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Summary of the Proposed Rule Applying Parity to Medicaid Managed Care, CHIP, and Alternative Benefit Plans

On April 10, 2015 the Department of Health and Human Services published a proposed rule in the Federal Register that would apply mental health (MH) and substance use disorder (SUD) parity to coverage offered by Medicaid managed care organizations (MCOs), the Children's Health Insurance Program (CHIP), and Medicaid Alternative Benefit Plans (ABPs). The proposed rule is detailed and comprehensive, and while we are generally very happy with the proposal, careful analysis is ongoing. The Coalition for Whole Health and other advocates are preparing comments and resources for the MH/SUD field to facilitate responses to the proposed rule by the June 9th deadline.

The Mental Health Parity and Addiction Equity Act (MHPAEA) was passed by Congress in 2008, and final regulations governing how MHPAEA applies to commercial health insurance coverage were published in 2013. MHPAEA also applied parity to Medicaid MCOs. When CHIP was reauthorized in 2009 Congress extended the requirements of MHPAEA to all CHIP plans, and the Affordable Care Act extended parity to all Medicaid ABPs in 2010.

MHPAEA's requirements include that:

- Financial requirements and treatment limitations imposed on MH/SUD benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits;
- There are no separate financial requirements or treatment limitations that apply only to mental health or substance use disorder services;
- Criteria for making medical necessity determinations is made available to any enrollee, potential enrollee, or participating provider upon request, and that the reason for the denial of payment or reimbursement for a MH or SUD service be made available within a reasonable period;
- If a plan provides out-of-network coverage for medical/surgical benefits, it must also provide out-of-network coverage for MH/SUD benefits.

The proposed Medicaid MCO, CHIP, and ABP parity rule is generally similar to the final MHPAEA regulations that apply to private market coverage, however the parity requirements in the proposed rule differ in some important ways from the commercial coverage requirements. Below is a summary of the proposed rule.

Application of parity to Medicaid MCOs

Coverage of MH and SUD services varies among state Medicaid programs. Most MH/SUD services are not mandatory under federal Medicaid law and states therefore have flexibility about what MH/SUD services to cover, if any, and what treatment limits to place on that coverage. States also have flexibility to design delivery mechanisms for MH/SUD and other services, such as through fee-for-service arrangements, managed care, or prepaid health plans. In addition, many states choose to deliver Medicaid services through a combination of structures; they often provide most medical/surgical services through MCOs and "carve out" MH/SUD from those MCO contracts, and instead deliver MH/SUD services through a fee-for-service or prepaid health plan arrangement.

While parity does not apply to traditional fee-for-service Medicaid coverage, the proposed rule clarifies that parity protections apply to all beneficiaries who are enrolled in a MCO for delivery of any services. Requiring parity in MH/SUD carve-out arrangements is a considerable departure by CMS from its suggestion in a 2013 letter to states that carve-out arrangements using prepaid health plans would not have to comply. Such a policy, had it been adopted, would have severely limited the impact of parity in a number of states.

Medicaid programs with multiple delivery model structures make parity determinations somewhat more difficult than in the commercial market, where such arrangements don't exist. In the proposed rule, CMS would give carve-out states two options for bringing their Medicaid programs into compliance. The first option would be for the state to amend its state plan to ensure that MH/SUD services provided on a fee-for-service basis complied with parity when combined with the medical/surgical services provided by the MCO. This option would also result in parity protections being indirectly applied to fee-for-service beneficiaries who are not covered under MHPAEA, an approach that would improve coverage for those beneficiaries and likely reduce administrative burdens for these states. The second option would be for the state to include relevant MH/SUD services in the MCO or prepaid health plan contract, in which case the MCO or prepaid health plan would be responsible for complying with parity. CMS explains its intent is to require states that use carve-outs to provide evidence of parity compliance when they submit their MCO contracts to CMS for approval.

In the discussion of the proposed rule, CMS explains that they considered requiring that all state plan MH/SUD services be included in the MCO contract as the best way to ensure that MCO enrollees received the full protections of parity. However, given the wide range of configurations across states and the potential disruptions such a requirement would have, CMS proposes to require parity analyses across the overall delivery system, including carve-outs. CMS is soliciting comments on their intended approach.

In managed care states without carve-outs—those states where the MCO has sole responsibility for the MH/SUD and medical/surgical coverage—CMS proposes to require the MCO to undertake the parity analysis and inform the state of any changes needed in the MCO contract. In states with carve-out arrangements, the state would be responsible for conducting the parity analysis across delivery systems to bring MH/SUD coverage into compliance.

The proposed rule also discusses responsibility for any increased costs associated with parity compliance. CMS intends to require that any additional costs be incorporated into the rates paid to MCOs and prepaid health plans that provide MH/SUD services. By building any costs into the capitated rates paid by the state, the Medicaid program rather than the plan would be responsible for the costs of parity compliance.

CMS similarly proposes not to include an increased cost exemption for managed care plans in the Medicaid regulations, both because plans will not be responsible for any increased costs and because parity compliance has had little impact on health plan costs in the commercial market. CMS also notes that bringing Medicaid coverage into compliance with parity may save money, as beneficiaries will better be able to access services for MH/SUD conditions that, when untreated, often contribute to higher healthcare costs.

Application of parity to CHIP

The CHIP Reauthorization Act of 2009 extended parity to all CHIP plans, regardless of whether services are provided through a managed care or fee-for-service arrangement. CHIPRA also applied parity to CHIP somewhat differently than parity applies to Medicaid managed care. For example, under the statute if the CHIP state plan provides full coverage of EPSDT, which provides comprehensive health care services for children under age 21, then parity requirements are deemed met, although the proposed rule clarifies that any non-quantitative treatment limits (NQTLs) placed on EPSDT coverage must meet parity requirements. CHIPRA also applies MHPAEA to CHIP "in the same manner as such requirements apply to a group health plan." The proposed rule reflects these differences.

Application of parity to ABPs

The Affordable Care Act applied the requirements of MHPAEA to Medicaid ABPs, which is the Medicaid coverage that is required for most beneficiaries of the ACA's Medicaid expansion and that's optional for certain others. The proposed rule applies parity to ABP benefits delivered through managed care in the same way it applies parity to other Medicaid managed care enrollees, and separately applies the financial requirement and treatment limitation protections of parity to fee-for-service ABP beneficiaries. CMS notes in the proposed rule that ABPs must provide the ten categories of essential health benefits, which includes MH/SUD benefits, in addition to meeting parity. The proposed rule also

excludes fee-for-service ABP coverage from parity's requirements related to in-network and out-of-network access, because there are no such networks in a fee-for-service system.

Determining parity compliance

The proposed rule generally uses the same methods as the final MHPAEA rule to determine whether coverage is in compliance with parity, with some notable differences. For example, the proposed rule reduces the number of benefit classifications from the MHPAEA final rule's six to four for Medicaid managed care, CHIP, and ABPs. The six benefit classifications used to determine parity for commercial coverage are inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency services; and prescription drugs. The proposed rule eliminates the in-network/out-of-network distinction to reflect unique cost-sharing and network protections given to beneficiaries in Medicaid and CHIP, and proposes to analyze parity for these programs through inpatient, outpatient, emergency services, and prescription drug classifications. All Medicaid, CHIP, or ABP MH/SUD services and medical/surgical services, with the exception of long-term care services, would fall into one of the four classifications, and financial requirements and treatment limitations would be applied on a classification by classification basis.

The proposed rule would apply the MHPAEA final rule's "predominant/substantially all" test in the same way to Medicaid managed care, CHIP, and ABPs. Under the proposed rule, like the final MHPAEA rule for commercial coverage, a financial requirement or treatment limitation on a MH/SUD benefit would be prohibited if it is more restrictive than the "predominant" financial requirement or treatment limitation (that applied to more than half of the medical/surgical benefits) of that type applied to "substantially all" (at least two-thirds) of the medical/surgical benefits in the same classification.

In the final MHPAEA rule there was considerable discussion of "intermediate" services, or those MH/SUD services like residential, intensive out-patient, and partial hospitalization, that may not fit neatly into one of the classifications used for parity analysis. The proposed Medicaid/CHIP rule would allow the state or the MCO/prepaid health plan to assign intermediate services to a classification, as long as assignment is done in a consistent manner for medical/surgical services and MH/SUD services, just as it requires for other services.

Other important provisions of the proposed rule

Finally, the proposed rule includes other notable provisions that apply to Medicaid managed care, the CHIP program, and ABPs. These include:

- Duplicating the requirements related to NQTLs from the final MHPAEA rule, including the "comparable to and applied no more stringently" standard;
- Allowing quantitative treatment limits and financial requirements to accumulate separately for MH/SUD benefits and medical/surgical benefits, unlike the final MHPAEA rule, because CMS believes that requiring benefits in a classification to accumulate jointly would be operationally difficult for states with multiple delivery systems;
- Excluding long term care services from parity analysis, because the kinds of long-term care services and supports provided by Medicaid and CHIP are not commonly provided by commercial coverage and CMS claims that including long-term care in parity analyses is beyond what Congress intended;
- Allowing MCOs or prepaid health plans to subdivide the prescription drug classification into tiers based on reasonable factors and without regard to whether a drug is generally prescribed for medical/surgical benefits or MH/SUD benefits;
- Retaining the same sub-classification allowance and limits as the final MHPAEA rule, which would allow plans to, for example, sub-classify office visits from other outpatient services;
- Maintaining essentially the same disclosure requirements as the final MHPAEA rule, while noting that there are much stronger appeals protections for Medicaid and CHIP than for enrollees in commercial insurance coverage;
- Not applying parity to Medicare beneficiaries enrolled in Medicaid MCOs, because Medicare benefits are governed by Medicare law and regulations;
- Maintaining similar scope of service requirements for Medicaid managed care, CHIP, and ABPs as required by the final MHPAEA rule, and not requiring coverage of any specific service beyond what is covered by the contract;
- Citing the ability of CMS to withhold federal financial participation from a state that has not documented parity compliance.

The parity requirements for Medicaid managed care, CHIP, and ABPs would go into effect 18 months after the proposed rule is finalized. CMS argues that states and MCOs need the time to bring their programs into compliance, however many in the MH/SUD fields will argue in comments that beneficiaries need enforceable parity protections in place sooner than CMS is proposing.

CMS estimates that the proposed rule will impact 21.6 million Medicaid beneficiaries and 850,000 CHIP beneficiaries, although CMS has strongly urged states to implement parity in a way that applies protections to additional beneficiaries not required to be included by federal law. As a result, millions more may benefit from parity indirectly.

Comments on the proposed rule are due to CMS by June 9, 2015. The Coalition for Whole Health will be developing its own comments and additional materials to support comments from other organizations across the MH/SUD and broader health fields.