Final Regulation on Mental Health Parity in Medicaid: NAMD Summary

April 21, 2016

In April 2016, the Centers for Medicare and Medicaid Services (CMS) released a final regulation which implements mental health parity in Medicaid, as required by the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). In general, MHPAEA stipulates that treatment limitations and financial requirements applicable to mental health/substance use disorder (MH/SUD) benefits in Medicaid cannot be more restrictive than those limitations applicable to medical/surgical benefits. In addition, if MH/SUD benefits are provided in one classification (inpatient, outpatient, pharmacy, emergency), MH/SUD benefits must be provided in every classification in which medical/surgical benefits are available.

The parity requirements apply to the following Medicaid service delivery models:

- Individuals served in Medicaid managed care organizations (MCOs), including when some services are provided through PIHPs, PAHPs, and FFS to MCO enrollees;
- Medicaid alternative benefit plans (ABPs) in all delivery models; and
- The Children's Health Insurance Program (CHIP) state plan, regardless of delivery model.

In essence, the parity requirements under MHPAEA are only not applicable when medical/surgical state plan services are delivered through fee-for-service Medicaid.

There are a number of important considerations for states stemming from the final rule. Most notably, the regulation does not provide relief on the IMD payment exclusion despite the apparent conflict with the mental health parity requirement. In addition, the final rule applies parity requirements to long-term services and supports (LTSS), but does not include a definition for LTSS. This may give states flexibility but could also increase the administrative burden on states to classify this heterogeneous set of services and comply with the rule. The final regulation will also likely require significant state administrative resources to demonstrate compliance, especially for states using MCOs in conjunction with other delivery models. Likewise, these states may have trouble accessing necessary information from plans to comply with the parity rule, since it may be considered proprietary by the plans.

States are required to comply with the parity requirements by **October 2, 2017** (18 months from the publication date of the final rule). Depending on state delivery models and existing benefit structure, states are likely to need to take one or more of the following actions to comply with this rule: conduct the parity analysis, add MH/SUD services or service units, effectuate contract amendments, and/or submit state plan amendments (SPAs). As states consider the steps required to come into compliance, it may be helpful to consider these changes in context of the forthcoming Medicaid managed care rule. States also may need to re-visit plans for LTSS-related initiatives, such as managed LTSS.

The following memo explores state Medicaid program and MCO roles and responsibilities under the final regulation, as well as the general parity requirements. In exploring these provisions, the summary highlights key considerations for states, as well as areas where CMS intends to provide technical assistance to states and MCOs. NAMD welcomes Medicaid agency feedback on the final regulation and state concerns with its implementation. States are encouraged to send feedback to Lindsey Browning [lindsey.browning@medicaiddirectors.org].

State and MCO Roles in Parity Compliance

The following table discusses the role of states and MCOs in complying with the parity requirements, since these roles and responsibilities will differ based on a Medicaid program's delivery model. A table included later in this document discusses the general application of parity to quantitative and non-quantitative treatment limits.

Delivery Model	State Responsibility	MCO Responsibility	Unique Considerations for States
Comprehensive MCOs	The Medicaid agency is responsible for MCO compliance with parity, but the state is not expected to conduct the parity analysis. Note: it is unclear if the state could elect to perform the analysis instead of the MCOs if it wished to do so. By Oct. 2, 2017, all contracts with MCOs must be compliant with parity.	According to the preamble, MCOs that are responsible for the comprehensive set of services are expected to conduct the parity analysis. The MCOs are then expected to work with the state on any changes necessary for the MCO contract to be compliant with parity.	States that do not already have language in their contracts requiring compliance with parity will need to add such language by the compliance deadline. CMS also encourages states to require MCOs to provide documentation of its parity findings and analysis in the contract language, as such documentation is not otherwise required by the final rule. CMS also notes that states may want to consider including penalties in their contracts to address MCOs that may be non-compliant.
Benefits delivered through MCOs, in conjunction with other models (PIHPs, PAHPs, FFS)	The Medicaid agency is responsible for: • Conducting the parity analysis across the various plans and delivery models to ensure all		We believe states need to plan for the complex additional administrative tasks required when using this delivery model. This will include collecting significant information from plans on quantitative and non-

Delivery Model	State Responsibility	MCO Responsibility	Unique Considerations for States
	Medicaid enrollees in an MCO receive parity compliant benefits. • Documenting the parity analysis and compliance when submitting contracts for CMS review and approval. • Ensuring all contracts with MCOs, PIHPs, and PAHPs are compliant by Oct. 2, 2017. • Demonstrating compliance with parity to the public on its website by Oct. 2, 2017. • Completing a new parity analysis whenever operations are changed in a way that would affect compliance. Further, if the state identifies parity concerns, there are two pathways for remedying them: • Revise the state plan to ensure the service package is parity compliant; or • Amend managed care contracts to include the necessary services or service units.		quantitative treatment limits and carrying out a complex analysis. It is important to note that CMS does permit states to use third parties to gather information or make the preliminary parity analysis, but the state must review and accept the preliminary analysis. States are also likely to have to effectuate contract amendments for all of its plans. The rule requires all MCOs, PIHP and PAHP contracts to include contract language requiring compliance with parity by the compliance deadline. It also requires states to document compliance with its contract submissions. CMS plans to provide TA to states on the requirement to document compliance with parity in its contracts.

Delivery Model	State Responsibility	MCO Responsibility	Unique Considerations for States
Alternative Benefit Plans in FFS Medicaid (*for ABPs delivered through MMC, see above*)	States are responsible for ensuring parity in ABPs, and the Medicaid agency must provide sufficient information with its SPA to document compliance with parity requirements for its ABP.		The preamble notes that CMS initially reviewed all ABPs for parity compliance; therefore, only new SPAs for ABPs will be reviewed under this final rule. CMS intends to provide technical assistance that clarifies expectations on the documentation that must be submitted with ABP state plan amendments. ABPs that provide EPSDT benefits are deemed compliant with the parity requirements for children receiving EPSDT.
Children's Health Insurance Program	State plans for CHIP must comply with the parity requirements by Oct. 2, 2017. This applies to states that also contract with an MCO.		CHIP programs that provide EPSDT are deemed compliant with the parity rules if it covers all EPSDT services required in 1905(r) and meets the informing requirements of 1902(a)(43). The child health plan must also include a description of how the state will comply with applicable Medicaid statute, and separate CHIPs cannot exclude any particular condition, disorder, or diagnosis under EPSDT.

General Parity Requirements

The following table discusses the application of parity to Medicaid and CHIP, including how states and MCOs will determine if quantitative and non-quantitative limits may apply to MH/SUD services. For information on state and MCO roles and responsibilities for the parity analysis and compliance, see the table above.

Parity Requirement	Description	Considerations for States
Classifying Benefits	To assess parity, Medicaid benefits must be considered using four categories: inpatient, outpatient, emergency and pharmacy.[1] It is important to note that the final rule applies mental health parity to all benefits delivered in Medicaid, including intermediate services and long-term services and supports (LTSS). All benefits must fall into one of these four classifications. The rule notes that intermediate services and LTSS must be classified using a reasonable method and using the same standards for medical/surgical services as for MH/SUD services.	The inclusion of LTSS in the parity rule raises a number of considerations for states, such as how the requirement is reconciled with the IMD exclusion and how it applies to 1915(c) waiver services. The final rule also leaves it up to the state or managed care plan to assign LTSS services to the four classifications, and does not define LTSS. This allows states and MCOs to define LTSS in the context of their service package. While this flexibility may be helpful, it could also increase the administrative burden on states to classify this heterogeneous set of services. It could also make it difficult to comply with CMS' requirement that the same standards are used to classify medical/surgical LTSS as are used to classify MH/SUD LTSS. CMS indicates that it intends to offer TA to states and MCOs on the classification of

[1] Note: the rule permits sub-classification for office visits, separate from all other outpatient services.

Parity Requirement	Description	Considerations for States
		intermediate services and LTSS.
Financial Requirements and Quantitative Treatment Limitations (QTLs)	*Determining if a Financial Requirement or QTL is Permissible* Financial requirements or QTLs of a given type may only apply to MH/SUD services when that type of requirement/limit applies to "substantially all" medical/surgical services in a classification (inpatient, outpatient, emergency, or pharmacy). A type of financial requirement or QTL applies to substantially all services in the classification if it applies to at least 2/3 of those medical/surgical benefits in that classification (determined using the projected dollar amount for medical/surgical benefits in each classification expected to be paid in a contract year). *Determining the Permissible Level* If the 2/3 threshold is met, the level of the limit or QTL for MH/SUD services must not be more restrictive than the "predominant limit" of that type applied to medical/surgical services. The predominant limit is the level of the financial requirement (i.e., dollar amount) or QTL (i.e., number of visits allowed), that applies to more than 50 percent of physical health benefits in the classification subject to that type of limit/requirement. If no single level applies to half of services in a classification, different levels may be combined until reaching the 50 percent threshold. *Other Considerations* The rule does not permit separate cumulative financial requirements for MH/SUD and medical/surgical services,	The analysis of financial requirements and QTLs may be a particular challenge for states when services are delivered across multiple plans and delivery models (see table above). To do the parity analysis, states will need to identify and collect the appropriate information from MCOs, PIHPs and PAHPs, such as projected dollar amount for medical/surgical benefits in each classification, the type of limits/QTLs that apply to physical health services in each classification, and the type of limits that apply to various MH/SUD services.

Parity Requirement	Description	Considerations for States
	such as separate deductibles for MH/SUD. However, it does permit quantitative treatment limits to accumulate separately for medical/surgical and MH/SUD.	
Non-Quantitative Treatment Limitations (NQTLs)	Treatment limits that are not expressed numerically are NQTLs. NQTLs may only apply to MH/SUD if the factors used to apply them to MH/SUD benefits in a classification are comparable to and applied no more stringently than factors used in applying the limitation for medical/surgical benefits in the same classification. Processes, strategies, and evidentiary standards are some of these factors. The rule also provides examples of NQTLs, such as medical management standards, formulary design, network tier design, standards for provider participation in a network, methods for determining charges, fail-first policies, and standards for accessing out-of-network providers. CMS adds that "soft benefit limits," which allow for numerical limits to be exceeded when medically necessary, are considered NQTLs, and the NQTL rules apply. Of particular note, the rule addresses the application of NQTL requirements to provider reimbursement. As with other NQTLs, the factors used to determine MH/SUD reimbursement must be applied in a manner comparable to and no more stringent than for reimbursement for medical/surgical services. CMS adds, disparate results in reimbursement do not necessarily mean there is a failure to comply with parity. Finally, multi-tiered prescription drug benefits are permitted as long as they comply with the requirements for	In response to state concerns around the application of NQTLs, CMS indicates that NQTLs should be considered on a classification-by-classification basis, not through a one-to-one comparison of a MH/SUD service to a medical/surgical service. In other words, NQTLs for inpatient medical/surgical services would be compared to NQTLs for inpatient MH/SUD services. CMS also notes that it intends to provide technical assistance to states on the implementation of the NQTL provisions. The agency will also consider sub-regulatory guidance or rulemaking on NQTLs if questions arise about the appropriateness of criteria used to apply NQTLs to MH/SUD benefits. We believe there is the potential that states using a carve-out model (see table above), may face challenges receiving the necessary information from MCOs, PIHPs and PAHPs to conduct the parity analysis for NQTLs. Some of this information, such

Parity Requirement	Description	Considerations for States
	NQTLs and the tiers are established without regard to whether a prescription is for medical/surgical services or MH/SUD services.	as medical management criteria, may be considered proprietary by the plans.
Lifetime and Annual Dollar Limits	For individuals in MCOs or enrolled in CHIP, an aggregate lifetime or annual dollar limit on MH/SUD services may only apply if a lifetime or annual dollar limit applies to at least 1/3 of medical and surgical benefits (determined by amount of payments for medical and surgical benefits in a contract year). If this criterion is met, the final regulation provides information on how such limits may be applied.	

Other Issues

The following table explores other relevant provisions of the final parity regulation.

Provision	Description	Consideration for States
Availability of Information	Under the final rule, states and MCOs, PIHPs, and PAHPs, must make certain information available to enrollees and providers. The state or plan must make medical necessity criteria for MH/SUD benefits available to any enrollee, potential enrollee or contracting provider upon request. In addition, the state or plan must make the reason for denial of MH or SUD services available to the enrollee.	
No Cost Exemption	Unlike parity requirements for commercial plans, this final rule does not include a cost exemption for states or managed care plans. CMS notes that the cost of compliance with parity will be borne by the Medicaid program, as the rule permits the costs associated with parity compliance can be	The lack of a cost exemption may be problematic for states that face significant costs in order to come into compliance. Depending on the delivery model and current limitations on

Provision	Description	Consideration for States
	accounted for in the actuarial soundness calculation. Therefore, if MCOs, PIHPs or PAHPs pay for services beyond what is included in the state plan, it is expected that the capitation rates will cover these costs.	MH/SUD services, costs of compliance may result from completing the parity analysis, making contract amendments, overseeing managed care plan compliance with parity, and revising the MH/SUD benefit structure and QTLs or NTQLs.
IMD Exclusion	The preamble acknowledges the comments CMS received on the IMD exclusion and its apparent conflict with parity, but the regulatory text does not remedy state concerns. CMS notes that the IMD exclusion is a statutory requirement, and the full range of covered services can be provided to beneficiaries when they are in non-IMD facilities.	It is important to note that the final regulation on Medicaid managed care (expected to be released shortly) may address the IMD exclusion. Specifically, the proposed version of that rule permitted states to cover short-term IMD stays through managed care. This provision may be included in the final rule.