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CLIENT ALERT

Mental Health Parity Final Rule for Medicaid and CHIP: Few Changes from the Proposed Version

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On March 30, 2016, the Centers for Medicare & Medicaid Services ("CMS") published its long-awaited final rule ("Final Medicaid Parity Rule" or "Final Rule")[1] implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("MHPAEA")[2] and addressing the application of certain mental health parity provisions to Medicaid managed care organizations ("MCOs"), Medicaid benchmark or benchmark-equivalent plans (known as "Alternative Benefit Plans" or "ABPs"), and the Children's Health Insurance Program ("CHIP'). The Final Rule largely implements the provisions of the proposed version of the rule,[3] leaving little flexibility for the many states whose enrollees receive Medicaid or CHIP services through MCOs.

The effective date for this Final Rule is 18 months from its publication date. Accordingly, states and their contracted Medicaid managed care entities, state ABPs, and CHIP state plans must be in compliance with the Final Rule by September 29, 2017.

I. Legislative Background

In 1996, Congress enacted the Mental Health Parity Act ("MHPA"), which requires parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits offered by certain health plans.[4] These provisions are codified at section 2726 of the Public Health Service Act. In 1997, through the Balanced Budget Act, Congress

[1] Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18,390 (March 30, 2016), *available at* https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of.

[2] The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), enacted on October 3, 2008, as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Pub. L. 110–343).

[3] 80 Fed. Reg. 19418 (April 10, 2015).

[4] Mental Health Parity Act of 1996 (Pub. L. 104-204, enacted September 26, 1996).

amended the Social Security Act to apply certain aspects of MHPA, including the parity requirement in aggregate lifetime and annual dollar limits, to Medicaid MCOs and CHIP benefits.[5] MHPAEA amended the existing mental health parity provisions and added new parity requirements, including those for substance use disorder benefits.

Congress amended the mental health parity laws twice since enacting MHPAEA. In 2009, under the Children's Health Insurance Program Reauthorization Act, CHIP state plans that provide both medical/surgical benefits and mental health or substance use disorder ("MH/SUD") benefits were required to comply with prohibitions on health factor-based discrimination in eligibility and enrollment. In 2010, under the Affordable Care Act ("ACA"), Congress again amended the parity provisions to add other requirements affecting coverage of MH/SUD services and treatments. Specifically, the ACA included mental health benefits as one of the categories of services to be covered through ABPs and directed that such plans include medical/surgical benefits and MH/SUD benefits and ensure that the financial requirements and treatment limitations applicable to these benefits comply with the mental health parity provisions.

MHPAEA's statutory provisions were self-implementing and generally became effective for plan years beginning after October 3, 2009. In 2010, the U.S. Departments of Health and Humans Services, Labor, and the Treasury (collectively, "Departments") published an interim final rule[6] further implementing MHPAEA and applicable to plan years beginning on or after July 1, 2010. In 2013, the Departments published a final rule applicable to employment-related group health plans and health insurance coverage offered in connection with a group health plan for plan years beginning on or after July 1, 2014 ("2014 Final Rule").[7] These rules, however, did not apply to MCOs, ABPs, or CHIP.

II. Overview of Final Rule

A. Summary of Medicaid and CHIP Coverage of MH/SUD Services

State Medicaid programs have flexibility in defining how they cover and deliver MH/SUD services, which are largely optional benefits under the traditional Medicaid benefits package. Some states provide such services through MCOs or through entities offering more limited benefit packages, such as prepaid inpatient health plans ("PIHPs") or prepaid ambulatory health plans ("PAHPs"), or through a combination of mechanisms. This Final Rule aims to ensure that beneficiaries enrolled in MCOs have access to a set of benefits that meets parity requirements, regardless of the mechanism or multiple mechanisms through which MH/SUD services are provided. Similarly, the Final Rule defines how ABPs and CHIP state plans are expected to provide both medical/surgical benefits and MH/SUD benefits in a manner that ensures that financial requirements and treatment limitations for such benefits comply with parity requirements to the same extent as such requirements apply to a group health plan.[8]

[5] The Balanced Budget Act of 1997 (Pub. L. 105-33, enacted on August 5, 1997).
[6] 75 Fed. Reg. 5,410 (Feb. 2, 2010).
[7] 78 Fed. Reg. 68,240 (Nov. 13, 2013).
[8] Regardless of whether services are delivered in managed care or non-managed care arrangements, all Medicaid ABPs (including benchmark equivalent and benchmark plans approved by the Secretary of the U.S. Department of Health and Human Services) and CHIP state plans are required to meet the financial requirements and treatment limitations component of the mental health parity provisions.

If a state uses private health plans or MCOs to provide ***any*** of its state plan benefits under an MCO contract, then MHPAEA's parity protections apply to the MH/SUD services, regardless of whether the MCO provides the MH/SUD services. Where the MH/SUD services provided to MCO enrollees are delivered through non-MCO managed care (or non-managed care) delivery vehicles, the parity protections apply across the delivery systems in the Medicaid program and CHIP, to the entire package of services that MCO enrollees receive, whether from the MCO, PIHP, or PAHP or through traditional fee-for-service ("FFS").

CMS expects states to work with their MCOs (and PIHPs and PAHPs, where applicable) to determine the best method of achieving compliance with these proposed parity requirements for benefits provided to the MCO enrollees. In states where the MCO has responsibility for offering all medical/surgical and MH/SUD benefits, the Final Rule makes the MCO responsible for conducting the parity analysis and informing the state of additional changes that would be required to bring the MCO contract into compliance with parity requirements. In states where some or all MH/SUD benefits are provided across multiple types of Medicaid managed care entities or across Medicaid managed care entities and FFS, the state itself is responsible for completing the parity analysis across these delivery systems and determining if the existing benefits and any financial or treatment limitations are consistent with these regulatory requirements. Based on its analysis, the state must make any changes needed to ensure compliance with parity requirements for its Medicaid MCO enrollees and make the analysis public within 18 months of the release date of the Final Rule.

The Final Rule amends regulatory provisions addressing state development of actuarially sound rates for MCOs, PIHPs, and PAHPs that provide MH/SUD services to take into account costs for services beyond those in the state plan that are required to ensure that the MCO, PIHP, or PAHP complies with the parity requirements.

B. Definitions

The definitions in the Final Rule include most terms included in the 2014 Final Rule, with some modifications, additions, and deletions to reflect the terminology used in the Medicaid program and CHIP statutes, regulations, or policies.

CMS finalized revised definitions of "medical/surgical benefits," "mental health benefits," and "substance use disorder benefits" so that they ***include***, rather than exclude, ***long-term care services***. Although CMS had originally proposed to exclude long-term care services from these definitions, CMS agreed with public comments stating that long-term care services should be included in the appropriate benefit classification(s) (e.g., inpatient, outpatient, emergency care, and prescription drugs) for purposes of the parity analysis. CMS states that this change will (i) reduce the likelihood that states would have disparate policies regarding which services would be subject to parity and ensure that beneficiaries have similar protections, regardless of where they live; (ii) prevent states from applying treatment limits to long-term care services needed for MH/SUD conditions more restrictively than treatment limits are applied for long-term care services for medical/surgical conditions; and (iii) improve beneficiary access to needed MH/SUD benefits and provide MCOs and states with needed clarity regarding the application of parity to these services. CMS intends to

provide additional information to states regarding the application of parity to long-term care services.

Further, under existing law, states have the responsibility of identifying what is a covered benefit for Medicaid and CHIP. MCOs, PIHPs, and PAHPs are responsible for providing the covered benefits identified by the state. CMS declined to provide in the Final Rule a list (either exhaustive or non-exhaustive) of mental health conditions to be included in a state's definition of "mental health conditions." Instead, CMS provides states with guidance regarding generally recognized independent standards of current medical practice to determine what conditions are medical/surgical or MH/SUD conditions.

C. Parity Requirements for Aggregate Lifetime and Annual Dollar Limits

Parity requirements for aggregate lifetime and annual dollar limits for MCOs (including PIHPs and PAHPs when providing coverage for MCO enrollees) and CHIP are generally the same as under the 2014 Final Rule. The following table illustrates how lifetime or annual dollar limits, where permissible, may be applied to MH/SUD benefits:

Lifetime/Annual Limits on Medical/Surgical Benefits	Application to MH/SUD Benefits
No aggregate lifetime or annual dollar limit on medical/surgical benefits	No aggregate lifetime or annual dollar limit on MH/SUD benefits
Aggregate lifetime or annual dollar limit applied to less than 1/3 of all medical/surgical benefits	No aggregate lifetime or annual dollar limit on MH/SUD benefits
Aggregate lifetime or annual dollar limit applied to between 1/3 and 2/3 of all medical/surgical benefits	Either • impose no aggregate lifetime or annual dollar limit on MH/SUD benefits, OR • impose an aggregate lifetime or annual dollar limit on MH/SUD benefits that is no more restrictive than the average limit for medical/surgical benefits
Aggregate lifetime or annual dollar limit applied to at least 2/3 of all medical/surgical benefits	Either • apply the aggregate limit both to medical/surgical benefits and to MH/SUD benefits in a manner that does not distinguish between the medical/surgical and MH/SUD benefits, OR • do not include an aggregate lifetime or annual dollar limit on MH/SUD benefits that is less than the aggregate limit on medical/surgical benefits

D. Parity Requirements for Financial Requirements and Treatment Limitations

1. Clarification of Terms

Parity requirements for financial requirements and treatment limitations must be applied on a classification-by-classification basis. A financial requirement or treatment limitation must be compared only to financial requirements or treatment limitations of the same "type" within a classification. Different types of financial requirements and treatment limitations include copayments, coinsurance, annual visit limits, and episode visit limits.

The term "level" refers to the magnitude (such as the dollar, percentage, day, or visit amount) of the financial requirement or treatment limitation.

2. General Parity Requirement for Financial Requirements and Treatment Limitations

The general parity requirement ***prohibits*** an MCO, a PIHP, or a PAHP (when providing benefits to an MCO enrollee), an ABP (when used in a non-managed care arrangement), or the CHIP state plan (or managed care entity contracting with a CHIP state plan) from ***applying any financial requirement or 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***. For this purpose, the general parity requirement would apply separately for each type of financial requirement or treatment limitation (for example, unit limits are compared to unit limits, or co-pays are compared to co-pays).

CMS finalized the use of four classifications of benefits in assessing parity under the Final Rule: inpatient, outpatient, emergency care, and prescription drugs (the 2014 Final Rule contained six classifications). These classifications are the only classifications to be used for purposes of applying the parity requirements to Medicaid and CHIP. In addition, these classifications must be used for all financial requirements and treatment limitations to the extent that an MCO, a PIHP, a PAHP, an ABP, or a CHIP state plan provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification. The Final Rule does not define what services are included in the inpatient, outpatient, or emergency care classifications. These terms are subject to the design of a state's managed care program, and their meanings may differ depending on the benefit packages.

As proposed and finalized, CMS declined to create a new intermediate level services classification. Instead, the applicable regulated entity (the MCO, PIHP, or PAHP, or state in connection with the ABP, and CHIP) may assign intermediate level services to any of the four benefit classifications, but the assignment to those classifications must be done using the same standards for both medical/surgical services and MH/SUD services. Further, the method used to assign services to the four classifications must be reasonable. Similarly, the applicable regulated entity may assign long-term care services to any of the four benefit classifications, but that assignment to those classifications must be done using the same reasonable standards for both medical/surgical services and MH/SUD services.

3. Applying the General Parity Requirement to Financial Requirements and Quantitative Treatment Limitations

A type of financial requirement or quantitative treatment limitation is considered to apply to "substantially all" medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification. 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 a contract year (for MCOs, PIHPs, and PAHPs) or for the year starting on the effective date of the approved ABP or CHIP state plan (effective dates for these plans will vary based on the date of approval by CMS). For purposes of this calculation, the MCOs (when such organizations are responsible for coverage of MH/SUD benefits) or the state (in cases where PIHPs and PAHPs are used in conjunction with MCOs) must determine the total amount projected to be expended to determine the two-thirds threshold.

4. Special Rules for Multitiered Prescription Drug Benefits and Other Benefits

As proposed, MCOs, PIHPs, PAHPs, ABPs, or CHIP state plans may subdivide the prescription drug classification into tiers based on reasonable factors without regard to whether a drug is generally prescribed for medical/surgical benefits or for MH/SUD benefits. Subclassification also is permitted for office visits, separate from other outpatient items and services. Other subclassifications not specifically permitted, such as separate subclassifications for generalists and specialists, cannot be used for purposes of determining parity.

After the subclassification is established, MCOs, PIHPs, PAHPs, ABPs, or CHIP state plans may not impose any financial requirement or quantitative treatment limitation on MH/SUD benefits in any subclassification (e.g., office visits or non-office visits) that is more restrictive than the "predominant" financial requirement or quantitative treatment limitation that applies to "substantially all" medical/surgical benefits in the subclassification, using the parity analysis for financial requirements and quantitative treatment limitations.

While multiple network tiers may be used in Medicaid managed care, the parity standards for Medicaid managed care do not address such network structures because Medicaid cost-sharing rules apply regardless of network status. Any financial restriction or quantitative treatment limitation outlined in the managed care contract must be applied to the service broadly and, therefore, cannot have separate restrictions or limitations based on network tiers. MCOs, PIHPs, and PAHPs with multiple network tiers may use network tiers when recommending providers to enrollees or structuring their provider directories. Accordingly, MCOs, PIHPs, and PAHPs with multiple network tiers should be constructing them and providing beneficiary access to them in a way that is consistent with the parity standard for nonquantitative treatment limitations ("NQTLs").

E. Cumulative Financial Requirements

As proposed, separate cumulative financial requirements (separate for mental health, substance use, or medical/surgical) will not be permitted for MCOs, PIHPs, and PAHPs in connection with coverage provided to MCO enrollees, and in ABPs and CHIP state plans.

However, quantitative treatment limitations may accumulate separately for medical/surgical and MH/SUD services as long as they comply with the general parity requirement (e.g., that any such limit for MH/SUD benefits is no more restrictive than the "predominant" limit applied to "substantially all" medical/surgical benefits in a given classification).

F. Compliance with Other Cost-Sharing Rules

States and the MCOs, PIHPs, and PAHPs that contract with states are bound by the existing Medicaid and CHIP cost-sharing rules for both managed care and non-managed care delivery systems. All financial requirements included in a parity analysis must be in compliance with both existing cost-sharing rules and the parity requirements of the Final Rule. Compliance with the parity requirements does not mean that a state, or an MCO, a PIHP, or a PAHP, can violate existing cost-sharing requirements. Therefore, some cost-sharing structures in a state's Medicaid program or CHIP may need to change to be compliant with the parity standards.

G. Nonquantitative Treatment Limitations

NQTLs are limitations that are not expressed numerically and cannot be translated into quantitative limitations. Examples of NQTLs include prior authorization, geographic limitations, medical management standards, prescription drug formulary design, standards for provider admission to participate in a network, and conditioning benefits on completion of a course of treatment.

NQTLs may not be imposed for MH/SUD benefits in any classification unless, under the policies and procedures of the MCO, PIHP, or PAHP, or under the terms of the ABP or CHIP state 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. The term "factors" means the processes, strategies, evidentiary standards, or other considerations used in determining limitations on coverage of services. The phrase "applied no more stringently" requires that any processes, strategies, evidentiary standards, or other considerations that are comparable on their face be applied in the same manner to medical/surgical benefits and MH/SUD benefits.

In a Medicaid managed care environment, if a provider network is unable to provide necessary services covered under the contract to a particular enrollee, the MCO, PIHP, or PAHP must adequately (and on a timely basis) cover these services out-of-network for the enrollee for as long as the MCO, PIHP, or PAHP is unable to provide them in-network. As proposed, the standard for providing access to out-of-network services (when they cannot be provided in-network) is considered to be an NQTL for the purposes of the Final Rule. The factors used in determining access to out-of-network providers for MH/SUD benefits must 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 to both sets of benefits, as originally proposed by CMS). This requirement would not apply in the context of ABPs or CHIP state plans that use an FFS delivery system or another non-managed care arrangement because providers must be enrolled in Medicaid or CHIP and would not be considered out-of-network.

Further, CMS proposed, but did not finalize, a provision that would allow an MCO, a PIHP, a PAHP, an ABP, or a CHIP state plan provided through managed care that complies with network adequacy requirements to be deemed in compliance with the parity requirements for access to out-of-network providers. Instead, these regulated entities must comply with both the network adequacy requirements and the parity requirements for access to out-of-network providers.

CMS provided clarification in response to questions raised by public commenters about the NQTL parity requirements, including the following:

- The types of factors used to apply the NQTL will depend on the nature of both the NQTL and the benefit. In some cases, it may be appropriate to use the same factors to apply the NQTL for both medical/surgical and MH/SUD benefits. However, in other cases, there may not be a single factor or set of factors that can practically be applied to both medical/surgical and MH/SUD benefits, and instead factors that are comparable may need to be used.

- Medical necessity determinations for long-term care services or other services, including clinical determinations as to the intensity of services that is medically necessary for an individual, are NQTLs. The parity analysis does not insist on a one-to-one comparison of a MH/SUD service to a medical/surgical service, but instead requires that such NQTLs must comply with the requirements of the Final Rule (e.g., a NQTL may not be imposed for a MH/SUD benefit unless any factors used in applying the NQTL to the MH/SUD benefit are comparable to, and applied no more stringently than, factors used in applying the same NQTL to medical/surgical benefits in the classification).

- Even in instances where an MCO enrollee receives the majority of his or her services through an FFS delivery system, the MCO still needs to deliver any MH/SUD services in compliance with the parity requirements (even if that means that the ability to use NQTLs to manage the utilization of MH/SUD services is limited).

- Regulated entities may consider a wide array of factors in determining provider reimbursement methodologies and rates for both medical/surgical services and MH/SUD services, such as service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and the training, experience, and licensure of providers. These or other factors must be applied comparably to and no more stringently than those applied for medical/surgical services. However, disparate results alone do not mean that the NQTLs in use fail to comply with these requirements.

H. Parity for MH/SUD Benefits in CHIP Programs Covering Early and Periodic Screening, Diagnostic, and Treatment

The Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) benefit is a required benefit under the Medicaid program for categorically needy individuals under the age of 21. The EPSDT benefit is optional for the medically needy population, and if elected

for that population, the EPSDT benefit must be made available to all Medicaid-eligible individuals under the age of 21. Under the EPSDT benefit, states must provide for screening, vision, hearing, and dental services at intervals that meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. States must also provide for medically necessary screening, vision, hearing, and dental services, regardless of whether such services coincide with established periodicity schedules for these services. Other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses, and conditions identified by the screening services, must be provided to EPSDT beneficiaries whether or not such services are otherwise covered under the Medicaid state plan.

CMS clarified in the Final Rule that CHIP state plans are deemed to satisfy the parity requirements related to financial requirements and treatment limitations if a CHIP state plan elects to cover all EPSDT services required under section 1905(r) of the Social Security Act ***and*** if the state meets the provisions under section 1902(a)(43) of the Social Security Act requiring states to inform individuals under 21 about the availability of the full range of EPSDT services available to them; to provide and arrange for medically necessary screenings, diagnostic services, and treatments; and to assure needed transportation as part of the administration of those benefits. If a state has elected in its CHIP state plan to cover EPSDT benefits only for certain eligible children, the state is deemed compliant with parity requirements only with respect to such children.

States that apply NQTLs to EPSDT services must ensure that these limitations are applied in a manner that is consistent with the parity provisions. For example, states have the discretion to exclude coverage of some experimental services. However, the application of annual and lifetime limits is not consistent with Medicaid and/or EPSDT, and this practice would preclude a state from deemed compliance. Further, the exclusion of treatment for any conditions is not permitted for individuals under the age of 21 who are enrolled in Medicaid. Therefore, a CHIP state plan cannot be deemed compliant with mental health parity requirements if it excludes benefits for a particular condition, disorder, or diagnosis.

For CHIP programs that do not provide full EPSDT benefits (and, therefore, do not meet the deeming requirements), a full benefit and cost-sharing analysis of the CHIP state plan must be conducted by the state to determine compliance with the parity standards in the Final Rule. The state's parity analysis must also include an examination of the processes, strategies, evidentiary standards, and other factors used in the application of NQTLs to MH/SUD benefits. The state must ensure that these factors are comparable to, and applied no more stringently than, those used in applying NQTLs to medical/surgical benefits in the same classification.

I. Availability of Information

As proposed, MCOs, PIHPs, and PAHPs subject to parity requirements must make their medical necessity criteria for MH/SUD benefits available to any enrollee, potential enrollee, or contracting provider, upon request. MCOs, PIHPs, and PAHPs found to be in compliance with existing regulations at 42 C.F.R. § 438.236(c)—which require dissemination by MCOs, PIHPs, and PAHPs of practice guidelines (including medical/surgical and MH/SUD) to all affected providers, and, upon request to enrollees and potential enrollees—will be deemed

to meet this requirement. In addition, MCOs, PIHPs, or PAHPs must make available the reason for any denial of reimbursement or payment for services for MH/SUD benefits to the enrollee. MCOs, PIHPs, and PAHPs are already required under 42 C.F.R. § 438.210(c) to notify the requesting provider and give the enrollee written notice of any decision by an MCO, a PIHP, or a PAHP to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

Also as proposed, CMS has extended the requirement regarding the availability of plan information to all ABPs, as well as those ABPs with services delivered through MCOs, PIHPs, and PAHPs. States delivering ABP services through a non-MCO must make available to beneficiaries and contracting providers, upon request, the criteria for medical necessity determinations for MH/SUD benefits, as well as make available to the enrollee the reason for any denial of reimbursement or payment for services for MH/SUD benefits.

Further, disclosure is required, upon request, to any current or potential CHIP enrollee or contracting provider of the criteria for medical necessity determinations. The reason for any denial of reimbursement or payment for MH/SUD benefits must be made available to the enrollee. The CHIP rule also applies to managed care plans. However, the managed care entity may be deemed in compliance with the parity disclosure requirement if it has complied with the 42 C.F.R. § 438.236(c) disclosure requirements.

The requirements of 29 C.F.R. § 2560.503-1—which relate to notices for group health plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA")—do not apply to Medicaid or CHIP, and these provisions are not applicable as a condition for deemed compliance because similar requirements (as described above) are already applicable to Medicaid and CHIP.

J. Application to Essential Health Benefits and Other ABP Benefits

ABPs that provide both medical/surgical benefits and MH/SUD benefits must comply with certain parity requirements. States have oversight responsibility for ensuring parity in ABPs, similar to their responsibility for ensuring parity in managed care contracts. Further, ABPs must provide the 10 categories of benefits that make up essential health benefits ("EHBs"), including MH/SUD services. As a state determines its ABP service package, the state must use all of the EHB services from the base-benchmark plan selected by the state to define EHBs. States have flexibility to provide medical assistance by designing different benefit packages, including other services beyond the EHBs for different groups of eligible individuals, as long as each benefit package contains all of the EHBs and meets certain other requirements, including the applicable parity provisions.

K. ABP State Plan Requirements

States using ABPs, including where ABPs are provided on an FFS basis, must provide sufficient information in the ABP state plan amendment to assure and document compliance with parity provisions. CMS will review the ABP state plan amendment to assure compliance with parity requirements and EHB antidiscrimination provisions.

L. Application of Parity Requirements to the Medicaid State Plan

Under the terms of the law, parity protections apply solely to the total benefit package provided to individuals enrolled in Medicaid MCOs, regardless of the service delivery system. Despite comments urging CMS to more broadly apply parity requirements, the agency stated that it could do no more than encourage states to apply parity protections to individuals not enrolled in MCOs as the law did not authorize CMS to mandate parity protections to the FFS benefit package.

M. Responsibility for Completing the Parity Analysis

When the MCO is not providing all MH/SUD services to Medicaid enrollees, the Final Rule requires the state to perform the parity analysis. While the state may rely on third parties to collect relevant information and even complete a preliminary analysis, the state itself must review and accept that analysis. The state also will be required to provide relevant documentation to CMS and answer related questions and will be held accountable for the accuracy and completeness of the parity analysis.

If the MCO is responsible for providing all medical/surgical and MH/SUD services, the Final Rule requires the MCO to perform the parity analysis. States should monitor these efforts as they must ensure that benefits are being delivered in a manner that complies with parity requirements, including implementing needed changes to the MCO contracts. States (or their MCOs) must comply with parity requirements even if operating under a demonstration or waiver program. CMS explicitly states that parity requirements will not be waived under a section 1115 waiver request.

States must conduct oversight to ensure that enrollees in MCOs receive services in compliance with parity requirements. While the Final Rule does not require MCOs to provide documentation or otherwise report on their parity analysis to the state, CMS encourages states to include terms in their MCO contracts, as necessary, for oversight and implementation of the parity requirements. CMS indicates that it will provide technical assistance and tools for both states and MCOs to clarify the types of documentation that CMS seeks to have submitted with the MCO contracts and ABP state plan amendments in order to show compliance with parity requirements. The parity analysis need not be completed on an annual basis unless there is a change in operations by the state or the plans that would impact parity compliance. The Final Rule requires that state documentation demonstrating compliance be made available to the general public through the state's website.

N. Scope of Services

The Final Rule does not require Medicaid MCOs, PIHPs, or PAHPs to provide any MH/SUD benefits beyond those that they are required to cover under their contract with the state. For states providing benefits through ABPs, the Final Rule does not require a state to provide any specific MH/SUD benefits. However, when providing coverage through an ABP, the state must meet applicable ABP requirements, including the provision of EHBs based on the 10 identified EHB categories as laid out in the applicable EHB reference benchmark plan.

O. No Increased Cost Exemption

CMS provided an increased cost exemption as part of the 2014 Final Rule implementing MHPAEA in the commercial market, but the agency does not include such an exemption for Medicaid managed care entities or for states delivering services through an ABP or CHIP state plan. The increased cost exemption is available for commercial plans that make changes to comply with parity requirements and, in doing so, incur an increased cost of a certain level (at least 2 percent in the first year of parity application or at least 1 percent in any subsequent plan year). Qualification for the increased cost exemption renders the plan exempt from parity requirements for the year following the year in which it incurred the costs.

CMS does not believe that these Medicaid managed care entities will incur any net increase in costs because regulations require that the actuarially sound payment methodology take costs of compliance with parity requirements into account. However, the Final Rule does contain changes to Medicaid managed care payment provisions to allow states to include the cost of providing additional services or removing or aligning treatment limitations in their actuarially sound rate methodology when such costs are necessary to comply with the MHPAEA parity provisions.

The exclusion of a cost exemption for states delivering services through an ABP or a CHIP state plan is due to the "mandatory delivery of EHB and the requirement that ABPs be compliant with MHPAEA."

P. Enforcement, Managed Care Rate Setting, and Contract Review and Approval

CMS finalized provisions on enforcement, managed care rate setting, and contract review and approval largely as proposed. The Final Rule allows for states' rate setting process to account for additional services that exceed those listed in the state plan (or exceed listed treatment limits for such services) to the extent that these additional services are needed to comply with parity regulations. Similarly, states may also adjust their capitation rates to provide for additional services if such services would not be included, except for the parity requirements of the Final Rule.

State contracts with Medicaid managed care entities must include provisions requiring compliance with parity rules and are expected to include a methodology for an MCO, a PIHP, or a PAHP to demonstrate its compliance with parity requirements. The methodology must enable all MCOs, PIHPs, or PAHPs in the Medicaid delivery system to collaborate to ensure that the benefit package provided to any of a state's MCO enrollees complies with parity requirements, regardless of whether MH/SUD benefits are provided by the MCO.

While CMS declined to provide standardized contract language for states to use in their MCO, PIHP, and/or PAHP contracts, the agency did state that it will release subregulatory guidance on the documentation that will be required to show parity compliance under the Final Rule. In addition, CMS is working to develop tools and will provide technical assistance to states in analyzing whether their delivery systems, benefit design, and medical management meet the provisions of these parity rules.

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