MEDICAID/CHIP PARITY COMPLIANCE: INSIGHTS FROM THE FIELD

States with Medicaid managed care organizations (MCOs), alternative benefit plans (ABPs), and separate CHIP programs are focused on demonstrating compliance with parity requirements by October 2, 2017. For most states, it is a steep learning curve that requires interpreting the final Medicaid/CHIP parity rule and absorbing CMS guidance while simultaneously implementing a reasonable process to assess and document compliance by the October 2 deadline.

Given that most Medicaid MCO, ABP and CHIP policies and program operations predate the final Medicaid/CHIP parity rule, it is expected that at least some policies and operational protocols will need to change to demonstrate compliance with parity. All of this needs to occur while maintaining ongoing program operations with existing staff resources. It is no surprise that states are seeking to expedite understanding of the rule and to develop an efficient process that minimizes disruption to Medicaid/CHIP beneficiaries, contractors, and state staff.

FIVE CRITICAL STEPS

While the rule and guidance can seem daunting, the parity process really breaks down to five critical steps:

1. Identifying benefit packages
2. Defining mental health and substance use disorder (MH/SUD) and medical/surgical benefits
3. Defining benefit classifications (inpatient, outpatient, emergency care, and prescription drugs) and mapping benefits in each benefit package to the four classifications
4. Identifying and testing financial requirements (FRs), quantitative treatment limitations (QTLs), aggregate lifetime and annual dollar limits (AL/ADLs), and non-quantitative treatment limitations (NQTLs)
5. Addressing and documenting parity compliance

KEY ISSUES

Based on our experience assisting six states with determining parity compliance and as a subcontractor to Truven Health Analytics to help CMS provide parity technical assistance to states, some of the key issues related to the parity analysis include:

1) How to streamline the analysis for states with multiple managed care entities and/or benefit packages;
2) How to incorporate long term services and supports;
3) How to define MH/SUD benefits using a standard specified in the parity rule while being as consistent as possible with state practice;
4) How to identify and define NQTLs;
5) How to conduct the parity analysis when the Medicaid/CHIP program is undergoing delivery reform or changing managed care entities;
6) How to collect relevant information from managed care entities as efficiently as possible;
7) How much support and oversight to provide managed care organizations (MCOs) that are conducting the parity analysis for fully integrated benefit packages;
8) How to determine what changes are necessary to comply with parity; and
9) The level of detail needed for parity documentation.

IN CONCLUSION

Our experience has shown that the parity analysis works best when our diverse team of policy, financial, clinical and pharmacy program operations specialists work together with the state to understand and implement the final rule. For most states, some MH/SUD or M/S services are carved out of the MCOs and administered fee-for-service or by behavioral health contractors. In these instances, we find that establishing a cross agency work group with regular key decision meetings promotes collaboration and drives the efficiency necessary to the compliance analysis process. It is also important for the state to have a good working relationship with its managed care vendors.