Proposed Rule for the Application of Mental Health Parity Requirements to Medicaid and CHIP Coverage

Medicaid and CHIP Payment and Access Commission
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MACPAC

Overview

- During this session we will:
  - Provide an overview of mental health parity laws and their application to Medicaid and CHIP
  - Describe key provisions of the proposed rule
  - Identify areas where CMS has requested public comments and where the Commission may wish to make comments

Medicaid and CHIP Coverage and Delivery of Mental Health Services

- Medicaid and CHIP coverage of most mental health and substance use disorder (MH/SUD) services is optional
  - Children are entitled to services as determined through EPSDT
- State use a variety of delivery systems
  - Fee for service
  - Managed care with a mental health carve-out to fee for service or to a specialty vendor
  - Comprehensive managed care

Statutory History

- 1996 Mental Health Parity Act (MHPA)
  - Required parity between medical and mental health benefits
  - Applied to aggregate lifetime and annual dollar limits
- 1997 Balanced Budget Act (BBA)
  - Applied MHPA to Medicaid managed care plans and CHIP
- 2008 Mental Health Parity and Addiction Equity Act (MHPAEA)
  - Extended parity requirements to include substance use disorder
  - Added rules regarding financial and non-financial limits

Mental Health Parity in Medicaid and CHIP

- In 2009 CMS issued guidance applying the MHPAEA parity requirements to comprehensive Medicaid MCOs that provide medical and mental health services
- In 2013 CMS released additional guidance regarding the implementation of MHPAEA requirements in Medicaid managed care, Medicaid ABPs, and CHIP
- In 2015 CMS issued a proposed rule that would formalize previous guidance in regulation and impose additional requirements on states and plans

Significance of Proposed Rule

- Takes existing subregulatory guidance and puts it into regulation, but also proposes some significant changes and invites public comment
  - Applies parity standards to a broader group of Medicaid and CHIP enrollees, including anyone enrolled in managed care
  - Does not extend parity to Medicaid and CHIP enrollees covered under FFS
- Changes expand the reach of the rules but are not expected to create substantial new costs
  - CMS estimates that changes will increase Medicaid spending by 0.03 percent each year ($157.4M total increase in 2015)

Extension of Parity Requirements

- Proposed rule notes that parity rules should apply to all managed care enrollees, whether or not MH/SUD benefits are provided by the MCO
- States that contract with Medicaid MCOs are required to ensure that the plan complies with parity rules if it covers medical and MH/SUD benefits
- States that provide medical and MH/SUD benefits under different delivery systems will need to develop approaches to ensure compliance with the new rule

Changes to Rate-setting Rules

- Current rules require payments to MCOs to be actuarially sound and be based solely on the cost to provide services under the contract
- Proposed rule would revise this to specify that actuarially sound rates could take into account the cost of services necessary to comply with parity rules
- May be challenging for states to determine the actuarial value of services needed to comply with parity rules
- CMS has raised concerns that this change could open the door to inclusion of a variety of additional services in the capitation rates

Criteria for Medical Necessity Determinations

- Proposed rule will require all plans subject to parity requirements to:
  - Make medical necessity criteria for MH/SUD benefits available
  - Make available the reason for denial of payment for MH/SUD services
- CMS estimates that the administrative burden of compliance will be $450,000 per year
  - Medicaid and CHIP plans are already required to share information on the reasons for denial, upon request

CMS Has Requested Comments

- Should CMS require states that use managed care to include all MH/SUD benefits in the MCO contract, or should states continue to be allowed to use multiple delivery systems?
- Does the proposed change to the actuarial soundness rules create a risk that inappropriate services and costs could be included in the rates, and, if so, how might that risk be mitigated?
- Are other provisions concerning the availability of plan information or notice of adverse determinations necessary to facilitate compliance?

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