



# Webinar #1: Application of Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs

**February 9, 2017**

**1:30-2:30pm ET**

***Center for Medicaid and CHIP Services***



# Webinar Outline

- Timeline and Key Requirements
- Webinar Series
- New CMS Resources
  - Parity Compliance Toolkit
  - Parity Implementation Roadmap
- Key Steps in Parity Analysis
- Additional Resources
- Q&A

# Timeline

The Mental Health Parity Act of 1996

- Prohibits lifetime and annual dollar limits for mental health if aggregate limits not also applied to medical

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

- Requires full parity for financial requirements and treatment limitations; expands aggregate limits requirements to substance use disorders

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

- Applies provisions of MHPAEA to the Children's Health Insurance Program (CHIP)

Affordable Care Act of 2010 (ACA)

- Applies parts of MHPAEA to Medicaid Alternative Benefit Plans (ABPs)

March 30, 2016: Final Rule for Medicaid/CHIP published

October 2, 2017: Compliance required

# Key Requirements

- Generally prohibits the application of more restrictive limits and requirements to mental health/substance use disorder (MH/SUD) benefits than limits/requirements that generally apply to medical/surgical (M/S) benefits.
- Prohibits the application of lifetime or annual dollar limits to MH/SUD benefits unless dollar limits apply to at least one-third of M/S benefits.
- Prohibits the application of financial requirements (FR) and quantitative treatment limitations (QTL) to MH/SUD benefits that are more restrictive than the ***predominant*** financial requirement or treatment limitation of that type applied to ***substantially all*** M/S benefits in that same classification.

# Key Requirements

- Prohibits the application of non-quantitative treatment limits (NQTL) to MH/SUD benefits in any classification unless, as written and in operation, any processes, strategies, standards, or other factors used in applying the NQTL to the MH/SUD benefit are ***comparable to and applied no more stringently*** than those used in applying the same NQTL to M/S benefits in the classification.
- MH/SUD and M/S benefits must be defined consistent with a “generally recognized independent standard of medical practice.” For purposes of comparing benefits to assess parity, benefits must be mapped to one of four classifications: inpatient, outpatient, prescription drugs, and emergency care.

# Key Requirements

- Parity does not mandate coverage of MH/SUD benefits. However, when coverage for MH/SUD benefits is provided in any classification, coverage must be provided in every classification in which M/S benefits are provided.
- The criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries and providers upon request. The reason for any denial of reimbursement or payment for a MH/SUD benefit must be made available to beneficiaries.

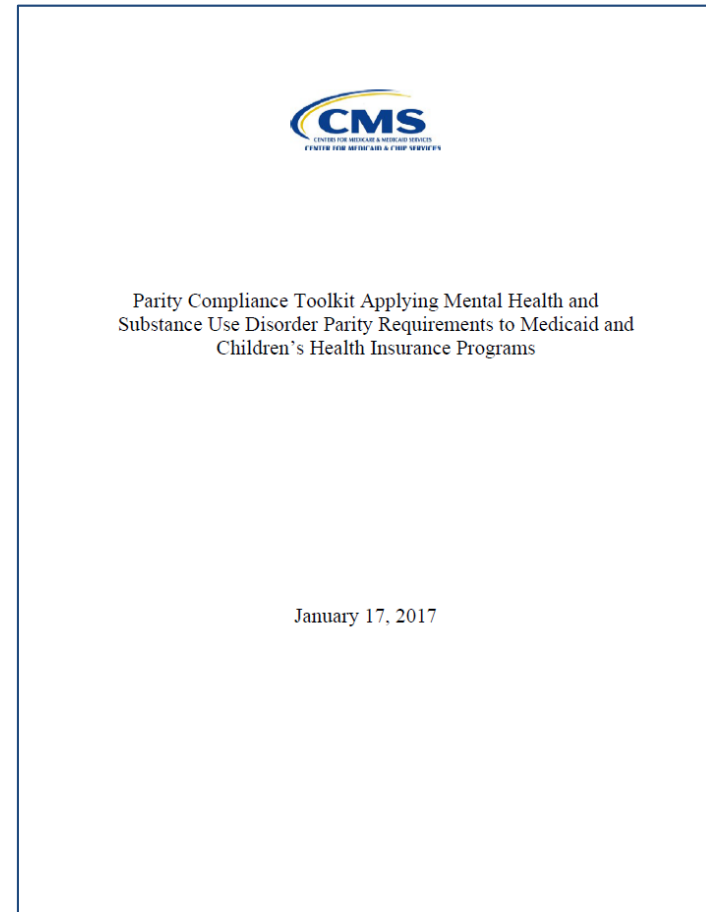
# Webinar Series

## Overview & Purpose

- Today's webinar will provide an overview of recently released guidance documents and review key steps in assessing parity compliance to assist in the implementation of the Medicaid/CHIP parity rule.
- Upcoming webinars two and three will provide more detailed information on parity requirements, strategies, and considerations.
- Target audience: state Medicaid and CHIP officials, other state officials responsible for the delivery of MH/SUD benefits to Medicaid/CHIP beneficiaries.

# Parity Compliance Toolkit

The Toolkit provides detailed technical information and guidance to help states assess compliance with the final Medicaid/CHIP parity rule.



Available at

<https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>

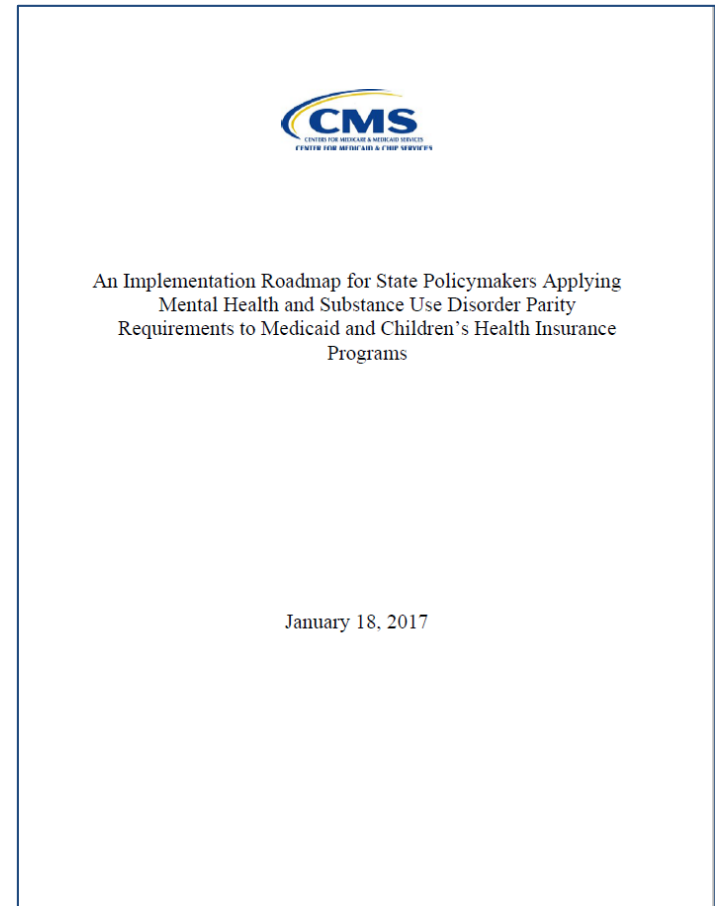


# Parity Compliance Toolkit

- Discusses and provides examples, tips, and key considerations on the following topics:
  - General Parity Requirements and Approach to Determining Parity (Section 2)
  - Defining MH and SUD Benefits (Section 3)
  - Defining Classification and Mapping Benefits to Classifications (Section 4)
  - Identifying and Analyzing Financial Requirements, Quantitative Treatment Limitations, and Aggregate Lifetime and Annual Dollar Limits (AL/ADLs) (Section 5)
  - Identifying and Analyzing Non-Quantitative Treatment Limitations (Section 6)
  - Parity Requirements for Medicaid Alternative Benefit Plans (ABPs) (Section 7)
  - Parity Requirements for CHIP (Section 8)
  - Availability of Information Requirements (Section 9)
- Table 1 in Section 2.1 identifies which parity requirements apply to which program type (coverage to enrollees in a Medicaid MCO, coverage provided by ABPs, and coverage provided by CHIPs).
- Section 2.2 outlines key steps in the parity analysis.

# Parity Implementation Roadmap

The Roadmap provides an operational resource to assist state policymakers in planning and organizing work related to assessing compliance with the final Medicaid/CHIP parity rule.



Available at

<https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-roadmap.pdf>

# Parity Implementation Roadmap

- The Roadmap is a guidance tool designed for Medicaid and CHIP officials who are engaged in parity compliance activities.
- Presents suggestions for steps states may undertake to achieve parity compliance, and the types of organizations and staff that states may engage to implement those requirements.
- Addresses initial preparatory steps for states, issues to consider when performing the analysis, potential parity deficiencies, and ongoing monitoring.

# Parity Implementation Roadmap

- Each section in the Roadmap gives a basic overview of a requirement, links back to relevant portions of the Toolkit, and offers key considerations for that parity-compliance activity:
  - General Parity Requirements and Approach to Determining Parity
    - Initial Implementation Tasks and Considerations
  - Conducting the Parity Analysis
  - Demonstration of Parity Compliance
  - Ongoing Compliance and Monitoring Activities

# Roadmap: Initial Implementation Tasks

The following table suggests initial steps for state policymakers before beginning the parity analysis:

Key Tasks:
1. Identify the scope of the state's parity analysis
2. Convene a parity work group
3. Align state-specific timelines
4. Consider existing resources for additional technical support
5. Engage stakeholders

# Scope of the Analysis: Roadmap

- What program are you reviewing?
  - Medicaid State Plan:
    - Determine whether beneficiaries are served under managed care, and if in managed care whether all benefits are carved in.
  - Alternative Benefit Plans:
    - Determine if the benefits are offered only through FFS. If yes, only select parity provisions apply.
    - No action required for approved ABPs.
  - CHIP:
    - Document compliance with parity requirements in the state child health plan
    - Consider whether to conduct a full parity analysis of each benefit package, seek EPSDT deemed compliance, or both
    - If state provides EPSDT to some or all of the separate CHIP population, and intends to request EPSDT deemed compliance:
      - Does EPSDT meet all of Medicaid's EPSDT statutory requirements?

# Scope of the Analysis: Roadmap Appendix A



# Steps in Parity Analysis

Identify benefit packages to which parity applies

Define Benefits and Conditions

Define Classifications and Map Benefits to Four Classifications

Identify and Analyze FRs, QTLs, and AL/ADLs

Identify and Analyze NQTLs

Availability of Information

Documentation



# Identify Benefit Packages

- Parity applies by benefit package
- A benefit package includes a unique set of benefits, financial requirements and treatment limitations that are provided to a specific population.
- States or MCOs should perform a single parity analysis for benefits provided to each population or eligibility category to the extent the same benefits, FRs, and TLs are covered.
  - E.g. if financial requirements are applied according to the income level of the beneficiary, a separate analysis is needed at each income level.
  - If a state provides benefits through different delivery systems to different beneficiaries (e.g. an MCO, PIHP, PAHP, and/or FFS), a unique parity analysis is needed for each delivery system combination.

# Define MH/SUD Benefits

- In order to determine whether MH/SUD benefits are provided in parity with M/S benefits, the state must identify which benefits are MH/SUD benefits and which are M/S benefits.
- The rule defines MH/SUD benefits as items or services for MH/SUD conditions and M/S benefits as items or services for M/S conditions.
- The rule does not identify specific conditions as MH/SUD or M/S conditions.
- The state must choose a “generally recognized independent standard of current medical practice” to define MH/SUD and M/S conditions.
  - Options include most current ICD and DSM

# Define Classifications and Map Benefits to Classifications

- Parity requirements for financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations apply by benefit classification, which are defined in the rule as inpatient, outpatient, emergency care, and prescription drugs.
  - Outpatient can be further divided into office visits and all other outpatient benefits.
- In defining what benefits are included in a particular classification, the same reasonable standard must be applied to M/S and MH/SUD benefits.
  - M/S and MH/SUD benefits may not be mapped to the inpatient classification solely for the purpose of assuring certain financial requirements or treatment limitations will be applicable (i.e., not a reasonable standard).

# Identify and Analyze FRs and QTLs

- States (or MCOs) must identify and analyze financial requirements (FRs) and quantitative treatment limitations (QTLs) using a two-part, cost-based test.
  - The “substantially all” test requires a type of FR (e.g., copayment) or QTL (e.g., visit limit) to apply to at least two-thirds (i.e., substantially all) of the expected payments in a year for all M/S benefits in the same classification.
    - If the type of FR or QTL passes the “substantially all” test, then the “predominant test” is required to determine the permissible level of the FR or QTL
  - To pass the “predominant” test, the level (or magnitude) of the type of FR (e.g., **\$5** copayment) or QTL (e.g., **60** visit limit) must apply to more than one-half (i.e., the predominant amount) of the payments for M/S benefits in the same classification that are subject to that type of FR or QTL.

# Identify and Analyze AL/ADLs

- States (or MCOs) must identify and analyze aggregate lifetime and annual dollar limits (AL/ADLs) using a cost-based test.
- The rule prohibits the application of AL/ADLs to MH/SUD benefits unless dollar limits apply to at least one-third of M/S benefits.
- If an AL/ADL applies to between one-third and two-thirds of M/S benefits, an AL/ADL may be applied to MH/SUD benefits if it is no more restrictive than the weighted average of the limit applied to the M/S benefit.
- If an AL/ADL applies to at least two-thirds of M/S benefits either:
  - Apply the AL/ADL to both the M/S and MH/SUD benefits subject to the limit without distinguishing between the M/S benefits and MH/SUD benefits or
  - Apply an AL/ADL on MH/SUD benefits that is no more restrictive than the AL/ADL on M/S benefits

# Identify NQTLs

- States (or MCOs) must identify and analyze non-quantitative treatment limitations (NQTLs).
- NQTLs are limitations on the scope or duration of benefits, such as prior authorization or network admission standards. “Soft limits,” or benefit limits that allow for an individual to exceed numerical limits based on medical necessity are also considered NQTLs.
- Examples of NQTLs from the final rule include:
  - Medical management standards, e.g., medical necessity or appropriateness criteria and processes or experimental/investigational determinations
  - Admission standards for provider networks
  - Provider reimbursement rates
  - Restrictions based on location, facility type, or provider specialty
  - Fail-first policies or step therapy protocols
  - Exclusions based on failure to complete a course of treatment

# NQTL Analysis

- The rule prohibits the application of NQTLs unless, under the policies and procedures of the state/MCO, **as written and in operation**, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are **comparable to**, and **applied no more stringently** than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification.
- The NQTL analysis is conducted by classification – it does not require a one-to-one comparison of a MH/SUD service to a M/S service.

# Availability of Information

- The parity rule includes two requirements regarding availability of information related to MH/SUD benefits:
  - The criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries and affected providers upon request.
    - MCOs are deemed compliant with this requirement if they disseminate practice guidelines in compliance with the Medicaid managed care rule (42 CFR 438.236 (c)).
  - The reason for any denial of reimbursement or payment for a MH/SUD benefit must be made available to the beneficiary.
    - There is no deeming provision, but if an MCO provides notices of adverse benefit determination for payment denials in accordance with managed care regulations, that would meet the requirement.



# Documentation

- States must submit documentation regarding parity compliance with an MCO contract/contract amendment for a carve-out program.
- States must document parity compliance as part of an ABP SPA or a CHIP SPA.
- States that use an MCO to deliver some or all of its benefits must provide documentation of compliance with parity to the general public and post this information on the state's Medicaid website by October 2, 2017.
- Documentation (and the parity analysis) must be updated when there is a change that impacts parity compliance.

# Additional Resources

- Parity Compliance Toolkit
  - <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>
- Parity Implementation Roadmap
  - <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-roadmap.pdf>
- SAMHSA Parity Policy Academies
  - Two parity policy academies to occur from February 2017 through August 2017
- Upcoming Webinars
- TA Mailbox
  - Email: [parity@cms.hhs.gov](mailto:parity@cms.hhs.gov)

# Future Presentations

- **Webinar 2: Parity Implementation, Part 1**
  - February 23, 2017, 3:00-4:30 ET
  - Topics:
    - Identify benefit packages to which parity applies
    - Define benefits and conditions
    - Define classifications and map benefits to four classifications
    - Identify and analyze FRs, QTLs, and AL/ADLs
- **Webinar 3: Parity Implementation, Part 2**
  - March 9, 2017, 3:00-4:30 ET
  - Topics:
    - Identify and analyze NQTLs
    - Availability of Information
    - Documentation

# Questions



# Additional Questions?

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Please send additional questions to the mailbox dedicated to this rule:

[parity@cms.hhs.gov](mailto:parity@cms.hhs.gov)

While we cannot guarantee individualized responses, inquiries will inform future guidance and presentations.