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A Review of the Final Medicaid Parity Rule as Applied to Massachusetts

Clare McGorrian, Director
Mental Health Parity and Addiction Equity Initiative

On March 30, 2016 the U.S. Department of Health and Human Services (HHS) issued a Final Rule applying the federal Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid Managed Care Organizations (MCOs), Alternative Benefit Plans (ABPs), and the Children's Health Insurance Plan (CHIP). This measure, which took effect May 31, 2016 and requires state compliance by September 30, 2017, follows a Proposed Rule issued on April 10, 2015. The Final Medicaid Parity Rule stands alongside another Final Rule, issued in November 2013, implementing federal parity requirements under MHPAEA with respect to group health plans, individual health plans, and non-federal government employee health plans for plan years beginning on or after July 1, 2014. The following is a summary and analysis of the key elements of the Medicaid Parity Rule and their application in Massachusetts.

MCOs and their behavioral health contractors are subject to the Medicaid Parity Rule.
Mental health and substance use disorder benefits offered through a Medicaid MCO are subject to parity requirements, regardless of whether the behavioral health benefits are delivered by the MCO, a Prepaid Inpatient Health Plan (PIHP), a Prepaid Ambulatory Health Plan (PAHP) or Fee-for-Service (FFS).[1] This is important in Massachusetts where the majority of Medicaid MCOs contract with a separate entity to administer behavioral health benefits.[2]

Alternative Benefit Plans (ABPs) offered through an MCO must comply with the Rule.
The Medicaid Parity Rule also applies, regardless of delivery system, to all beneficiaries enrolled in an Alternative Benefit Plan (ABP). However, only ABPs offered through an MCO must

[1] Both *prepaid inpatient health plans* (PIHPs) and *prepaid ambulatory health plans* (PAHPs) provide medical services to enrollees under contract with a state Medicaid agency, on the basis of prepaid capitation payments or other payment arrangements that do not use State Medicaid plan payment rates, and do not have a comprehensive risk contract. A PIHP provides, arranges for, or otherwise has responsibility for the provision of certain inpatient hospital or institutional services for its enrollees while a PAHP does not provide or arrange for, and is not otherwise responsible for the provision of any such inpatient or institutional services. The Massachusetts Behavioral Health Partnership (MBHP) is considered a PIHP.
[2] Neighborhood Health Plan, Fallon Health and Boston Medical Center HealthNet Plan all contract with Beacon Health Strategies to manage mental health and substance use disorder benefits for MassHealth members; CeltiCare Health uses Cenpatico to manage behavioral health benefits; and Health New England uses the Massachusetts Behavioral Health Partnership. Only Tufts Health Plan - Network Health internally manages behavioral health benefits for MassHealth enrollees.

comply with *all* of the Federal Parity Law requirements. ABPs offered on a fee-for-service basis must comply only with the financial requirements and treatment limitations rules. Since Massachusetts' ABP MassHealth CarePlus is primarily delivered through MCOs, the plan must comply with all aspects of the Rule.[3]

A separate State Children's Health Insurance Plan (CHIP) must comply in full with EPSDT requirements to satisfy the Medicaid Parity Rule.

The Medicaid Parity Rule applies to CHIP plans, regardless of whether benefits are offered through an MCO or on a fee-for-service basis. A state may demonstrate parity-compliance for a separate CHIP plan in one of two ways: 1) by electing in the state plan to cover all EPSDT services and meet EPSDT informing and administrative requirements (in this case compliance is "deemed"); or 2) for states that do not provide "full" EPSDT benefits in their separate CHIP plan, by satisfying the standards in the Medicaid Parity Rule.[4] . MassHealth Family Assistance is Massachusetts' separate CHIP program. Family Assistance covers non-disabled children from birth to 18 with family incomes between 150 percent (200 percent for under age 1) and 300 percent of the Federal Poverty Level. Family Assistance does not include Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits.[5] To comply with these standards, a separate CHIP must cover the same scope of services that a child covered by Medicaid would receive -- all benefits and services described in section 1905(a) of the Medicaid Act if medically necessary and consistent with section 1905(r) of the Medicaid Act.

Because section 1905(r) of the Medicaid Act prohibits the exclusion of services for particular conditions or diagnoses for children entitled to EPSDT services, a separate state CHIP that excludes any particular condition, disorder, or diagnosis cannot be deemed compliant with the Medicaid Parity Rule.

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[3] MassHealth CarePlus members may choose an MCO or the Primary Care Clinician (PCC) plan but the majority choose an MCO. *See* MassHealth All Provider Bulletin 255 (September 2015); MassHealth: The Basics, Facts and Trends, Blue Cross Blue Shield Foundation Massachusetts (updated June 2016).
The ABP must include Essential Health Benefits (EHBs), including MH/SUD benefits, as determined by reference to the state's benchmark insurance plan. Since Massachusetts' ABP is offered through MCOs, the prohibition on annual and lifetime limits for EHBs applies to CarePlus plans.

[4] *See* at 45 CFR §457.496. The EPSDT provisions of the Medicaid Act require that, for categorically needy Medicaid-eligible children under 21, a state must: 1) cover all services needed to correct or ameliorate defects and mental and physical illnesses or conditions; 2) cover screening and diagnostic services and medically necessary health care services or treatments (screening to be done at medically appropriate intervals); 3) provide and arrange for medically necessary screenings, diagnostic services, and treatments, and 4) inform eligible children about the full range of EPSDT services available to them.

[5] *See* R. Seifert, MassHealth and the Importance of Continued Federal Funding for CHIP, Massachusetts Medicaid Policy Institute, April 2015.

States not providing EPSDT in their CHIP program must prepare a full benefit and cost sharing analysis of the CHIP state plan, including assessment of any NQTLs that apply to behavioral health benefits, to determine compliance with the parity standards.

Parity requirements apply to Medicaid programs operated under a section 1115 demonstration waiver.

The Medicaid Parity Rule applies to MCOs and ABPs regardless of the authority a state employs for its Medicaid program. So, the MassHealth program, which is operated under a section 1115 demonstration waiver, must comply in full with the Medicaid Parity Rule. The Centers for Medicare and Medicaid Services (CMS) within HHS has stated that it will not approve waivers of the parity requirements in a request for (or renewal of) a section 1115 waiver.

The MassHealth Primary Care Clinician Plan, MassHealth Fee-for-Service and Medicare Benefits under OneCare are Exempt from the Medicaid Parity Rule.

The Medicaid Parity Rule does not apply to Medicaid state plan beneficiaries who are not enrolled in an MCO and therefore does not govern the MassHealth fee-for-service (FFS) plan.[6] The MassHealth Primary Care Clinician (PCC) Plan is not considered a Medicaid MCO for purposes of the Federal Parity Law and therefore is also not subject to the Medicaid Parity Rule. This is confusing because MassHealth treats the PCC plan as one of a member's managed care options. Finally, Medicare benefits offered through integrated plans for Medicaid/Medicare "dual eligibles" (OneCare in Massachusetts) are also exempt from the Medicaid Parity Rule. However, CMS has offered to provide technical assistance to states, such as Massachusetts, that are participating in the CMS Financial Alignment Initiative and implementing a capitated/managed care model (OneCare), on how to structure and assess a dual demonstration plan for compliance with MHPAEA with respect to Medicaid benefits.

The Medicaid Parity Rule is Applied within Classifications of Benefits.

The 2013 Final Rule for private health plans established six "classifications" of benefits: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency services, and prescription drugs. The Medicaid Parity Rule eliminates the in/out-of-network distinction, leaving only four classifications: inpatient, outpatient, emergency services, and prescription drugs. The Rule does not define what services are included in which classifications; however, all benefits should be assigned to a classification.

[6] MassHealth fee-for-service coverage is limited to individuals who have other primary insurance, such as through an employer or Medicare.

The Medicaid Parity Rule includes long term care services in medical/surgical, mental health, and substance use disorder benefits. This is a reversal from the 2015 Proposed Rule and also varies from the 2013 Final Rule for private plans, which does not address long term care services.

A Medicaid or CHIP plan subject to the Medicaid Parity Rule must assign all medical/surgical and MH/SUD benefits to a classification, including intermediate level services (e.g., partial hospitalization) and long term care services. In making such assignments, the plan must use the same reasonable standards for assigning medical/surgical services and MH/SUD services to a classification.

Further, states must indicate in their Medicaid state plan the standard used, such as state guidelines or the most current versions of the Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases (ICD), when classifying benefits under medical/surgical, mental health or substance use disorder categories.

A plan subject to the Medicaid Parity Rule may assign prescription drugs to tiers.

A Medicaid plan that has an outpatient drug benefit must include all "covered outpatient drugs," as defined under section 1927 of the Medicaid Act, when such drugs are prescribed for medically accepted indications.[7] Pursuant to the Medicaid Parity Rule, a Medicaid MCO, ABP or CHIP plan may subdivide the prescription drug classification into tiers if the tiering is based on reasonable factors and without regard to whether a drug is generally prescribed for medical/surgical benefits or for MH/SUD benefits. These plans may apply different levels of financial requirements and treatment limitations to different tiers of prescription drugs.

MassHealth MCOs, CarePlus and Family Assistance (CHIP) must comply with the Medicaid Parity Rule with respect to financial requirements and quantitative treatment limitations.

As under the 2013 Final Rule for private plans, the Medicaid Parity Rule mandates that financial requirements (e.g., copays, deductibles) and quantitative treatment limitations (e.g. number of

[7] "Covered outpatient drug" for purposes of the Medicaid program, means, in broad terms, a drug which may be dispensed only upon prescription, is FDA-approved for safety and effectiveness, is used for a medically accepted indication, and is not provided incident to services covered under another provision of the Medicaid Act (e.g., inpatient hospital services). *See* 42 U.S.C. 1396r–8(k)(2).

inpatient days or outpatient visits) applied to MH/SUD benefits be no more restrictive than the financial requirements and quantitative treatment limitations applied to medical/surgical benefits. The Medicaid Parity Rule adopts the "predominant level/substantially all" test set out in the 2013 Final Rule for private health plans. Parity analysis of financial requirements and quantitative treatment limitations must be applied by classification, using the same *type* of requirement/limitation within a classification. Thus, MassHealth MCOs, CarePlus, and Family Assistance (CHIP) may not apply any financial requirement or quantitative treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type that is applied to substantially all medical/surgical benefits in the same classification.

As for private plans under the 2013 Rule, a contractual exclusion of all benefits for a particular condition or disorder is not deemed a "treatment limitation" when applied to MassHealth MCOs and CarePlus plans. However, as noted above, Family Assistance (CHIP) cannot exclude coverage of particular conditions or disorders, consistent with the requirements of EPSDT.

In keeping with the 2013 Final Rule for private plans, for Medicaid MCOs, ABPs and CHIP plans, the portion of medical/surgical benefits in a classification subject to a financial requirement or quantitative treatment limitation is based on the dollar amount of all payments for medical/surgical benefits in the classification expected to be paid during the relevant year. For MCOs, PIHPS and PAHPs, this means dollar amounts for payment during a contract year. For ABPs and CHIP state plans, this means dollar amounts for the year starting the effective date of the approved ABP or CHIP state plan. An MCO that is responsible for coverage of MH/SUD benefits must determine the total amount projected to be expended; the state must make this determination when a PIHP or PAHP is used in conjunction with MCOs.

MassHealth MCOs, CarePlus and Family Assistance (CHIP) must satisfy parity requirements for non-quantitative treatment limitations.

Non-quantitative treatment limitations (NQTLs) include medical management standards such as prior authorization policies, standards for provider admission to a network, and other policies or practices that limit treatment but cannot be measured by a dollar figure or number.[8] MassHealth MCOs, CarePlus (as an ABP delivered through an MCO), and Family Assistance (CHIP) must

[8] However, benefit limits that allow an individual to exceed numerical limits for medical/surgical or MH/SUD benefits based on medical necessity are considered an NQTL.

ensure that any NQTLs used for MH/SUD benefits are comparable to, and applied no more stringently than, NQTLs used for medical/surgical benefits in the same benefit classification.[9]

States that apply NQTLs under a separate CHIP program must ensure that such limits are consistent with EPSDT requirements at section 1905(r)(5) of the Medicaid Act and are applied in keeping with the intent of MHPAEA.

An NQTL may not be imposed for MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any *factors* used in applying the NQTL to MH/SUD benefits in a classification are comparable to and applied no more stringently than factors used in applying the limitation for medical surgical/benefits in the classification. *Factors* in this context are the processes, strategies, evidentiary standards, and other considerations used in determining limitations on coverage of services.

NQTLs: Provider reimbursement methodologies and rates

Plans covered by the Medicaid Parity Rule may consider an array of factors in determining provider reimbursement methodologies and rates for medical/surgical services and MH/SUD services.[10] These factors are NQTLs which must be applied to MH/SUD services in a comparable manner to and no more stringently than those applied to medical/surgical services. As with private plans under the 2013 Final Rule, disparate results alone do not mean that the NQTLs used for provider reimbursement methodologies and rates fail to comply with the Rule.

NQTLs: Network adequacy and access to out-of-network providers

The Medicaid Parity Rule does not address network tiers because Medicaid cost-sharing rules are the same regardless of network status. This contrasts with treatment of private plans under the 2013 Final Rule. However, MCOs, PIHPs and PAHPs with network tiers must construct such tiers and provide access to them in a way that is consistent with the NQTL parity standard. If a provider network cannot provide necessary covered services to an enrollee, the MCO, PIHP or PAHP must adequately and timely cover these services out-of-network for as long as they are not available in-network. The Medicaid Parity Rule requires 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 same classification. (The April 2015 proposed rule required the

[9] As stated previously, the Medicaid Parity Rule does not require ABPs delivered on a fee-for-service basis to comply with the NQTL rule.

[10] These factors include but are not limited to service type, geographic market, demand for services, supply of providers, provider practice size, Medicare reimbursement rates, and training, experience and licensure of providers.

same factors.) States may not deem compliance with the Medicaid Parity Rule's requirements for access to out-of-network providers based on compliance with the provider network standard in the Medicaid managed care regulation.[11] Finally, CMS has declined to provide standards for number and types of providers that must be in a network to achieve network adequacy, on the grounds that doing so is beyond the scope of the Medicaid Parity Rule.

Plans subject to the Medicaid Parity Rule must disclose certain information, upon request, to enrollees, prospective enrollees and contracting providers.

The Medicaid Parity Rule requires that covered plans make medical necessary criteria and practice guidelines available to enrollees, potential enrollees and contracting providers. The Rule further requires that the reason for a denial of reimbursement or authorization be made available to the affected enrollee and provider. These requirements apply to MCOs and ABPs, and any contracting PIHPs or PAHPs, as well as CHIP plans.[12]

MCOs found to be in compliance with the Medicaid managed care regulation on disclosure will be deemed to meet the disclosure requirements of the Medicaid Parity Rule.[13]

CMS has declined to establish a firm time frame under the Medicaid Parity Rule for the release of medical necessity criteria and practice guidelines as required by this provision. CMS also declined to establish penalties for Medicaid MCOs, ABPs and CHIP plans that fail to make plan information available on a timely and accessible basis on the grounds that the Medicaid managed care rules address these concerns.[14]

Responding to a comment that licensed and proprietary criteria should not be required to be disclosed unless relevant to specific services and requested by current/prospective enrollees or contracting healthcare providers, CMS agreed that plans do not have to disseminate to the general public medical necessity criteria for specific treatments.

Notably, the Medicaid Parity Rule does not require covered plans to disclose to enrollees or providers the comparative information with respect to financial requirements and treatment

[11] This is a change from the April 2015 proposed rule.
[12] *See* 45 CFR §457.1130 and §457.1180 (state CHIP plans must issue a notice that includes the reasons why a determination was made).
[13] *See* 45 CFR §438.236(c) which requires dissemination of practice guidelines to all affected providers, and, upon request to enrollees and potential enrollees.
[14] *See* 45 CFR §438.236 and §438.404 (requiring MCOs to provide practice guidelines and medical necessity criteria for all benefits to enrollees and potential enrollees), 45 CFR §431.210 and §438.404 (requiring MCOs, PIHPs, PAHPs and states to provide the reason for a denial).

limitations (medical/surgical and MH/SUD benefits within a classification) that employer-sponsored health plans must release under the 2013 Final Rule for private plans.[15] Such comparative information must, however, be provided by MCOs to the state Medicaid authority.

Responsibility for the parity compliance analysis lies with the state or the Medicaid MCO depending on the delivery system for MH/SUD benefits.

The state must initially provide documentation supporting compliance with these rules when submitting MCO contracts to CMS for review and approval. In states where the MCO has responsibility for offering all medical/surgical and MH/SUD benefits, the MCO is responsible for the parity analysis and for working with the state on contract changes needed for parity compliance. The Medicaid Parity Rule does not require specific documentation from the MCOs when they complete the parity analysis. In states where some or all MH/SUD benefits are provided to MCO enrollees through PIHPs, PAHPs, or FFS, the state must undertake the parity analysis and determine if the benefits and any financial or treatment limitations are consistent with MHPAEA.

CMS rejected a recommendation that the parity analysis be completed annually, provided the state can show that neither the plans nor state have changed operations in a way that would affect compliance with the Medicaid Parity Rule.

The state must demonstrate compliance with the Medicaid Parity Rule within 18 months of the Rule's publication, by September 30, 2017, regardless of whether that date is at the start or in the middle of a contract year. (This period was shortened by 60 days from the Proposed Rule.) The state must post its parity analysis showing compliance on the state Medicaid program website. This documentation must be updated with any change in MCO, PIHP, PAHP or Medicaid state plan benefits.

Medical/surgical and MH/SUD benefits must both be reviewed to determine compliance.
Under the April 2015 Proposed Rule, states were required to review only MH/SUD services to ensure that the full scope of services (set of benefits available to the Medicaid beneficiary) meets the requirements. Consistent with the 2013 Final Rule for private health plans, the final Medicaid Parity Rule requires that the state review *both* medical/surgical and MH/SUD benefits to determine parity compliance.

[15] The right to this broader information derives from the Employee Retirement Income Security Act (ERISA) requirements. *See* Department of Labor, Employee Benefits Security Administration, FAQs about Affordable Care Act Implementation, Part 31 (April 20, 2016) on disclosure of information under MHPAEA.

States are primarily responsible for ensuring parity compliance.
States have primary responsibility for ensuring that services are covered in compliance with the Medicaid Parity Rule. CMS will review documents submitted by the states, including MCO contracts, State Plan Amendment (SPA) documents, and the state's parity analysis. CMS will also review a state's assurance as part of the CHIP or ABP SPA review process to ensure compliance with EPSDT requirements.

The state may adjust MCO capitated rates under certain circumstances.
A state's rate-setting structure may account for MH/SUD services covered by an MCO, PIHP, or PAHP in excess of services/treatment limits listed in the State plan if such services are necessary for the MCO, PIHP or PAHP to comply with the Medicaid Parity Rule. The state may adjust capitation rates to provide for additional MH/SUD services offered by MCOs, PIHPs or PAHPs only to the extent that these services are required by the Medicaid Parity Rule.

CMS may defer Federal Financial Participation if a MCO contract is not parity-compliant.
MCO, PIHP, and PAHP contracts must expressly require compliance with the Medicaid Parity Rule, as well as provide a methodology for establishing and demonstrating compliance. Where MH/SUD services outside of the MCO contract are needed to achieve parity compliance, the state must show how enrollees are provided these services. If the MCO contract does not demonstrate access to parity-compliant MH/SUD services in each classification in which medical and surgical services are provided, the state must submit supplemental materials to CMS or amend the MCO contract to demonstrate compliance. If a state fails to adequately demonstrate that an MCO's contract and practices comply with the Medicaid Parity Rule, CMS may defer federal financial participation (FFP) on expenditures for the MCO contract.

The Medicaid Parity Rule eliminates review of psychiatric admissions by the state agency.
Current Medicaid regulations require medical and other professionals at the Medicaid agency (or its designee) to evaluate a Medicaid beneficiary's need for a psychiatric hospital admission. The final Medicaid Parity Rule eliminates this requirement as it is more restrictive than medical management of medical and surgical hospital admissions.

The Medicaid Parity Rule leaves in place the IMD exclusion.
An Institution for Mental Disease (IMD) is a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. The IMD exclusion prohibits federal matching funds for services provided to Medicaid beneficiaries ages 21 to 64 who are inpatients in an IMD, and applies whether a facility is in or out-of-network. The IMD payment exclusion applies to all medical assistance

plans. The Medicaid Parity Rule leaves intact the IMD payment exclusion. To provide parity coverage of inpatient mental health or substance use disorders, a state may have to show that coverage of inpatient or residential MH/SUD services is provided in environments that treat both physical and mental health conditions.

CMS will provide technical assistance to states and MCOs.

CMS proposes to offer technical assistance to states and MCOs on the Medicaid Parity Rule, including: 1) educational materials about the parity requirements for MCOs, ABPs and CHIP plans; 2) strategies to ensure that managed care contracts reflect best practices and promote quality of care; 3) documentation that must be submitted with MCO contracts and ABP state plan amendments; and 4) analysis of state delivery systems to ensure parity-compliant benefit design and medical management techniques. CMS promises to identify and promote best practices and quality control strategies for states to help MCOs ensure that benefits and service delivery adheres to the requirements of parity. CMS specifically plans to release sub-regulatory guidance around the documentation required to show compliance with the Rule and proper implementation of the EPSDT benefit.