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Mental Health Parity and Addiction Equity Act

With the publication of the final Medicaid Mental Health Parity and Addiction Equity Act (MHPAEA) rule, many states are looking at what steps to take to implement the new federal requirements. States have come to Mercer with questions and challenges, such as:

- How do I apply the final Medicaid parity rule if I carve-out mental health and substance use disorder benefits from the managed care organization (MCO)?
- What is an non-quantitative treatment limit (NQTL) and which ones do I have to test?
- How do I document my parity analysis?
- Will it take more than 18 months to assess compliance with the mental health parity rule?
- How have commercial vendors complied with parity requirements?
- Have other states begun work implementing the final parity rules?
- The MCOs have raised concerns regarding the Medicaid parity rule. What guidance should we give them?
- What do we need to do now that the Medicaid parity rule is final?

MOVING TOWARD COMPARABLE COVERAGE

Parity ensures that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are generally no more restrictive than medical/surgical benefits.

The Centers for Medicare & Medicaid Services (CMS) issued a final rule that applies parity requirements to Medicaid MCOs, the Children's Health Insurance Program (CHIP), and Medicaid alternative benefit plans (ABPs). The final rule is effective May 31, 2016. States have 18 months from the publication date of March 30, 2016, to comply with final rule requirements. The final rule can be viewed at https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf.

PARITY TESTING

The final Medicaid parity rule generally aligns with the commercial parity rules, which were finalized in 2013, creating consistency between the Medicaid and commercial markets. This allows states to draw on the commercial market's experience in implementing parity. Like employee benefits plans, MCOs and state Medicaid agencies must ensure that financial requirements (such as cost sharing) and treatment limitations (both quantitative, such as day limits, and non-quantitative, such as utilization review strategies) comply with the final rule. State Medicaid agencies must ensure that MCO enrollees receiving MH/SUD services from other delivery systems, such as fee-for-services and prepaid inpatient health plans, are in compliance with parity. The final Medicaid rule also

addresses aggregate lifetime and annual dollar limits, prescription formularies, and tiering of prescription drug benefits, and disclosure requirements.

Parity requirements apply on a classification-by-classification basis. The final Medicaid rule requires all medical, surgical, mental health and substance use disorder (MH/SUD) Medicaid benefits for MCO enrollees, including long-term care benefits, to be classified into one of the four classifications: inpatient, outpatient (with the option to have a sub-classification for office visits), emergency care, and prescription drugs (with an option to have multi-tiered prescription drug benefits based on reasonable factors without regard to whether the drug is generally prescribed for medical/surgical or MH/SUD benefits). CMS clarified that any limits applied to out-of-network services must be comparable, but not necessarily identical, for medical/surgical and MH/SUD benefits. Standards for classification assignment must be reasonable and applied in the same manner when assigning medical/surgical and MH/SUD benefits to classifications. MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. States will want to classify services in a manner that does not inadvertently negatively impact the parity analysis (for example, classification of medical/surgical services without limits could inadvertently affect the ability of the state to apply limits in MH/SUD).

Service classifications are tested to ensure that MH/SUD services are not more restrictive than the medical/surgical counterpart. For each service classification, states are required to test each of the following for parity:

- Financial requirements (for example, copay, coinsurance, provider reimbursement)
- Quantitative treatment limits (for example, service visit limits)
- Non-quantitative treatment limits (for example, prior authorization, utilization review, network inclusion standards and standards for accessing out-of-network providers)

The financial and quantitative assessment requires a multi-step formula based on the total dollars expected to be paid for medical/surgical benefits in a year for each benefit classification. To be compliant, the MCO covering both medical/surgical and MH/SUD benefits, or the state, if some MH/SUD services for MCO enrollees are provided outside of the MCO contract, must analyze and determine that the types of MH/SUD limitations apply to substantially all (two-thirds) medical/surgical services in the classification. If so, the MCO or state must further attest that any MH/SUD limits are not more restrictive than the predominant (half) limit applied to medical/surgical services.

NQTLs require an assessment of whether the processes, strategies, evidentiary standards, or other factors used to apply those limits are applied in a comparable manner to, and no more stringently to MH/SUD than, the non-quantitative treatment limits applied to medical/surgical services in the classification.

Overall, MCOs and states will have to draw on program, clinical, financial, and data system expertise to comply with the final Medicaid parity rule. Failure to supply the appropriate documentation may result in CMS not approving federal reimbursement for MCO contracts.

MERCER CAN HELP

The parity requirements are difficult to apply. We can help with the full array of issues such as:

- Training related to understanding the requirements and how to conduct analyses required under the final Medicaid rule
- Assisting the state to develop a plan to assess compliance with mental health parity rule (for example, project management, stakeholder discussion)
- Conducting the initial parity analyses or conducting parity analysis across multiple delivery systems (MCOs, PHIPs, PAHPs, FFS)
- Preparing the parity analysis and compliance submission for CMS (due to CMS in conjunction with contract amendments and state plan amendments no later than October 2, 2017)
- Assisting the state with conducting the parity analysis across delivery systems or assessing MCO compliance with required parity analysis (for example, assess parity application, data collection, service classification)
- Performing financial and quantitative treatment limit tests
- Analyzing NQTLs
- Advising states and MCOs on the design of new quality management approaches and strategies to replace those that are not parity compliant
- Determining how contracts, state plans, waivers, and rates will need to be modified
- Developing MCO instructions or contract revisions,
- Drafting or reviewing public documentation for the state website, demonstrating compliance with final rule

- Assessing the impact of changes necessary to comply with parity requirements on capitation payments and budgets
- Assisting with MH/SUD state plan benefit design changes, including modifying cost-sharing provisions in the state plan and the addition of MH/SUD benefits not previously covered. States may need assistance deciding whether to amend state plans or modify capitated contracts
- Drafting state plan Amendments
- Modifying capitated rates to include additional MH/SUD services necessary to comply with the final Medicaid rule
- Setting rates for new FFS services required for compliance with the final rule

Application to Medicaid MCO Enrollees

The final Medicaid rule applies to beneficiaries enrolled in Medicaid MCOs, including any other delivery system — for example, fee-for-service (FFS) or prepaid inpatient health plans (PIHPs) — that provides services to MCO enrollees. This rule does not apply parity requirements to non-ABP or non-CHIP Medicaid beneficiaries not enrolled in an MCO. However, CMS encourages states to provide state plan benefits to these beneficiaries in a way that comports with the parity requirements.

Below are highlights from the final Medicaid rule as applied to Medicaid MCO enrollees:

- All Medicaid services provided to MCO enrollees must be delivered in a parity-compliant manner
- The rule clarifies the state Medicaid agency determines parity compliance for all MCO contracts to ensure parity for MCO enrollees across the applicable delivery systems
- The inclusion of long-term care services is a significant change from the proposed Medicaid rule, which had excluded these services from the definition of MH and SUD benefits
- States are not required to include all state plan MH/SUD services in MCO contracts
- States are given the option of including MH/SUD services necessary for compliance with parity either in an amendment to the state plan or through the provision of capitated MH/SUD benefits
- States that choose not to change their state plans are authorized to include the cost of services necessary for compliance beyond the state plan in the development of actuarially sound rates. States may also choose risk mitigation for over and under payments
- CMS modified the definition of actuarial soundness to include parity required services in capitation rates, regardless of the cost effectiveness of those services (as is required for "in lieu of" services). The preamble to the final rule emphasizes that CMS does not expect MCOs to incur a net increase in costs because of compliance with parity
- In states where an MCO has sole responsibility for providing Medicaid services to Medicaid enrollees, the MCO is responsible for conducting the parity analysis. In states where any delivery system other than the MCO is offering services to MCO enrollees, the state is responsible for conducting the parity analysis

Application to CHIP

All CHIP programs, regardless of delivery system, must comply with the final rule. If a CHIP state plan provides full coverage of early and periodic screening, diagnosis, and treatment (EPSDT), the state will be deemed to comply with parity requirements for the specific CHIP populations covered for EPSDT. Full coverage of EPSDT will be determined only if 1) the state ensures provision of all medically necessary optional Medicaid services, whether or not the state plan includes the services, and does not exclude benefits on the basis of condition; and 2) publishes information that these medically necessary services are available. CMS referred readers to the July 7, 2014, and September 24, 2014, Medicaid guidance regarding whether applied behavior analysis is covered under the EPSDT benefit for children with autism.

Application to Medicaid ABPs/Medicaid Expansion Populations

ABP benefits provided through MCOs must comply with the final Medicaid rule's MCO requirements. ABP benefits provided outside of an MCO (for example, through FFS) must comply with the final Medicaid rule's financial requirements and treatment limitations provisions. ABPs offering EPSDT will be deemed in compliance for children under age 21 years with that coverage.