American Hospital Association

Special Bulletin

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CMS Finalizes Rule on Mental Health and Substance Use Disorder Parity for Medicaid and CHIP

The Centers for Medicare & Medicaid Services (CMS) yesterday issued a final rule applying certain provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 to Medicaid managed care organizations, Medicaid alternative benefit plans (ABPs) and the Children's Health Insurance Program (CHIP). Although the MHPAEA does not mandate coverage of mental health or substance use disorder (MH/SUD) benefits, it does require group health plans that offer these benefits to provide them at parity with their medical/surgical benefits. This final rule seeks to better align the Medicaid MCO and CHIP markets with the commercial insurance market (including the state and federal Marketplace) and promote consistency in benefits. **The AHA supports the final rule as an important step in bringing Medicaid MCOs, ABPs and CHIP into compliance with MHPAEA.**

The final rule applies parity standards to coverage for Medicaid MCO, ABP and CHIP enrollees. It sets standards to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on MH/SUD benefits generally are no more restrictive than the requirements and limitations for medical and surgical benefits. The rule also includes parity requirements for aggregate lifetime limits and annual dollar limits for MCO and CHIP enrollees, among other provisions.

Importantly, the final rule requires that beneficiaries receiving services through MCOs, ABPs or CHIP must have access to benefits that meet the parity provisions, irrespective of whether the services are delivered through an MCO or other system. For example, the parity requirements will apply to the entire package of services provided to an MCO enrollee, even if some MH/SUD services are delivered by a prepaid inpatient health plan (PIHP), a prepaid ambulatory health plan (PAHP) or through fee-for service (FFS).

However, the final rule does not extend the MHPAEA parity protections to FFS Medicaid beneficiaries, except those beneficiaries who receive benefits through an ABP. In other words, the provisions of the rule apply to Medicaid beneficiaries who are in an MCO, receive benefits through an ABP, or are CHIP-eligible. The provisions apply to ABP and CHIP beneficiaries irrespective of the delivery system.

Select provisions of the rule include:

- Benefit classifications. As proposed, CMS finalized four benefit classification categories, including inpatient, outpatient, emergency care and prescription drugs. The rule applies parity standards for financial requirements and treatment limitations using these classifications.

- Intermediate services. CMS did not include a classification for intermediate services, such as residential treatment, partial hospitalization and intensive outpatient treatment. CMS expects these types of benefits to be assigned among the four finalized classifications. The agency provides flexibility in how these assignments are made as long as the same reasonable standards are used for both medical/surgical services and MH/SUD services. However, CMS indicated it may provide further guidance about classification of intermediate services as needed.

- Parity analysis. According to CMS, states must determine "whether the overall delivery system complies with the provisions of this final rule." Where an MCO offers the medical/surgical and MH/SUD services, the MCO is expected to undertake the parity analysis. Where some or all of the MH/SUD services for MCO enrollees are delivered by a combination of MCOs, PIHPs and PAHPs, the state must undertake the parity analysis across these systems.

- MHPAEA cost exemption. The MHPAEA allows for an increased cost exemption if a health plan incurs a cost coming into compliance with the parity requirements. The final rule does not include a similar cost exemption for Medicaid MCOs, PIHPs or PAHPs. Rather, states can factor in the cost of providing services beyond the state plan into the actuarially sound rate methodology. Thus, CMS says, Medicaid will bear the cost of changes and managed care entities will not incur any net increases in costs.

- Information sharing. The rule requires that enrollees be provided information about the reasons for any reimbursement denial related to MH/SUD benefits.

- Long-term care services. In a change from the proposed rule, the final rule extends parity protections to long-term care services for MH and SUDs.

- Compliance date. States have until Oct. 2, 2017 to comply with the final requirements and to make certain documentation about compliance available to the public.

NEXT STEPS

For more information see CMS's factsheet on the proposed rule. You also may contact Molly Collins Offner, policy director, at mcollins@aha.org or Evelyn Knolle, senior associate director for policy, at eknolle@aha.org.