and shared decision-making among specialists, the person experiencing psychosis, and family members. CSC consists of five core services: therapy, medication management, family education and support, service coordination, case management and supported employment and education[xiv]. One NAMI state leader noted "CSC would be our top service that people have difficulty in accessing as we do not have enough teams for the needs in our state." Medicaid can be used to fund CSC for eligible individuals, as CMS detailed in 2015 guidance[xv]; however, most states do not cover the full continuum of CSC. <u>CSC is a critical service for the individuals and families that NAMI represents, and we urge CMCS to incorporate CSC into parity review and compliance to ensure individuals are receiving the full continuum of mental health care services.</u>

Addressing Access Barriers through Increased Accountability, Transparency, and Enforcement of Mental Health Parity in the Medicaid Program [Question 6]

NAMI appreciates CMCS' request for feedback on measures for identifying coverage that may be noncompliant with parity requirements. Based on the access barriers highlighted by our NAMI state leaders through our recent survey and previous communications, we think the proposed measures would help improve mental health parity and urge CMCS to move forward with proposing rules that implement these metrics. As described above, we heard from NAMI state leaders about the lack of mental health professionals and services, which is tied to "ghost networks" or inaccurate provider networks. <u>We think the comparison of average and median appointment wait times and comparison of the percentage of mental health and substance use disorder network providers actively submitting claims would strengthen mental health provider networks and improve parity.</u> Our recent survey highlighted travel time/distance to providers as a major barrier to mental health care, especially in rural areas. <u>One additional measure that would improve network adequacy is to include a comparison of time/distance or some similar geographic measure of access.</u> Relatedly, NAMI state leaders pointed to how provider network participation is hindered in their state by historically low Medicaid reimbursement rates for mental health services. <u>We support a comparison of payment rates for mental health and substance use disorder services, which would shed light on the inequities of payment between mental health and other medical services.</u>

In addition to supporting the proposed comparison measures, we urge CMCS to consider additional metrics to further address barriers to mental health care access. <u>As part of accessing parity in emergency care, we encourage CMCS to think about wait time standards for mental health crisis response services</u>. This would help build on the work that this Administration, states, and NAMI have done to set up the 988 Suicide and Crisis Lifeline. To improve the coverage of the full continuum of mental health services, CMCS should consider including a measure that captures the comprehensiveness of coverage for mental health interventions compared to other types of medical care. For instance, coordinated specialty care is the medically accepted standard of care for first episode psychosis, yet not all the CSC core services are covered by state Medicaid programs. <u>Finally, given the diverse racial/ethnic populations</u>

served by Medicaid, we encourage CMCS to work with advocates and community leaders to identify barriers specific to these communities. Within the scope of parity compliance, CMCS may consider including a comparison of language accessibility (e.g., availability of linguistically diverse providers, translator services, and materials in different languages), and a comparison of provider demographics to assess provider diversity which has been shown to improve patient experience[xvi].

NAMI's recent survey revealed that the vast majority of NAMI state leaders who responded said people in their state do not know how to report suspected mental health parity violations. We urge CMCS to develop a standardized process for receiving and investigating parity complaints in Medicaid and communicating that process publicly. NAMI encourages CMCS to consider leveraging the existing state website requirements within the outstanding *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality* proposed rule (discussed more in the section below) to include useful information for beneficiaries on parity and how they can report suspected parity violations. As part of this work, we think partnerships between states and local mental health organizations would help increase public awareness regarding parity violation reporting.

NAMI Recommendations to Improve Medicaid Access to MH/SUD Services

While not specifically addressed within the request for comment, NAMI encourages CMS to consider the following in context of any proposed rules to improve mental health parity within the Medicaid and CHIP programs.

- Ensure alignment between parity rules in Medicaid and CHIP and private health insurance.

The Administration must not allow weaker rules for parity to persist in Medicaid and CHIP compared to those for private insurance. The administration recently proposed robust mental health parity enforcement enhancements for private health insurance in "CMS-9902-P, Requirements Related to the Mental Health Parity and Addiction Equity Act." We urge CMCS to align parity enforcement requirements for commercial payers with those for Medicaid and CHIP to the extent possible and to swiftly enact the needed changes.

Alignment between parity rules for Medicaid and CHIP and private insurance is particularly important given the ongoing "unwinding" of the COVID-19 Public Health Emergency's Medicaid continuous enrollment protections. Millions of people have been unenrolled from Medicaid and CHIP. As people "churn" between Medicaid and private coverage, having consistent parity requirements between these forms of insurance will help ensure continuity of care.

- Finalize the outstanding proposed rules, *Ensuring Access to Medicaid Services (Access NPRM)* and *Managed Care Access, Finance, and Quality (Managed Care NPRM)*, released in April 2023.

NAMI believes that many of the proposals in the outstanding rules intended to enhance access to Medicaid and CHIP would also provide a basis for assessing and strengthening mental health and addiction parity compliance. We believe that the various reforms in these proposed rules will increase access to care and we appreciate the attention to behavioral health. In particular, we believe the following provisions will strengthen mental health parity:

- **National maximum appointment wait time standards and enforcement** for key services including outpatient mental health and substance use disorder.
- **Provider rate transparency rules** that would increase rate transparency and standardize rate information across states through targeted rate review, to ensure that Medicaid payment rates are set at levels sufficient to provide access to care for beneficiaries.
- **Independent third-party secret shopper surveys** to validate compliance with the appointment wait time standards and provider directory accuracy to help identify errors, as well as network providers who do not offer appointments.
- **Stronger state monitoring and reporting requirements** related to access and network adequacy, including a compliance threshold that will ensure that stakeholders have a common benchmark to evaluate network compliance.
- **Active beneficiary engagement** through Medicaid Advisory Committees and patient experience surveys, which will improve quality by giving beneficiaries a greater voice in the care they receive and incentivize improvements in the quality of mental health care delivered in the Medicaid program.
- **Corrective action plan requirements** when access to care issues are identified, which identify specific steps, timelines for implementation and completion, and responsible parties.

We support CMS' inclusion of behavioral health care as one of several categories under heightened scrutiny for access monitoring because of the inherent difficulties beneficiaries encounter when accessing these services in the Medicaid program. NAMI urges CMS to finalize the outstanding proposed rules to improve Medicaid access as expeditiously as possible.

Conclusion

Thank you for the opportunity to comment on this important issue. We strongly support the direction CMCS is taking and urge you to propose rules to advance mental health parity in the Medicaid and CHIP programs. We have highlighted the access and parity issues facing individuals with mental health conditions, and hope you consider our additional recommendations to improve parity compliance. We also urge CMS to finalize the outstanding proposed rules to improve Medicaid access as soon as possible. If you have any questions, or would like to discuss, please contact Jennifer Snow, NAMI's National Director of Government Relations and Policy at jsnow@nami.org.

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[ii] Kaiser Family Foundation (KFF), "Amid a Mental Health Crisis in the U.S., A New KFF Report Examines the Steps that State Medicaid Programs Are Taking to Help Shore Up the Availability of Crisis Services," May 25, 2023, https://www.kff.org/mental-health/press-release/amid-a-mental-health-crisis-in-the-u-s-a-new-kff-report-examines-the-steps-that-state-medicaid-programs-are-taking-to-help-shore-up-the-availability-of-crisis-services-beneficiaries/.

[iii] Elizabeth Khaykin *et al.,* "Health insurance coverage among persons with schizophrenia in the United States," *Psychiatric Services,* Vol. 61, No. 8, August 2010, https://pubmed.ncbi.nlm.nih.gov/20675843/.

[iv] MACPAC, "Chapter 2: Access to Mental Health Services for Adults Covered by Medicaid," June 2021, https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf.

[v] Centers for Medicare and Medicaid Services, "Race and ethnicity of the national Medicaid and CHIP population in 2020," July 2023, https://www.medicaid.gov/sites/default/files/2023-08/2020-race-etncity-data-brf.pdf.

[vi] KFF, "Health Care Disparities Among Asian, Native Hawaiian, and Other Pacific Islander (NHOPI) People," May 24, 2023, https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-care-disparities-among-asian-native-hawaiian-and-other-pacific-islander-nhopi-people/.

[vii] MACPAC, "Chapter 2: Access to Mental Health Services for Adults Covered by Medicaid," June 2021, https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf.

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[ix] Sharon Long, "Physicians May Need More Than Higher Reimbursements To Expand Medicaid Participation: Findings From Washington State," *Health Affairs,* Vol. 32, No. 9, September 2013, https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.1010.

[x] Tara Bishop *et al.*, "Acceptance of insurance by psychiatrists and the implications for access to mental health care," *JAMA Psychiatry,* Vol. 71, No. 2, February 2014, https://pubmed.ncbi.nlm.nih.gov/24337499/.

[xi] KFF, "Medicaid Behavioral Health Services: Collaborative Care Model Services," July 2022, https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-collaborative-care-model-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[xii] Janine Archer *et al.,* "Collaborative care for depression and anxiety problems," *Cochrane Database of Systemic Reviews,* Vol. 17, No. 10, October 2012, https://pubmed.ncbi.nlm.nih.gov/23076925/.

[xiii] National Alliance on Mental Illness, "Enhanced Medicaid Mobile Crisis Map," accessed December 1, 2023, https://reimaginecrisis.org/mobilecrisis/.

[xiv] Substance Abuse and Mental Health Services Administration (SAHMSA), "Coordinated Specialty Care for First Episode Psychosis: Cost and Financing Strategies," HHS Publication No. PEP23-01-00-003, 2023, https://store.samhsa.gov/sites/default/files/pep23-01-00-003.pdf.

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[xvi] Junko Takeshita *et al.,* "Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians With Patient Experience Ratings," *JAMA Network Open,* Vol. 3, No. 11, November 2020, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772682.