

## **SUMMARY OF KEY PROVISIONS IN MEDICAID PARITY FINAL RULE**

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On March 29, 2016, the Centers for Medicare and Medicaid Services (CMS) released a final rule on the application of requirements in the Mental Health Parity and Addiction Equity Act (MHPAEA) to coverage offered by Medicaid managed care organizations, Medicaid Alternative Benefit Plans and Children's Health Insurance Programs.

A copy of the rule, a CMS fact sheet and frequently asked questions and answers may be accessed [here](#). The final rule is effective on May 30, 2016.

Please find below a preliminary summary of key provisions in the final rule:

### **Compliance: Parity Analysis, Contracting Provisions & Online Disclosure**

- In a change from the proposed rule, the final rule clarifies that states have to review both medical/surgical benefits and mental health/substance use disorder (MH/SUD) benefits in order to determine compliance with the rule. (pages 93 – 94)
- The final rule specifies that information related to compliance with the rule must be made available on a state's website, that such documentation must be provided within 18 months of the date of publication of this final rule, and that the documentation must be updated with any changes to Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP) or Medicaid state plan benefits. (page 95)
- CMS notes additional sub-regulatory guidance will be released on the documentation that will be required to show compliance with the regulations and CMS is working with a contractor to "develop tools and provide technical assistance to states in completing the analysis of their delivery systems to ensure the benefit design and medical management techniques meet the requirements of these rules." (page 105)
- States are required to include contract provisions requiring compliance with parity standards in all applicable contracts for Medicaid managed care arrangements that provide services to enrollees in managed care organizations, including PIHPs and PAHPs. (page 114)

### **Long Term Care**

- In a change from the proposal rule, the final rule includes long term care services in the definitions of medical/surgical, mental health and substance use disorder benefits and the application of parity protections to such long term care services. Additional information will be provided to States regarding how long term care services would be classified in the four areas (inpatient, outpatient, pharmacy and emergency). (page 14)

### **Compliance Date**

- States have up to 18 months to comply with the final rule. (pages 117 - 118)
- In a change from the proposed rule, contracts with MCOs, PIHPs, and PAHPs offering Medicaid state plan services to enrollees must comply with the final rule's requirements no later than 18 months after the date of publication, regardless of whether that date is the start or middle of a contract year. (In the proposed rule, because a contract date could have begun just before date of publication, a plan could have been potentially allowed an additional 12 months to comply.)

## Enforcement

- While CMS will review documents submitted by the state, including documentation of analysis conducted to determine that the state's system and/or benefit design meet the final rule's requirements, states will be the primary oversight entity to ensure services are delivered in compliance with the final rule. (pages 105 – 106)
- Beneficiaries and stakeholders are directed to submit compliance issues to the state. However, CMS will accept compliance complaints around the final rule and may discuss issues with states to determine whether corrective actions are needed.

## Application of Parity Protections to Beneficiaries in MCOs, ABPs & CHIP

- The final rule requires that all beneficiaries who receive services through MCOs, ABPs, or CHIP be provided access to mental health and substance use disorder benefits that comply with parity standards, regardless of whether these services are provided through the managed care organization or another service delivery system. (page 80)

The final rule states, "If states carve out some MH/SUD services from the MCO contract and furnish those services by PIHPs, PAHPs, or through FFS [Fee-for-Service], we are applying the parity requirements to the entire package of services MCO enrollees receive."

## Disclosure

- The final rule requires managed care entities to make available upon request to beneficiaries and contracting providers the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits. (page 175)
- The rule also directs managed care plans to make available to the enrollee the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits. (page 175)

## NQTLs

- The final rule adopts the same approach to non-quantitative treatment limitations (NQTLs) as the MHPAEA final regulation, which prohibits the use of an NQTL unless it is "comparable to and applied no more stringently than factors used in applying the limitation for medical/surgical benefits in the classification. For these purposes, factors mean the processes, strategies, evidentiary standards, or other consideration used in determining limitation on coverage of services." (page 37)
- The proposed rule required use of the "same" standards regarding access to out-of-network providers. To more closely align with the general NQTL requirement, the final rule requires the use of "comparable" standards.

The final rule states, "We are revising the proposed regulation in this final rule for consistency with the general NQTL standard, to require that the factors used in determining access to out-of-network providers for MH/SUD benefits be comparable to and applied no more stringently than the factors used in determining access to out-of-network providers for medical/surgical benefits in the classification, rather than requiring that the same factors be applied in both sets of benefits." (page 38)

- The final rule prohibits the application of NQTLs (including prior authorization or other utilization management techniques) on medication assisted treatment (MAT) for MH/SUD unless "any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to the MH/SUD benefit are comparable to, and are applied no

more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the same classification.” (page 98)

#### **Definition of “MH/SUD Conditions”**

- The final rule allows states to identify which conditions are considered medical/surgical and MH/SUD conditions, which should be consistent with generally recognized independent standards of current medical practice. (pages 15 – 16)
- The final rule states, “Any condition defined by the State as being or not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD or State guidelines.” (page 178)

#### **IMD**

- The final rule does not modify the existing statutory Institution for Mental Disease (IMD) exclusion but notes the Medicaid Managed Care rule, which did address IMD, has not been finalized and CMS will provide guidance and technical assistance once that rule is released. (page 125)