

# Application of MHPAEA to Medicaid and CHIP (CMS-2333-F)

# Outline

- General parity requirements
- Alignment with the MHPAEA Final Rules
- Application of parity to Medicaid and CHIP
- Key Changes from the Notice of Proposed Rulemaking

# General Parity Requirements

# Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires group health plans to ensure that the financial requirements and treatment limitations that are applicable to mental health or substance use benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

# General Parity Requirements

- MHPAEA defines financial requirements as including deductibles, copayments, coinsurance and out of pocket expenses
- MHPAEA defines treatment limitations as including “limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment”

# General Parity Requirements

- Plans may not impose a non-quantitative treatment limit (NQTL) on MH/SUD benefits unless
  - any processes, strategies, evidentiary standards, or other factors used in applying the NQTL are
  - comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits
  - in the same classification.

# General Parity Requirements

- MH/SUD coverage is NOT mandated under MHPAEA
- However, if a plan provides coverage for MH/SUD benefits in any classification, coverage for MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided
- This final rule for Medicaid and CHIP includes four benefit classifications: inpatient, outpatient, emergency care, and prescription drugs

# Alignment with the MHPAEA Final Rules



# Alignment with MHPAEA Final Rules

- Final rules were issued in 2013 to apply MHPAEA to group health plans and individual issuers in the commercial market
- This final rule for Medicaid and CHIP has been aligned as much as possible with the final MHPAEA regulations, including provisions for:
  - General parity requirements for financial requirements, quantitative treatment limitations
  - Parity requirements and examples of NQTLs
  - Availability of information requirements

# Differences from MHPAEA Final Rules

- Several provisions of this Medicaid and CHIP rule are different than policies governing the commercial market, including:
  - Application of parity across different delivery systems
  - Change in the number of benefit classifications
  - Application for a cost exemption
  - Application of parity to Alternative Benefit Plan and CHIP state plans

# Application of Parity to Medicaid and CHIP

# Scope of Application – MCOs

- Parity applies to all individuals enrolled in a Managed Care Organization (MCO) as defined by § 438.2, regardless of whether that plan provides MH/SUD services
- Once an individual is enrolled in an MCO, their entire benefit package is subject to parity, including any services delivered through another type of managed care plan or FFS
- Parity does not apply to beneficiaries who receive FFS Medicaid state plan services only, or who are enrolled in a PIHP, PAHP or PCCM but are not also enrolled in an MCO

# Scope of Application – ABP and CHIP State Plans

- All parity requirements apply to benefits delivered through ABP and CHIP MCOs
- For benefits offered only through FFS under the ABP or CHIP state plan, the following provisions apply:
  - Parity of financial requirements and treatment limitations
  - Disclosure of medical necessity criteria upon request and reason for any denial of payment for MH/SUD services

# Application to MCOs

- This final rule allows states to include costs of becoming MHPAEA compliant (new services and additional units) in payments to MCOs
  - Medicaid regulations direct states to reimburse MCOs based only on state plan services (including limits)
  - Because the actuarially-sound payment methodology takes costs of compliance with parity into account, MCOs will not incur a net increase in costs
- Therefore, the final rule does not include an increased cost exemption

# Application to MCOs

- States have two options if they find that the benefit package afforded to enrollees of MCOs does not meet the requirements of this final rule:
  - Change their state plan so that the service package complies with these proposed rules; or
  - Add benefits or remove any relevant treatment limitations from the benefit package provided by the MCO, PIHP or PAHP without making any change to the service in the state plan



# Application Across Delivery Systems

- States have the flexibility to provide services through managed care entities other than MCOs, including prepaid inpatient health plans (PIHPs) or prepaid ambulatory health plans (PAHPs)
- The final rule allows states that have MCOs, PIHPS, and/or PAHPS, to apply parity requirements across the delivery systems and therefore allows states the maximum flexibility



# Application Across Delivery Systems

- In states where some or all MH/SUD services are carved-out through some combination of MCOs, PIHPs, PAHPs, or FFS, the state has the responsibility for assessing parity compliance across these delivery systems
- The state is required to make available documentation of parity compliance to the general public within 18 months of this rule's date of publication

# State's Responsibility

- States have a general responsibility to administer the state plan in compliance with federal law
- States are required to provide an assurance of compliance with parity requirements when submitting ABP or CHIP state plans
- State Medicaid agencies must include contract provisions requiring compliance with parity in applicable MCO, PIHP, and PAHP contracts

# Effective Date

- The final rule allows states up to 18 months after the date of the publication to comply with these requirements
- This 18-month compliance period allows states time to:
  - Make budget requests to add new services or additional service units
  - Make contract changes to their MCO, PIHP, or PAHP contracts
  - Obtain approval from CMS to make changes to their non-ABP state plan for services delivered through FFS (if they so choose)

# Key Changes from the Notice of Propose Rulemaking

# Long Term Care Services

- Definitions of “medical/surgical benefits,” “mental health benefits,” and “substance use disorder benefits” have been revised to include long term care services
- Long term care services must be classified in one of the four existing benefit classifications for the purposes of the parity analysis
- Technical assistance will be offered to assist states and managed care plans understand how to classify these services

# Deemed Compliance

- Consistent with the statute, the final rule provides that when ABPs or CHIPs are offering full EPSDT services, they will be deemed to be in compliance with parity
- § 457.496(b) has been revised to clarify that to meet the EPSDT standard and be deemed compliant with parity, separate CHIPs must meet certain standards. These include:
  - Complying with sections 1905(r) **and** 1902(a)(43) of the Act and the approved Medicaid state plan when providing EPSDT
  - Not excluding benefits on the basis of condition or diagnosis
  - Including a description of their efforts to comply with the deeming requirements within the state plan

# Deemed Compliance

- We have revised § 457.496(a) to clarify that a state's provision of EPSDT must also meet Medicaid standards at section 1902(a)(43) of the Act, which requires states to inform eligible children about EPSDT, provide screenings as medically necessary or at intervals consistent with medical standards, and provide for or arrange for the provision of services, including the assurance of non-emergency medical transportation and other enabling services.



# Other Changes

- We have modified the rule to require the standards used to assign mental health/substance use disorder benefits to a classification be “reasonable” as well as the same as the standards used for medical/surgical benefits.
- Regarding access to out-of-network providers, we have eliminated deemed compliance based on adherence to existing § 438.206(b)(4). The final rule clarifies that the requirements of these two provisions are complementary.
- The final rule clarifies that states must review both MH/SUD benefits and medical/surgical benefits when completing the parity analysis.



# Other Changes

- We have also revised the language in § 438.910(d)(3) and § 457.496(d)(5). As proposed it included a requirement to use the “same” standards regarding access to out-of-network providers, to more closely align with the general requirement for NQTLs; the rule is finalized to require the use of “comparable” standards.
- We have revised § 438.6(n) to require MCO contracts to provide for services to be delivered in compliance with this rule and new subpart K, rather than requiring those contracts to ensure that enrollees actually receive such services.
- We have modified § 457.496(f)(1) to specify that states must describe the standard being used to define medical/surgical, MH, and SUD benefits in their state plan.

Full text of this final rule is available at  
<http://www.regulations.gov>