CMS Final Rule: Mental Health/Substance Use Disorder Parity

Understanding the Impact of the Mental Health Parity and Addiction Equity Act - Final Regulations

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Centers for Medicare & Medicaid Services Final Parity Rule

Learning Objectives

• Identify key considerations and actions for behavioral health stakeholders, including managed care plans, state Medicaid regulators, providers and consumers and families

• Learn how the rules impact behavioral health coverage decisions by Medicaid managed care plans, including the criteria for medical necessity determinations

• Understand how state and federal regulators will work together to balance their roles in monitoring and demonstrating compliance and what that means for health plans, providers and consumers and families evaluating the rules’ provisions

• Find out how the rules impact the Medicaid managed care rate setting process and the flexibility afforded states to include the cost of additional services and the easing of benefit limitations
Summary of Final Parity Rule

Key Concepts of the Mental Health Parity and Addiction Equity Act (MHPAEA)

• Comparability
• Four Benefits Classifications
• Quantifiable Treatment Limits (QTL)
• Non-quantifiable Treatment Limits (NQTL)
• Applies to Medicaid managed care organizations (MCOs), alternative benefit plans (ABPs) and Children’s Health Insurance Programs (CHIP)
• State accountability
• Federal signoff
Centers for Medicare & Medicaid Services Released Final Parity Rule

Builds on guidance and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

- Health insurance plans must provide the same coverage for mental health and substance use disorder as offered within the medical and surgical benefits
- Objective: improve access to mental health and substance use disorder services for people with Medicaid or Children’s Health Insurance Program
- Affects 23 million enrollees
- Services may be provided through managed care delivery mechanisms including Medicaid managed care organizations and prepaid inpatient health or prepaid ambulatory health plans
Rule Requirements: Implications for States and MCOs

Recognizes federal/state partnership

- Affirms state responsibility for identifying medical/surgical and mental health and substance use disorder conditions
- Affirms that CMS has provided sufficient guidance to states and MCOs, to apply Quantifiable Treatment Limits (QTL) to mental health and substance use disorder benefits
- QTL cannot be more restrictive than the predominant limits applied to substantially all medical/surgical benefits in each classification
Rule Requirements: Implications for States and MCOs

Identify within Four Benefits Classification

• Inpatient services
• Outpatient services
• Pharmacy services
• Emergency services
Rule Requirements: Implications for States and MCOs

- Long term care services are included in the definitions of benefits
- States will need to identify services within the four benefits classifications
- CMS has committed to providing additional information to assist in application to the four categories
Alternative Benefit Plans

• All Medicaid Alternative Benefit (ABPs) and CHIP plans are statutorily required to meet financial requirements and treatment limitations
• State will need to provide sufficient information with State Plan Amendment (SPA) to document compliance with parity requirements for ABP
• Only new SPAs for ABPs will be reviewed*
• ABPs that provide Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) benefits are compliant with parity requirements*
  *(ABPs approved on or after 1/1/14 are already compliant)
Rule Requirements: Implications for States

- CHIP programs EPSDT must include all 1905(a) services*

- A CHIP health plan must comply with both EDPST and MHPAEA requirements, same as a Medicaid Health Plan

* (Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) covers physical, mental health and substance use disorder services regardless of any restriction that states may impose on coverage for adult services, as long as those services could be covered under the State Plan)
Rule Requirements: Implications for States

Parity applies across delivery systems and requires Medicaid to:

- Structure benefits and deliver them in compliance
- Develop methods/tools applicable under a variety of different delivery system arrangements
- Determine types of documentation submitted
- Add contract language to require parity compliance across delivery system

- Provide guidance regarding classification of intermediate and long term care services
- Identify and collect data to determine compliance issues
- Partner with CMS to evaluate parity’s impact on service utilization, spending and health outcomes for individuals with MH/SUD
Rule Requirements: Implications for States and MCOs

Plan Responsibilities: Benefits Classification - inpatient, outpatient, pharmacy, emergency
- Plan must include the same MH/SUD benefit classifications as identified for medical/surgical benefits
- Plan must disclose information on MH/SUD benefits upon request, including criteria for determinations of medical necessity

- Final rule requires state to disclose reason for any denial of reimbursement or payment for services pertaining to MH/SUD benefits
- Parity requirements under MHPAEA do not apply when medical/surgical state plan services are delivered through fee-for-service Medicaid
## Rule Requirements: Implications for States and MCOs

<table>
<thead>
<tr>
<th>Medicaid responsibility</th>
<th>MCOs responsibility</th>
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<tr>
<td>• Determine compliance</td>
<td>• Provide comprehensive set of services</td>
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<tr>
<td>• Work with MCOs on contract changes</td>
<td>• Conduct parity analysis</td>
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<tr>
<td>– Review if contract currently includes parity language; add if does not</td>
<td>• Work with state on MCO contract changes</td>
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<td>– Include language that MCOs document parity findings and analysis</td>
<td>• Provide documentation of parity findings and analysis</td>
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<td>– May define penalties in contracts for non-compliance</td>
<td>• Recommended stakeholder input and advisory process</td>
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<td>– Recommended stakeholder input</td>
<td>• Effective October 2, 2017</td>
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Rule Requirements: Implications for States

Quantitative Treatment Limits (QTL)/Permissible Level

- QTL cannot be more restrictive than the “predominant limits” applied to “substantially all” medical/surgical benefits in each classification
  - “Predominant limit” refers to level of financial or numeric limits (e.g. dollar amount or number of visits) that apply to more than 50 percent of physical health benefits in the classification with that type of limit
  - “Substantially all” means two-thirds (2/3)
  - If 2/3 threshold is met, QTL for mental health/substance use disorder services must be no more restrictive than predominant limit applied to medical/surgical services
Rule Requirements: Implications for States

- Separate cumulative financial requirements for mental health/substance use disorder and medical/surgical services are not allowed, i.e., separate deductibles
- The Rule permits QTLs to accumulate separately for medical/surgical and mental health and substance use disorder
Rule Requirements: Implications for States

• State analysis of financial requirements and QTLs may challenge States when services are delivered across multiple plans and delivery models

• States will need to identify and collect information from MCOs, PIHPs and PAHPs, such as
  – Projected dollar amount for medical/surgical benefits in each classification
  – Type of limits that apply to physical health services in each classification
  – Type of limits that apply to mental health/substance use disorder services
Rule Requirements: Implications for States

• Non-Quantitative Treatment Limitations (NQTLs) are limits that are not expressed numerically “which otherwise limit the scope or duration of benefits for treatment”

• NQTLs may apply to mental health / substance use disorder if factors used to apply benefits in classification are comparable to (no more stringently than) factors used in limiting medical/surgical benefits in same classification
Rule Requirements: Implications for States

NQTLs are processes, strategies, and evidentiary standards such as

• Medical management standards
• Prior authorization
• Formulary design
• Network tier design
• Standards for network provider participation
• Methods for determining charges
• Fail-first policies
• Standards for accessing out-of-network providers
Rule Requirements: Implications for States

• “Soft benefit limits” which allow for numerical limits to be exceeded when medically necessary are considered NQTLs and NQTL rules apply

• Application of NQTL requirements to provider reimbursement and the factors used to determine mental health and substance use disorder reimbursement must be applied in a comparable manner

• NQTL requirements cannot be more stringent than for reimbursement for medical/surgical services
Rule Requirements: Implications for States

States are to determine impact of parity implementation

- Assess how parity affects payers’ utilization management approaches such as preauthorization
- Determine utilization management strategies
- Evaluate if the strategies lead to efficient outcomes without adversely affecting enrollees’ health
Rule Requirements: Implications for States

• State delivery models and benefit structure will affect state responsibilities including
  – Conducting parity analysis
  – Adding MH/SUD services or service units
  – Effectuating contract amendments/MOUs
  – Submission of state plan amendments (SPAs)

• Forthcoming Medicaid managed care rule may affect state’s actions in parity compliance

• States may need to re-visit long term services and supports (LTSS)-related initiatives
## Rule Requirements: Implications for States

States must obtain and analyze Plan QTL / NQTL information

- State can hire third parties to obtain information or conduct parity analysis
- State responsibility to review and accept the preliminary analysis
- State must document parity analysis and compliance when submit MCOs, PIHPs, and PAHPs contracts for CMS review and approval (October 2017)
- State must report compliance with parity on website
- State need to complete parity analysis whenever operations changed
- State has two options for remedying parity compliance
  - Revise state plan to ensure the service package is parity compliant
  - Amend managed care contracts to include necessary services or service units
Rule Requirements: Implications for States

- LTSS inclusion raises considerations, e.g., how to reconcile with the IMD exclusion and how it applies to 1915(c) waiver services
- State/managed care plan must assign LTSS services to four classifications within service package without CMS definition of LTSS

- Administrative burden to classify diverse services
- Must use reasonable method and same standards
- States may experience difficulties in complying with CMS requirement that the same standards are applies to classify LTSS within medical/surgical as MH/SUD
Rule Requirements: Implications for States

- CMS has historically been available to states to provide technical assistance as states review and propose approaches to implementing and reporting parity
- CMS recognizes the complexities states face
- CMS requires compliance
Q&A

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