DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Frequently Asked Questions: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP

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General

Q1. What benefits are subject to the parity analysis?

A1. All medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) benefits that are provided through an Alternative Benefit Plan (ABP) in a state Medicaid program; through the Children's Health Insurance Program (CHIP); or to enrollees of a Managed Care Organization (MCO) (regardless whether the services are furnished by that MCO, a prepaid inpatient health plan (PIHP), a prepaid ambulatory health plan (PAHP), or through a fee-for-service (FFS) delivery mechanism) are subject to parity requirements, regardless of the statutory authority under which they are provided.

Q2. Is non-emergency medical transportation (NEMT) subject to the parity analysis?

A2. Medicaid managed care regulations specifically exempt NEMT PAHPs from parity requirements (42 CFR § 438.9(b)(iv)), in addition to a variety of other regulatory requirements that do apply to PAHPs that provide medical services. Consistent with the unique nature of the NEMT requirement under the state plan and the specific exemption of NEMT PAHPs from parity, the Centers for Medicare & Medicaid Services (CMS) will not pursue enforcement of parity requirements with regard to NEMT provided through other delivery systems, including MCOs, the state plan brokerage option, Medicaid FFS, or as a Medicaid administrative activity.

Q3. If a separate CHIP provides all benefits through an MCO, does the MCO have to complete the parity analysis?

A3. For separate CHIPs using an MCO to provide all benefits to enrollees, there is flexibility for either the MCO or the state (i.e. the CHIP agency) to conduct the parity analysis. In either case, the state should work closely with the MCO to ensure compliance with parity requirements. States with a separate CHIP program must submit a title XXI/CHIP state plan amendment (SPA), but may request deemed compliance with parity requirements if early and periodic screening, diagnostic and treatment (EPSDT) is provided, consistent with the requirements of §457.496(b). States with a Medicaid expansion CHIP will not need to submit a title XXI/CHIP SPA, and must follow all Medicaid managed care rules related to parity.

Defining MH/SUD

Q4. How should definitions of MH/SUD benefits and M/S benefits apply to long term supports and services that can be provided for both MH/SUD and M/S conditions?

A4. The parity rules for Medicaid and CHIP define MH benefits, SUD benefits, and M/S benefits to include long-term services and supports (LTSS) (42 CFR §§ 438.900, 440.395, and 457.396). LTSS are defined for Medicaid managed care programs as "services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting" (42 CFR § 438.2). LTSS include home and community-based services (HCBS).

A variety of LTSS benefits, such as personal care and respite care, could be defined as either MH/SUD or medical/surgical (M/S), depending on the condition of the beneficiary being treated. For these benefits, the state may define the benefit as MH/SUD or M/S for the entire beneficiary population using a reasonable method, such as whether the service is most commonly or frequently provided due to a MH/SUD or M/S condition. For example, if more than 50% of spending on personal care is for beneficiaries who are receiving the service due to M/S conditions, the state may reasonably define personal care services as a M/S benefit for the purposes of the parity analysis.

Non-Quantitative Treatment Limits (NQTLs)

Q5. Are states required to apply the NQTL analysis to Medicaid program eligibility criteria for participation in a program, such as participation in an array of services offered under a 1915(i) or 1915(k) state plan amendment?

A5. No, states are not required to apply the NQTL analysis to eligibility determinations and eligibility criteria for participation in a Medicaid program. For example, eligibility criteria for participation in a suite of services offered under a 1915(i) or 1915(k) state plan or Medicaid rehabilitation optional state plan services, or for enrollment in a Medicaid Health Home or similar program, do not require an NQTL analysis. Waiver programs and other benefit packages such as these are generally created to offer a set of intensive services for acute or high-need populations to supplement the core services offered through the state plan. Eligibility criteria for these programs may be restricted to beneficiaries with certain diagnoses or assessed as meeting a certain level of need.

Q6. Does the implementation of National Correct Coding Initiative (NCCI) edits require an NQTL analysis?

A6. No; the NCCI promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims. Section 6507 of the Affordable Care Act requires each state Medicaid

program to implement compatible methodologies of the NCCI, to promote correct coding, and to control improper coding leading to inappropriate payment. Compliance with federal requirements for implementing NCCI methodologies does not require an NQTL analysis under the Medicaid and CHIP parity rules.

Q7. If a state or managed care plan has a prior authorization requirement for some outpatient medical/surgical benefits, and a prior authorization requirement for some outpatient MH/SUD benefits, does the state or the managed care plan have to conduct the NQTL analysis to determine if the prior authorization requirement for outpatient MH/SUD benefits complies with parity?

A7. Yes. It is not sufficient to note that prior authorization applies to both M/S and MH/SUD benefits. Instead, it is necessary to analyze the processes, strategies and evidentiary standards as written and in operation associated with prior authorization for M/S and MH/SUD benefits within the same classification.

Q8. Some states/MCOs restrict beneficiaries who are not already on the state agency or provider's caseload from receiving MH or SUD counseling from an unlicensed practitioner. This is required because under state licensure laws, unlicensed practitioners are not permitted to diagnose or establish a treatment plan that would be necessary for new Medicaid patients. Would this NQTL be impermissible?

A8. To the extent the scope of practice of a health care provider is limited in order to comply with state licensure laws, it is not an impermissible NQTL. State/MCO limits on scope of practice that are more restrictive than state licensure requirements or that are only applicable to Medicaid/CHIP providers would be subject to the NQTL analysis under the Medicaid and CHIP parity rules.

Availability of Information

Q9. If an MCO already provides notices of adverse benefit determinations for payment denials in accordance with managed care regulations, does this have to be verified and/or documented as part of the parity analysis?

A9. If the managed care contract(s) specify that the plan(s) is required to provide a notice for adverse benefit determinations in the event of payment denials pursuant to 42 CFR § 438.404, this is sufficient in documenting compliance in this area. State monitoring of these notices through external quality review is recommended.

Documentation of Compliance

Q10. Does a state have to document authorization denial rates as part of the NQTL analysis?

A10. No. While highly disparate authorization denial rates for MH/SUD services as compared to M/S services may be an indication that utilization management protocols are not meeting NQTL requirements (in writing and/or in operation), states are not required to

document these differences for all services for the submission of MCO contracts or contract amendments. However, if concerns exist about whether a particular NQTL is in compliance with parity, a comparison of service denial rates may provide clarifying information. We recommend that states develop monitoring strategies to ensure ongoing parity compliance, and states may choose to track data on denial rates as an important component of that strategy.

Q11. What documentation does a state need to provide to CMS if the MCO provides all medical/surgical and MH/SUD benefits?

A11. All MCO contracts must require parity compliance. CMS will review parity provisions in MCO contracts as part of the normal contract review process. For more information about the requirements for parity compliance that must be included in MCO contracts, please see the State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval: https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf

In addition to the requirements outlined in the Contract Review tool, states may also wish to consider including provisions in their contracts with MCOs to ensure adequate oversight of the MCO's parity-related monitoring and compliance activities. The state's oversight process and documentation requirements should be sufficient to ensure that enrollees are receiving services in compliance with the federal Medicaid and CHIP parity rules. For example, in situations where the MCO has responsibility for offering all medical/surgical and MH/SUD benefits and is responsible for undertaking the parity analysis, the state may wish to include language in their contracts with MCOs to ensure the state can see the results of the MCO's analysis. This may help the state to work with the MCO to implement any changes to the MCO contract that are necessary for compliance with parity requirements.

Note that for separate CHIPs using an MCO to provide all benefits to enrollees, there is flexibility for either the MCO or the state to conduct the parity analysis. In either case, the state should work closely with the MCO to ensure compliance with parity requirements.