NATIONAL HEALTH LAW PROGRAM

Fact Sheet: Mental Health Parity Compliance in Medicaid

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Introduction

Behavioral health services are health care services that are provided for the treatment of mental health conditions and substance use disorders (SUD). Medicaid is the leading payer for mental health services in the United States and plays an important role in providing coverage and access to behavioral health services for millions of low-income individuals.[1] In 2014, approximately 21.5 million people above the age of 12 had a substance use disorder in the past year and 1 in 5 adults had experienced a mental health condition in the past year.[2] That year, Medicaid paid for 25% of all mental health spending and 21% of total spending on substance use disorders in the United States.[3] In 2015, an estimated 9.1 million adults with Medicaid had a mental health condition and over 3 million experienced an SUD.[4]

Despite the prevalence of mental health conditions, there is a tendency among both private and public payers to provide more comprehensive coverage for medical and surgical benefits than for mental health benefits. Congress has passed two Acts mandating that private insurers provide coverage for mental health conditions that is on par with coverage for other health conditions.[5] The parity requirements set forth in these Acts have also been extended to some public health care programs.[6] This primer will describe the application and scope of these laws to Medicaid and the Children's Health Insurance Program (CHIP), with a particular focus on recent guidance by the Centers for Medicare and Medicaid Services (CMS) concerning parity compliance. It will also discuss how compliance with parity rules is to be measured.

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[1] CMS, Behavioral Health Services, https://www.medicaid.gov/medicaid/benefits/bhs/index.html (last accessed January 22, 2018).
[2] SARRA L. HEDDEN, *ET AL.*, SAMHSA, BEHAVIORAL HEALTH TRENDS IN THE UNITED STATES: RESULTS FROM THE 2014 NATIONAL SURVEY ON DRUG USE AND HEALTH 56 (2015), https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf.
[3] JULIA ZUR, *ET AL.*, KAISER FAMILY FOUND., MEDICAID'S ROLE IN FINANCING BEHAVIORAL HEALTH SERVICES FOR LOW-INCOME INDIVIDUALS 7 (2017), http://files.kff.org/attachment/Issue-Brief-Medicaids-Role-in-Financing-Behavioral-Health-Services-for-Low-Income-Individuals (Kaiser Family Foundation analysis of the Substance Abuse and Mental Health Services Administration 2015 National Survey on Drug Use and Health).
[4] *Id.* at 1.
[5] *See* Mental Health Parity Act of 1996, Pub.L. 104–204; Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C. § 1185a.
[6] *See* Final Rule: Application of Mental Health and Substance Abuse Disorder Parity Requirements to Medicaid Managed Care, CHIP, and Benchmark Coverage, 81 Fed. Reg. 18389 (Mar. 30, 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf.

Mental Health Parity Laws and Medicaid and CHIP

Recognizing the disparity in medical/surgical benefits and mental health benefits in many health care plans, Congress has passed two Acts to promote mental health parity in the private sector. The Mental Health Parity Act (MHPA) of 1996 required parity in aggregate lifetime and annual dollar limits with medical and surgical benefits for health plans that provided coverage for mental health benefits.[7] Then in 2008, Congress passed the Paul Wellstone Mental Health Parity and Addiction Equity Act (MHPAEA), which applies to employer-based plans with more than 50 employees that provide services for mental health and substance use disorders, requiring the plans to cover those services in parity with medical and surgical benefits.[8]

While these laws specifically target the private sector, the parity requirements have been extended to public health care coverage under CHIP and some Medicaid programs. After the passage of MHPA in 1996, Congress applied the parity requirements for annual and lifetime dollar limits to Medicaid Managed Care Organizations (MCOs) and CHIP through the Balanced Budget Act of 1997.[9] Although parity applies to Medicaid MCOs, as defined by regulation, it does not apply to all forms of Medicaid managed care.[10] In 2009, the CHIP program was reauthorized by Congress and the parity requirements of MHPAEA were applied to all CHIP plans that provide both medical/surgical and mental health/substance use disorder benefits.[11] Then, in 2010, the Affordable Care Act (ACA) required Alternative Benefit Plans (ABPs)—the benefits packages offered to certain Medicaid beneficiaries, including those enrolled in the Medicaid Expansion—to include mental health and substance use disorder benefits in plans and provide those benefits in parity with medical/surgical benefits.[12]

Over the past several years, CMS has issued regulations and other guidance materials in an effort to assist states, Managed Care Organizations (MCOs), and other relevant stakeholders in ensuring parity compliance.[13] In January of 2013, CMS issued a State

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[7] Mental Health Parity Act of 1996, Pub. L. 104–204, title VII, § 702(a), 110 Stat. 2944 (1996) (codified as amended at 29 U.S.C. § 1185a).

[8] Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110–343, div. C, title V, § 512(a), (g)(1)(A), 122 Stat. 3881, 3892 (2008) (codified at 29 U.S.C. § 1185a); *see* AMANDA K. SARATA, CONG. RESEARCH SERV., MENTAL HEALTH PARITY AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 at 3 (2011), http://www.ncsl.org/documents/health/MHparity%26mandates.pdf.

[9] 42 U.S.C. §§ 1396u–2(b)(8), 1397cc(f)(2); *see also* CMS, State Health Official Letter (Jan. 2013) (describing the legislative history), https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.

[10] *See* 42 C.F.R. § 438.920(a).

[11] 42 U.S.C. § 1397cc(c)(6).

[12] 42 U.S.C. §§ 1396u–7(b)(6). For a more detailed explanation of what Alternative Benefit Plans (ABPs) are and how they work, see MICHELLE LILIENFELD, NAT'L HEALTH LAW PROG., HEALTH ADVOCATE: ALTERNATIVE BENEFIT PLANS (2014), http://www.healthlaw.org/about/staff/michelle-lilienfeld/all-publications/Health-Advocate-August-2014.

[13] *See, e.g.,* CTRS. FOR MEDICARE & MEDICAID SERVS., PARITY COMPLIANCE TOOLKIT APPLYING MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY REQUIREMENTS TO MEDICAID AND

Health Official letter providing guidance on the application of MHPAEA to Medicaid MCOs, CHIP plans, and ABPs.[14] In that letter, CMS provided specific guidance for states on how to comply with the parity requirements in the Medicaid plans, but did not provide timelines for compliance.[15] In March of 2016, CMS issued final regulations detailing MHPAEA's application to Medicaid MCOs, CHIP plans, and ABPs; these regulations set forth a scheme for evaluating parity that is substantially similar to the parity requirements for large group, small group, and individual health plans.[16] Some key differences are discussed in the following section. CMS has also provided two "frequently asked questions" documents to clarify outstanding issues concerning the regulations.[17]

In addition to the guidance materials described above, CMS provides enforcement oversight for Medicaid parity compliance, including reviewing state plan amendments, managed care contracts, and states' evaluations and analysis to determine parity compliance.[18] CMS has committed to issuing subregulatory guidance for states regarding parity compliance and will provide technical assistance to states in analyzing parity compliance in benefit design and medical management techniques.[19] For Alternative Benefit Plans (ABPs), CHIP plans, and state Medicaid plans using MCOs, states were required to comply with the parity requirements by October of 2017.[20] Many states, including California, Colorado, Iowa, New Hampshire, and Tennessee, have made their compliance plan reports available online.[21]

CHILDREN'S HEALTH INSURANCE PROGRAMS (2017), https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf.

[14] CMS, *supra,* note 9.

[15] *Id*.

[16] Mental Health Parity Application to Medicaid MCOs, ABPs, and CHIP Final Rule, 81 Fed. Reg. at 18390. For a comprehensive description of the rules that apply to large group, small group, and individual health plans, see ELIZABETH EDWARDS, NAT'L HEALTH LAW PROG., MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (2014), http://www.healthlaw.org/about/staff/elizabeth-edwards/elizabeth-edwards-publications/issue-brief-mhpaea2008.

[17] CTRS. MEDICARE & MEDICAID SERVS., FREQUENTLY ASKED QUESTIONS: MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY FINAL RULE FOR MEDICAID AND CHIP (2016), https://www.medicaid.gov/medicaid/benefits/downloads/faq-cms-2333-f.pdf [hereinafter CMS FAQ #1]; CTRS. MEDICARE & MEDICAID SERVS., FREQUENTLY ASKED QUESTIONS: MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY FINAL RULE FOR MEDICAID AND CHIP (2017), https://www.medicaid.gov/federal-policy-guidance/downloads/faq101117.pdf [hereinafter CMS FAQs #2].

[18] Mental Health Parity Application to Medicaid MCOs, ABPs, and CHIP Final Rule, 81 Fed. Reg. at 18418.

[19] *Id.*

[20] 42 C.F.R. § 438.930 (states using MCOs); *id.* § 440.395(e)(4) (ABPs); *id.* § 457.496(g) (CHIPs).

[21] *See* STATE OF CAL. HEALTH & HUM. SERVS. AGENCY, MEDICAID MENTAL HEALTHY PARITY AND ADDICTION EQUITY ACT COMPLIANCE PLAN (2017), http://www.dhcs.ca.gov/formsandpubs/Documents/Parity_Compliance_Plan_9.29.2017.pdf; Colo. Dep't Health Care Policy & Financing, Mental Health Parity and Addiction Equity Act (MHPAEA): Analysis and Demonstration of Compliance for Colorado's Medicaid and Children's

Scope of State's Requirement to Evaluate Parity for Medicaid/CHIP Plans

The MHPAEA parity requirement applies to all benefits provided through an ABP in a state Medicaid program, through CHIP, or to enrollees of an MCO (for all services furnished by that MCO, a PIHP, a PAHP, or through a fee-for-service (FFS) delivery mechanism).[22] There are four classifications subject to the parity analysis: inpatient, outpatient, emergency benefits, and prescription drugs.[23] Parity analysis for Medicaid includes long-term services and supports (LTSS), and CMS has clarified that for LTSS services that could be defined as either mental health and substance use disorder (MH/SUD) or medical/surgical (M/S), the state may define the benefit using a reasonable method.[24] CMS has also clarified that parity analysis will not be required for

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Health Insurance Programs (2017), https://www.colorado.gov/pacific/sites/default/files/MHPAEA%20Analysis.pdf; IOWA DEP'T HUM. SERVS., MENTAL HEALTH PARITY COMPLIANCE REPORT (2017), https://dhs.iowa.gov/sites/default/files/MH_Parity_Report_Oct2017.pdf; N.H. DEP'T HEALTH & HUM. SERVS., MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY (2017), https://www.dhhs.nh.gov/ombp/medicaid/documents/parity-analysis-100217.pdf; TENN. DEP'T FIN. & ADMIN., MENTAL HEALTH PARITY IN THE TENNCARE AND COVERKIDS PROGRAMS (2017), https://www.tn.gov/assets/entities/tenncare/attachments/MentalHealthParity.pdf. Some states were granted an extension by CMS.

[22] CMS FAQs #2, *supra,* note 17 at 1. For mental health parity to apply in Medicaid, the initial question is whether the individual is enrolled in a Managed Care Organization as defined in 42 C.F.R. § 438.2. PIHPs and PAHPs are required to comply with mental health parity requirements when providing coverage for MCO enrollees. *See* Mental Health Parity Application to Medicaid MCOs, ABPs, and CHIP Final Rule, 81 Fed. Reg. at 18394. The prohibition on annual and lifetime limits in section 2711 of the PHSA does not apply to ABPs that are not offered by an MCO or by a PIHP, or PAHP to enrollees of an MCO, although the financial requirements and treatment limitations components of mental health parity would still apply. *Id.*; 42 C.F.R. §§ 440.396, 438.900 & 438.930. If a group of beneficiaries are covered only through a FFS or PCCM delivery system, even if services for other beneficiaries are delivered through a managed care delivery system, mental health parity does not apply to the FFS or PCCM beneficiaries, although states are strongly encouraged to comply with parity for all beneficiaries. Mental Health Parity Application to Medicaid MCOs, ABPs, and CHIP Final Rule, 81 Fed. Reg. at 18403. Similarly, where a state uses a PCCM program to provide medical/surgical services and uses a PIHP or PAHP to provide MH/SUD services, a state is not using a MCO at all and thus would not be required to meet the requirements of part 438 of the Rule (regarding mental health parity in Medicaid managed care). *Id.* at 18414.

[23] Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68239 (Sept. 13, 2013) (codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590), https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf [hereinafter MHPAEA Final Rule].

[24] CMS FAQ #2, *supra,* note 17 at 2.

PAHPs that furnish only non-emergency medical transportation (NEMT), or for NEMT provided through other delivery systems, including MCOs, the state plan brokerage option, Medicaid FFS, or as a Medicaid administrative activity.[25]

CMS has also provided clarifications concerning nonquantitative treatment limits (NQTLs), such as pre-authorization requirements.[26] When subject to parity, Medicaid programs and CHIPs cannot impose NQTLs on MH/SUD benefits in any classification unless the processes, strategies, evidentiary standards or other factors for applying the limitation are comparable to and no more stringent than the limitations applied to medical/surgical benefits.[27] NQTL analysis does not apply to eligibility determinations and eligibility criteria for participation in a Medicaid program or CHIP.[28] However, states or MCOs must conduct NQTL analysis to determine if a prior authorization requirement for outpatient MH/SUD benefits complies with parity.[29]

Applying Parity Analysis for ABPs, Medicaid and CHIP Plans

In Medicaid, including CHIPs that are a part of state Medicaid programs, parity analysis must be performed by states, except that they may be performed by MCOs when the MCO provides all MH/SUD services to beneficiaries.[30] Where a separate CHIP provides benefits via an MCO, the MCO or the state may conduct the parity analysis.[31] However, the state is ultimately responsible for ensuring parity in CHIP, regardless of how benefits are delivered.[32] All Medicaid and CHIP MCO contracts must require parity compliance; CMS will review parity provisions in these contracts as part of the normal contract review process.[33] If a state or MCO determines that it is out of compliance with parity, it must take corrective action to achieve compliance.[34] CMS recommends that states develop monitoring strategies to ensure ongoing parity compliance with respect to

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[25] *Id.*

[26] *See* Mental Health Parity Application to Medicaid MCOs, ABPs, and CHIP Final Rule, 81 Fed. Reg. 18401.

[27] *See id.* (a state ABP plan cannot require preauthorization for all outpatient substance use disorder services when preauthorization is not required for any outpatient medical/surgical services); *see also* MHPAEA Final Rule, 78 Fed. Reg. at 68282.

[28] CMS FAQ #2, *supra,* note 17 at 2-3.

[29] *Id.*

[30] 42 C.F.R. § 438.902; *see also* Mental Health Parity Application to Medicaid MCOs, ABPs, and CHIP Final Rule, 81 Fed. Reg. at 18414. The State agency is the responsible party for the parity analysis when the MCO is not providing all MH/SUD services to Medicaid beneficiaries. Parity compliance is imposed on the MCO by statute when the MCO provides all medical/surgical and MH/SUD benefits. *Id.*; *see also* CMS FAQ #1, *supra*, note 17, at 2-3. For a detailed discussion of how a parity analysis is performed, see EDWARDS, *supra*, note16, at 8-10.

[31] CMS FAQ #2, *supra*, note 17, at 1.

[32] CMS FAQ #1, *supra*, note 17, at 3.

[33] CMS FAQ #2, *supra*, note 17, at 4.

[34] CMS FAQ #1, *supra*, note 17, at 2-3.

authorization denial rates, although such documentation is not required as part of the NQTL analysis.[35]

Conclusion

Although Behavioral Health Parity has applied to ABPs, CHIP plans, and Medicaid plans that use an MCO to deliver services for many years, CMS has recently taken action to require states to demonstrate compliance. The requirement to submit compliance plans in late 2017 flows from the various guidance CMS has issued over the past several years to ensure that states and plans do not have in place policies and procedures that make access to mental health and SUDs more difficult than access to physical health benefits. State advocates should review their state's Parity Compliance Plans to ensure that the state has addressed any inappropriate barriers to mental health and substance use disorder benefits. State advocates should also consider parity when reviewing treatment limits, especially for mental health and substance use disorder benefits.

[35] CMS FAQ #2, *supra*, note 17, at 4.