AMERICAN ACADEMY OF FAMILY PHYSICIANS

December 4, 2023

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Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP

Deputy Administrator Tsai:

On behalf of the American Academy of Family Physicians (AAFP), representing 129,600 family physicians and medical students across the country, I write in response to the request for information (RFI), "Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP," published by the Center for Medicaid and CHIP Services (CMCS).

The AAFP is encouraged by this RFI and has urged HHS and others to hold Medicaid agencies accountable for strong oversight of mental health parity and enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA). In response to inadequate mental health and substance use disorder (MH/SUD) benefits and the subsequent challenges accessing such care, this legislation required payers to achieve and maintain parity between medical and surgical (M/S) benefits and MH/SUD benefits. Medicaid and CHIP programs, including Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and Children's Health Insurance Program (CHIP) plans are required to comply with mental health and substance use disorder parity requirements in MHPAEA. Medicaid and CHIP were created to provide health coverage for low-income families and people with disabilities and thus the lack of timely access to mental health services for these beneficiaries further deepens health inequities. Medicaid and CHIP insure more than half of all children, nearly half of all pregnant and postpartum people, and play an outsized role in providing coverage for historically and contemporaneously underserved communities, including people of color and those living in rural areas.

Medicaid is also the largest single source of funding for MH/SUD services in the United States, and adults on Medicaid are more likely to face mental health concerns than their non-elderly counterparts covered by private payers[1]. However, the behavioral health needs of Medicaid and CHIP beneficiaries continue to go unmet. In 2018, less than 55 percent of non-institutionalized youth enrolled in Medicaid or CHIP who experienced a major depressive episode received mental health treatment.[2] These adolescents were more likely than those with private coverage to receive treatment in institutional settings, as opposed to outpatient care.[3]

Family physicians provide longitudinal care across a patient's lifespan, which often includes comprehensive mental health services. In fact, nearly 40 percent of all visits for depression, anxiety,

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or cases defined as “any mental illness” were with primary care physicians, and primary care physicians are more likely to be the source of physical and mental health care for patients with lower socioeconomic status and for those with comorbidities.[4] Family physicians also play a crucial role in safe pain management prescribing practices, screening patients for opioid use disorder (OUD), and prescribing and maintaining treatment of medications for OUD (MOUD). Primary care physicians are often the first point of care for patients and can provide necessary referrals or coordinate care with other mental health professionals when needed. Thus, family physicians share CMS’ commitment to advancing equitable, timely access to mental health services for Medicaid and CHIP beneficiaries.

As CMS considers oversight and enforcement of MHPAEA, **the AAFP strongly encourages the agency to implement appropriate guardrails to ensure Medicaid agencies continue to improve access to primary care while remaining in compliance with parity requirements**. The AAFP is concerned that if Medicaid agencies are narrowly focused on compliance parity requirements, they may be inadvertently disincentivized from making equally important changes in M/S benefits, such as increasing primary care payment, expanding primary care networks, and reducing prior authorizations and other nonquantitative treatment limitations (NQTLs) in primary care.

With this in mind, the AAFP is pleased to provide the following information, in response to your request.

Prioritizing NQTLs and Benefit Classifications for Review

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

The statutory language of MHPAEA is unambiguous in its requirement that treatment limitations applicable to MH/SUD benefits must be “no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits…” **Thus, the AAFP supports the use of the substantially all/predominant test to NQTLs, to prohibit the use of an NQTL on MH/SUD benefits if it does not apply to substantially all M/S benefits.**

The AAFP strongly agrees that states should accurately track the level of NQTLs applied to MH/SUD benefits and M/S benefits to ensure patient access is not adversely affected. Though as previously mentioned, the AAFP urges CMS to implement appropriate guardrails to ensure Medicaid agencies continue to improve access to primary care, including by reducing NQTLs, while remaining in compliance with this proposed rule.

Prioritization of NQTLs for review should emphasize the most cited barriers for mental health and SUD clinicians from accepting Medicaid enrollees or those receiving coverage through a particular MCO. This should also emphasize those clinicians who serve traditionally underserved populations like patients with limited English proficiency, LGBTQ+ populations, and those with serious mental illness. Data used to determine the most common NQTL barriers should be specific to clinicians who serve pediatric populations.

However, the AAFP also notes that levels of NQTLs for M/S benefits are already far too high, and this should be taken into consideration when comparing M/S and MH/SUD NQTLs. Administrative burden is one of the leading causes of practice closures and physician burnout, which comes from, in part, processes like prior authorization and step therapy. These processes already take up significant physician and staff time, and reduce time spent with patients. Physicians have noted that prior authorization requirements are continually increasing and imposing significant, time intensive and cumbersome administrative tasks on physicians and their staff, which also contributes

to burnout. According to an American Medical Association (AMA) survey, 85 percent of physicians report that the burden associated with prior authorization is “high” or “extremely high” and 30 percent of physicians report that prior authorization has led to a serious adverse event for a patient in their care.[5] The survey reports that physicians and their staff spend almost two business days each week completing an average of 40 prior authorizations per physician, per week.

The AMA survey also highlights the impact of prior authorization on patients: 90 percent of physicians say that prior authorization somewhat or significantly impacts patients’ clinical outcomes. Furthermore, 79 percent of physicians report that issues related to prior authorization can at least sometimes lead to patients abandoning their recommended course of treatment while 94 percent of physicians report care delays associated with prior authorization. These delays increase wait times for medical services and prescriptions for patients while diminishing access to timely care. Further, a study of physician time in ambulatory practice across four states and several specialties reports physicians spend 27 percent of their total time on direct clinical face time with patients and almost 50 percent of their total time on electronic health record (EHR) and desk work, which includes working through prior authorization requests with plans.[6] Taken together, evidence demonstrates that prior authorizations are causing care delays, worsening patient outcomes and satisfaction, and are a significant driver of administrative burden and physician burnout.

The AAFP urges CMS to address the overall care delays and administrative burden associated with prior authorization across benefit types. A recent OIG report showed that some MCOs had prior authorization denial rates as high as 25 percent, but state Medicaid agencies failed to routinely sample and review denials for appropriateness.[7] The review process in MCOs falls short of that under Medicare, where Medicare Advantage plans routinely collect and report data on denials and appeals, and offer automatic external reviews of denials.[8] While Medicare Advantage beneficiaries continue to face barriers to care due to prior authorization requirements and denials, the available appeals processes are more effective and could serve as a useful starting point for strengthening protections in Medicaid managed care. Without similar structures for MCOs, low-income individuals, pregnant and postpartum patients, children, and those predominately in rural and underserved areas will face excessive care delays and inequitable access to lifesaving care, including MH/SUD care. Thus, we recommend CMS use its available authority to improve oversight of prior authorization, strengthen the appeals process, and take steps to reduce the overall volume of prior authorizations in Medicaid managed care.

Measures for Identifying Potential Parity Violations

- *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?*
- *How should data on these or other recommended measures be collected?*
- *Are there any other measures that should be considered regarding provider network composition and standards for provider network admission?*

The AAFP supports data collection and comparison of multiple datapoints is necessary to evaluate and flag potential parity violations. **Overall, the AAFP strongly recommends that the data points for MH services and SUD services be separately collected, analyzed and reported, consistent with MHPAEA statutory and regulatory requirements**. Given the well documented lack of SUD treatment providers, the importance of care continuity throughout SUD treatment, and the potential harm that could be caused by long appointment wait times, we believe data between MH and SUD should be disaggregated to ensure equitable access to SUD care

We also urge CMS to require that all data be collected, analyzed, and reported by age group and by race/ethnicity (where possible). CMS should also develop uniform definitions and methodologies for the collection of all data points so that valid data are collected and can be compared across states.

The AAFP supports the use of many of the example datapoints listed in the RFI, including:

- Comparison of payment rates,
- Comparison of coverage denial rates,
- Comparison of average and median appointment wait times,
- Comparison of time from receipt of claim to payment of claim, and
- Comparison of clinicians actively submitting claims.

In the recently released proposed rule and technical release on MHPAEA enforcement, the AAFP supported the proposal to require plans to analyze allowed amounts for CPT codes 99213 and 99214 (M/S) and CPT codes 90834 and 90837 (MH/SUD) and compare M/S and MH/SUD payment rates to each other, across clinician types, and to the national Medicare rate for these codes. The AAFP noted several factors that the Departments should be mindful of in making these comparisons and to provide appropriate adjustments, such as for physician time, physician work, and practice expense inputs.

The AAFP encourages CMS to implement a similar provision to measure payment rates within Medicaid managed care arrangements, Medicaid ABPs, and CHIP to flag potential parity violations. However, the AAFP notes that Medicare is not subject to MHPAEA and may not be an effective comparison for MH/SUD benefits, nor does it include pediatric or pregnant/postpartum populations. As such, the AAFP recommends CMS work with HHS and others to develop an appropriate independent comparison tool for pediatric-specific services as well as those focused on pregnant and postpartum patients.

Further, the AAFP strongly supports the suggestion that CMS collect detailed data on the percentage of enrollees who can access specified clinician types in-network within a certain time and distance. The Department of Health and Human Services has already put forward strong proposed standards for Medicaid managed care and the Children's Health Insurance Program (CMS-2439-P), which, if finalized, would establish maximum appointment wait time standards for routine outpatient mental health and substance use disorder services of 10 business days and require such independent secret shopper surveys. These standards align with appointment wait time metrics that have been adopted for Qualified Health Plans, and the AAFP supports enforcement of these standards across Medicaid and CHIP.

To protect physician practices and ensure Medicaid agencies take appropriate actions to comply with wait time standards, the AAFP recommends CMS clarify that plans must hold physicians and practices harmless if their wait times are longer than the required standards under this rule. The onus for meeting wait time standards must be on the Medicaid agencies. Thus, CMS should consider additional regulatory guardrails to ensure agencies do not pass on wait time standards requirements to their in-network clinicians and practices by requiring them to schedule appointments within a certain timeframe or including other stipulations in contracts that would further disincentives clinicians from accepting Medicaid patients.

The AAFP previously recommended HHS and others collect data on routine and crisis appointments, including for follow-up and ongoing care, specifically with disaggregated age groups to assess wait

times and travel for children and adolescents. Granular data that distinguishes between types of care and initial appointments versus ongoing care is necessary to ensure patients are receiving effective care and are not being forced to wait for follow-up after an initial visit. The AAFP encourages CMS to work with HHS and others to utilize this data for parity compliance evaluation.

The AAFP supports requiring Medicaid agencies to report data on the percentage of in-network clinicians actively submitting claims. This is an important step to guard against Medicaid agencies overstating availability of services by listing significant numbers of in-network clinicians not actively submitting claims. Accurate collection of this data is critically important to determining the true adequacy of a network and whether patients are actually able to access and utilize care when they need it. This metric is essential to understanding real access availability and can help to illuminate other issues which may be limiting in-network access, such as low reimbursement that incentivizes clinicians to remain out-of-network and cater to cash-pay patients. The AAFP encourages CMS to evaluate all types of pediatric mental health clinicians, beyond child psychiatrists and child psychologists, as well as those who specialize in pregnant and postpartum care.

The AAFP also recommends CMS collect data from Medicaid agencies on the length of time between when a clinician requests to be admitted into the network and when the admission is final, as well as the availability of in-network clinicians. Reports suggest other plans and issuers fail to admit new MH/SUD clinicians due to the networks being "closed" or "full," despite patients being unable to find appropriate clinicians. CMS must evaluate this issue within Medicaid and CHIP and ensure that clinicians are not being denied or delayed participation based on inaccurate determinations of a network being "closed" or "full." Further, the AAFP is concerned that network adequacy often includes clinicians who have limited to no availability for new patients. CMS should collect data to ensure the network for Medicaid and CHIP beneficiaries appropriately meets their needs by, at a minimum, specializing in children and adolescents. Ideally such information would also include those who specialize in eating disorders or LGBTQ patients, and those who meet the language needs of the population served by the network.

Regarding network composition, the AAFP encourages CMS to work with HHS and others to develop clear guidance to Medicaid agencies for how to include primary care physicians who provide mental health and substance use disorder (MH/SUD) care in their analyses, reports, and data collection. This guidance should consider primary care physicians who bill MH/SUD codes, care coordination codes, and E/M codes that include MH/SUD treatment. We recognize that counting all primary care physicians as mental health clinicians would vastly overestimate access to care, particularly for specialty mental health care, and would adversely impact patient access. Additionally, primary care physicians who do not provide extensive behavioral health care should not be penalized by Medicaid agencies. However, ensuring primary care physicians who provide MH/SUD care are appropriately represented in network analyses will help states expand their MH/SUD network in the areas most lacking access.

The AAFP appreciates the opportunity to provide this feedback, and we look forward to working with CMS to improve access to behavioral health care for all patients. For additional questions, please contact Morgan Bailie, Senior Regulatory Specialist, at mbailie@aafp.org.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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