

STRATEGIES FOR STATE OVERSIGHT OF IMPLEMENTATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT IN ALTERNATIVE BENEFIT PLANS

ABOUT THIS TOOL

This tool is designed to assist states in overseeing implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) with respect to the Alternative Benefit Plans (ABPs) for their enrollees. This tool suggests strategies that states can use to assess whether managed care organizations (MCOs) are complying with MHPAEA.¹

Information about the application of MHPAEA to Medicaid MCOs, the Children's Health Insurance Program, and ABPs was provided by the Centers for Medicare & Medicaid Services (CMS) in a State Health Officials (SHO)/State Medicaid Directors (SMD) letter issued on January 16, 2013 (SHO #13-001, ACA #24). The SHO/SMD letter is available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>. The tool is designed to build on the guidance provided in the SHO/SMD letter.

HOW TO USE THIS TOOL

This tool is designed primarily for state monitoring of MCOs' compliance with parity. The tool identifies the MHPAEA standards, the types of evidence states should consider in assessing whether or not their MCOs comply with MHPAEA, and additional information to facilitate assessment of MCO compliance.

Although MHPAEA applies when states carve out MH/SUD services to separate behavioral health organizations or that provide services through a fee-for-service Medicaid program, this tool is not specifically designed for those situations. States are encouraged to develop a methodology to establish that Medicaid beneficiaries receive MH/SUD services and medical/surgical services at parity under these other payment mechanisms.

¹ This includes arrangements in which the MCO is capitated for both MH/SUD and medical/surgical benefits, as well as when MCOs subcapitate a separate vendor for delivering MH/SUD services. The MCO remains responsible for compliance with MHPAEA when it carves-out MH/SUD benefits to a separate vendor.

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MHPAEA Standard	Evidence to Consider	Comments
Quantitative Financial Requirements and Treatment Limitations		
<p>Does the plan comply with the mental health parity requirements for parity in financial requirements and quantitative treatment limitations?</p> <p>A plan may not impose a financial requirement or quantitative treatment limitation applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. See 45 CFR 146.136(c)(2). Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. See 45 CFR 146.136(c)(1)(ii).</p> <p>Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. See 45 CFR 146.136(c)(1)(ii).</p> <p>The six classifications of benefits are:</p> <ul style="list-style-type: none"> • inpatient, in-network; • inpatient, out-of-network; • outpatient, in-network; • outpatient, out-of-network; • emergency care; and • prescription drugs. <p>See 45 CFR 146.136(c)(2)(ii).</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Member handbooks (description of benefits) <input type="checkbox"/> Enrollee notices of coverage denials <input type="checkbox"/> Appeals notices and enrollee rights <input type="checkbox"/> Consumer complaints regarding coverage of mental health services <input type="checkbox"/> Records of coverage appeals <input type="checkbox"/> Records of grievances <input type="checkbox"/> Records of beneficiary requests/complaints <input type="checkbox"/> MCO network directories 	<p>State Medicaid programs establish benefits, quantitative treatment limitations, and financial requirements as part of their state plans. MCOs are obligated to manage and pay for these benefits consistent with state plan parameters pursuant to their state contracts. State contracts would need to comport with parity between MH/SUD and medical/surgical benefits, with regard to quantitative treatment limitations (e.g., day and visit limits) and financial requirements (e.g., deductibles, copayments, coinsurance, and out-of-pocket maximums) that are put in place by the MCO as opposed to the state plan.</p> <p>States may use the evidence to ensure that MCOs are complying with federal parity requirements, and disseminating accurate information about parity in MH/SUD and medical/surgical benefits to providers and members.</p>

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<p>(Note: For outpatient services a plan may establish two sub-classifications of benefits: (1) office visits and (2) all other outpatient items and services. The plan could then apply this financial requirement and treatment rule separately to each of these two sub-classifications. See 45 CFR 146.136(c)(3)(iii)(C).</p> <p>A plan may subclassify in-network services by tiers of providers, such as preferred versus participating providers, as long as the tiers are established by reasonable criteria. Once subclassifications are established, the comparisons between medical/surgical services and MH/SUD services are made within each subclassification. See 45 CFR 146.136(c)(3)(iii)(B).</p> <p>A plan may satisfy the parity requirements for quantitative treatment limitations for prescription drugs by establishing tiers of drugs that apply uniform financial requirements to drugs within the tier, irrespective of whether they are prescribed principally for MH/SUD or medical/surgical conditions, as long as the plan uses reasonable criteria to establish the tiers. See 45 CFR 146.136(c)(3)(iii)(A).)</p>		
Benefits Classification		
<p>Does the MCO comply with the mental health parity requirements for coverage in all classifications?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> MCO contracts <input type="checkbox"/> Member handbooks <input type="checkbox"/> Consumer complaints regarding 	<p>States may use the evidence to: (1) evaluate the settings in which MH/SUD benefits are offered, in comparison with the settings where medical/surgical benefits are offered; (2) analyze</p>

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MHPAEA Standard	Evidence to Consider	Comments
MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. See 45 CFR 146.136(c)(2)(ii)(A).	<ul style="list-style-type: none"> <input type="checkbox"/> coverage of mental health services <input type="checkbox"/> Enrollee notices of coverage denials <input type="checkbox"/> Appeals notices and enrollee rights <input type="checkbox"/> Records of coverage appeals <input type="checkbox"/> Records of grievances <input type="checkbox"/> Records of beneficiary requests/complaints <input type="checkbox"/> MCO network directories <input type="checkbox"/> Claims/encounter data 	whether MH/SUD benefits are offered in the same classifications as compared with the classifications where medical/surgical benefits are offered; and (3) ensure that MH/SUD benefits are consistently assigned to one of the six benefit classifications using the same standards applied to medical/surgical benefits. For example, intermediate MH/SUD benefits (e.g., residential treatment facilities for MH/SUD) must be assigned to the six benefit classifications in the same way that comparable medical/surgical benefits are assigned.
Nonquantitative Treatment Limitations		
<p>Does the MCO comply with the provisions for parity with respect to nonquantitative treatment limitations?</p> <p>Nonquantitative treatment limitations (NQTLS) limit the scope or duration of benefits for treatment, without involving a numerical limitation.</p> <p>An MCO may not impose an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan (as written and in operation), any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the NQTL with respect to medical/surgical benefits in the classification. See 45 CFR</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Member handbooks <input type="checkbox"/> Standards for medical necessity for medical surgical and MH/SUD benefits <input type="checkbox"/> Prior authorization requirements and policies <input type="checkbox"/> Concurrent review requirements and policies <input type="checkbox"/> Retrospective review requirements and policies <input type="checkbox"/> Data showing number of approvals (e.g., prior authorization, medical necessity, etc.) for medical /surgical and MH/SUD services <input type="checkbox"/> Data showing number of and reasons for denials (e.g., prior authorization, medical necessity, etc.) of medical /surgical and MH/SUD services 	<p>States may use the evidence to (1) evaluate documentation of MCO NQTL standards to ensure that they are comparable across medical/surgical and MH/SUD benefits; (2) monitor potential differential application of NQTLS for medical/surgical and MH/SUD benefits; (3) ensure that the MCO formulary for MH/SUD is provided in parity with the medical/surgical prescription drug benefit; and, (4) ensure that NQTLS are not designed or used to restrict access to MH/SUD benefits. Following are three examples of how a state could evaluate MCOs. Additional examples are available in the final rule.</p> <p>EXAMPLE 1: Plan X covers neuropsychological testing but only for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing the clinical efficacy of such testing for different conditions</p>

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<p>146.136(c)(4)(i).</p> <p>Following is an illustrative, nonexhaustive list of NQTLs. See 45 CFR 146.136(c)(4)(ii):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative <input type="checkbox"/> Formulary design for prescription drugs <input type="checkbox"/> Standards for provider admission to participate in a network, including reimbursement rates <input type="checkbox"/> Plan methods for determining usual, customary, and reasonable charges <input type="checkbox"/> Refusal to pay for higher-cost therapies until it can be shown that a lower cost therapy is not effective (also known as fail-first policies or step therapy protocols) <input type="checkbox"/> Exclusions based on failure to complete a course of treatment <input type="checkbox"/> Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage 	<ul style="list-style-type: none"> <input type="checkbox"/> Descriptions of other non-quantitative treatment limitations (such as step therapy protocols) <input type="checkbox"/> Drug formularies <input type="checkbox"/> Narrative descriptions/interviews with MCO officials on how NQTLs are developed <input type="checkbox"/> MCO documentation of how NQTLs are developed <input type="checkbox"/> Standards for admission to provider network <input type="checkbox"/> Standards for developing provider reimbursement rates <input type="checkbox"/> Enrollee notices of coverage denials <input type="checkbox"/> Appeals notices and enrollee rights <input type="checkbox"/> Records of coverage appeals <input type="checkbox"/> Records of grievances <input type="checkbox"/> Records of beneficiary requests/complaints 	<p>and the degree to which such testing is used for educational purposes with regard to different conditions. Does the plan have documentation indicating that comparable criteria are used for MH/SUD and medical conditions in determining which conditions to cover for neuropsychological testing, as well as evidence showing that the plan applied these criteria no more stringently for behavioral health diagnoses?</p> <p>EXAMPLE 2: Plan Y applies concurrent review to inpatient psychiatric care and retrospective review for general medical hospitalizations that are reimbursed based on diagnosis related group (DRG) codes. The plan explains that DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. Thus, it appears that concurrent management by the plan is clinically appropriate and permissible for psychiatric hospitalizations as long as general medical hospitalizations that are not reimbursed based on DRGs are also subject to concurrent review.</p> <p>EXAMPLE 3: Master’s degree training and state licensing requirements often vary. Plan Z consistently applies its standard that any provider must meet whatever is the most stringent licensing requirement standard related to supervised clinical experience requirements in order to participate in the network. Therefore, Plan Z requires master’s-level therapists to have post-degree, supervised clinical experience in</p>

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		order to join their provider network. There is no parallel requirement for master’s-level general medical providers because their licensing does not require supervised clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD level psychologists since their licensing already requires supervised training. The requirement that master’s-level therapists must have supervised clinical experience to join the network is permissible, as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers.
Disclosure Requirements		
<p>Does the plan comply with the mental health parity disclosure requirements?</p> <p>The MCO must make available the criteria for medical necessity determinations made with respect to MH/SUD benefits (or plan coverage with respect to MH/SUD benefits) to any current or potential beneficiary or contracting provider upon request. See 45 CFR 146.136(d)(1).</p> <p>The MCO must make available the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits to any beneficiary. See 45 CFR 146.136(d)(2).</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Member handbooks <input type="checkbox"/> Coverage determination notices <input type="checkbox"/> Claims and appeals processing manuals <input type="checkbox"/> Appeals notices and enrollee rights <input type="checkbox"/> Standards for medical necessity for MH/SUD and medical/surgical benefits <input type="checkbox"/> Information regarding processes, evidentiary standards, and other factors used to apply medical necessity and other NQTLs to MH/SUD benefits 	<p>The state should evaluate whether the MCO notices and procedures satisfy the MHPAEA disclosure requirements. The state should look at general medical necessity criteria applicable to medical/surgical and MH/SUD benefits and also the processes, evidentiary standards, and other factors used to apply medical necessity criteria and other NQTLs in connection with specific adverse benefit determinations.</p>