

The Hilltop Institute



analysis to advance the health of vulnerable populations

Overview of the March 29, 2016 Final Rule on the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program, and Alternative Benefit Plans

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Overview of the March 30, 2016 Final Rule on the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program, and Alternative Benefit Plans

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Introduction

On March 29, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule on *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 (MCOs), the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans (ABPs)* (<https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf>). This rule provides new requirements for Medicaid and CHIP compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA) and the Affordable Care Act (ACA). Final MHPAEA regulations for group health insurance plans were issued in 2013. Much of this final rule extends the MHPAEA requirements for group health plans to Medicaid MCOs, CHIP, and ABPs, with exceptions and changes as applicable to address the unique aspects of state Medicaid mental health (MH) and substance use disorder (SUD) delivery systems. This document provides a high-level summary of the rule and highlights the changes to the proposed rule.

A. Meaning of Terms (§§438.900, 440.395, 457.496)

CMS proposed to include most terms in the MHPAEA final regulations at 45 CFR 146.136(a) with modifications to reflect terminology used in the Medicaid and CHIP programs. CMS identified the differences between the definitions in this proposed rule and the MHPAEA regulations. For the definitions of “aggregate lifetime dollar limit” and “annual dollar limit,” CMS proposed to replace the words “group health plan for any coverage unit” with “MCO, “Prepaid Inpatient Health Plan” (PIHP), “Prepaid Ambulatory Health Plan” (PAHP), or “ABP” to reflect the common terms for Medicaid health plans. For CHIP, CMS proposed to replace the words “group health plan for any coverage unit” with “CHIP state plan or a managed care entity (MCE).” CMS proposed to add the terms “ABP” and “Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits.” CMS also proposed to add the definition of “essential health benefits (EHBs).” CMS is finalizing this provision as proposed.

CMS proposed a different definition for the term “medical/surgical benefits” because states define this term in the Medicaid and CHIP context. CMS also proposed to exclude long-term care services in the Medicaid and CHIP context because the long-term care services offered in Medicaid/CHIP are not commonly offered in commercial health insurance. The proposed rule required states to define which benefits are medical/surgical, consistent with generally recognized standards of current medical practice. In response to comments, CMS has revised this final rule to include long-term care services in the definitions of medical/surgical, MH, and SUD



benefits, and thus to apply parity protections under this final rule to long-term care services. Long-term care services will need to be included in the appropriate classification(s) of benefits provided for in this rule for the purposes of parity analysis. CMS will provide additional information to states regarding the application of parity to long-term services to assist states in determining how various medical/surgical and MH/SUD long-term services would be classified in the four areas (inpatient, outpatient, pharmacy, and emergency).

CMS proposed to define “MH benefits” and “SUD benefits” as “benefits for items and services for mental health conditions and SUDs, as defined by the state and in accordance with applicable state and federal law.” States must also define MH and SUD benefits consistent with generally recognized standards of current medical practice. Consistent with the MHPAEA regulations for group health insurance, this requirement is included to ensure that a benefit is not misclassified to avoid compliance with the parity requirements. In response to comments, CMS revised this final rule to include long-term care services in the definitions of MH and SUD benefits and to apply parity protections under this final rule to long-term care services. Therefore, long-term care services will need to be included in the appropriate classification(s) of benefits provided for in this rule for the purposes of the parity analysis. CMS will provide additional information to states regarding the application of parity to long-term services.

CMS proposed that the definition of “treatment limitation” be the same as under the MHPAEA regulations, including distinguishing between a quantitative and non-quantitative treatment limitation (NQTL). A permanent exclusion of all benefits for a specific condition or disorder is not a treatment limitation. CMS is clarifying in this final rule that benefit limits that allow for an individual to exceed numerical limits for medical/surgical or MH/SUD benefits based on medical necessity are not considered to be quantitative treatment limits under this rule but are subject to the provisions of this rule governing NQTLs for medical/surgical or MH/SUD benefits. The processes, strategies, evidentiary standards, or other considerations that are used to determine whether to apply a soft limit must be comparable to and applied no more stringently than factors used in applying the limitation for medical surgical/benefits in the classification.

B. Parity Requirements for Aggregate, Lifetime, and Annual Limits (§§438.905, 457.496)

CMS proposed that the application of the parity requirements for aggregate lifetime and annual dollar limits will generally be the same as under the MHPAEA regulations. CMS is finalizing this provision as proposed with minor technical changes to the title wording and paragraph numbering.



C. Parity Requirements for Financial Requirements and Treatment Limitations (§§438.910, 440.395(b), 457.496(d))

1. Clarification of Terms

CMS clarified that, for the purpose of the proposed rule, “classification of benefits” means a classification as described in 42 CFR 438.910. The proposed rules required parity for financial requirements and treatment limitations to be applied on a classification-by-classification basis. The proposed rules used the term “type” to refer to financial requirements and treatment limitations of the same nature, including copayments, coinsurance, annual visit limits, and episode visit limits. A financial requirement or treatment limitation must be compared only to requirements and limitations of the same type within a classification. A “level” of a type of financial requirement or treatment limitation refers to the magnitude (such as the dollar, percentage, day, or visit amount) of the requirement or limitation.

CMS did not receive comments on this provision and will finalize as proposed.

2. General Parity Requirement for Financial Requirements and Treatment Limitations

The proposed general parity requirement prohibits an MCO, PIHP, PAHP, ABP, or 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 applied to substantially all medical/surgical benefits in the same classification. The general parity requirement applies separately for each type of financial requirement or treatment limitation.

One commenter emphasized the difficulty of ensuring parity requirements across delivery platforms, especially as they relate to NQTLs and intermediate services. The commenter noted that the line between intermediate services and long-term care services is not always clear and stated that medical necessity criteria would need to be established to differentiate levels of care within long-term care services. The commenter requested additional guidance on how to address parity requirements for services that are unique to Medicaid and for which comparable services on the medical/surgical side do not exist. CMS responded that the parity analysis does not require a one-to-one comparison of an MH/SUD service to a medical/surgical service; instead, it requires that an NQTL may not be imposed for an MH/SUD benefit in any classification unless, under the terms of the coverage, as written and in operation, 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. If questions persist regarding the development and use of medical necessity criteria under this rule and/or methodologies for classifying intermediate and long-term care services into the four benefit



classifications provided in this rule, then CMS may develop further guidance or provide technical assistance as needed.

Classification of Benefits

Under the MHPAEA regulations, if a group health plan provides MH/SUD benefits in a classification of benefits (inpatient in-network, inpatient out-of-network, outpatient out-of-network, emergency care, and prescription drugs), then MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. Because the benefit structure of traditional Medicaid, ABPs, and CHIP may vary significantly from commercial insurance coverage, CMS proposed to eliminate the in-network and out-of-network distinctions for the inpatient and outpatient classification. Instead, CMS proposed the following four classifications: inpatient, outpatient, emergency care, and prescription drugs. All Medicaid benefits, with the exception of long-term care services, should fall into one of these four classifications, and these are the only classifications to be used for purposes of applying the parity requirements.

CMS did not propose to specify an intermediate classification to be used in the parity analysis for Medicaid or CHIP programs. Similar to the MHPAEA regulations, CMS proposed to allow the applicable regulated entity to assign intermediate-level services to any of the classifications listed, but assignment to those classifications must be done in a consistent manner for medical/surgical services and MH/SUD services. The proposed rule did not define the services included in each classification, which gives states the flexibility to define the services for each classification.

CMS finalized these provisions as proposed with the exception of amending the provisions at §§438.910(b)(2), 440.395(b)(2)(ii) and 457.496(d)(2)(ii) to note that the factors used to classify services in the four classifications must be reasonable in addition to being the same for medical/surgical and MH/SUD services.

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

CMS proposed standards similar to those in the MHPAEA regulations for determining the portion of medical/surgical benefits subject to a financial requirement or quantitative treatment limitation for purposes of the parity analysis. The portion of medical/surgical benefits in a classification subject to a financial requirement or treatment limitation would be based on the dollar amount of all payments for medical/surgical benefits in the classification expected to be paid during the year. For MCOs, PIHPS, and PAHPs, this would be dollar amounts for payment in a contract year, and for ABPs and CHIP state plans, it would be for the year starting the effective date of the approved ABP or CHIP state plan. For purposes of this calculation, the MCOs, PIHPS, and PAHPs would collectively determine the total amount projected to be expended to determine the two-thirds threshold (discussed below).



Similar to the MHPAEA final regulations, the first step in applying the general parity requirement to a given financial requirement or treatment limitation is to determine whether it applies to “substantially all” medical/surgical benefits in a classification. CMS proposed to define “substantially all” as at least two-thirds of the medical/surgical benefits in that classification as measured by the total dollar amount of payments for medical/surgical benefits in the classification expected to be paid within a measurement year.

If a type of financial requirement or treatment limitation applies to substantially all medical/surgical benefits in a classification, then the next step is to determine the predominant level of that type of financial requirement or treatment limitation that applies to mental health benefits in the classification. CMS proposed that the level of a type of financial requirement or treatment limitation would be the predominant level if it applies to more than one-half of medical/surgical benefits subject to the requirement or limitation in that classification. If a single level of a type of financial requirement or treatment limitation applies to more than one-half of the medical/surgical benefits subject to the requirement or limitation in a classification, then the applicable regulated entity may not apply that particular requirement or limitation to MH/SUD benefits at a level that is higher or more restrictive than the level that has been determined to be predominant.

States that choose to use PIHPs, PAHPs, or the fee-for-service (FFS) delivery system to provide some of the MH/SUD benefits to Medicaid enrollees would be required to complete an analysis to determine if the benefits comply with these rules. If no single level applies to more than one-half of medical/surgical benefits in a classification, then multiple levels of the same type of financial requirement or treatment limitations can be combined by the state until the portion of the medical/surgical benefits subject to the requirement or limitation exceeds one-half. For any combination of levels that applies to more than one-half of medical/surgical benefits subject to the financial requirement or treatment limitation in a classification, the state may not apply that particular requirement or limitation to MH/SUD benefits at a level that is more restrictive than the least restrictive level within the combination. The proposed rule provided an example that illustrates this approach.

CMS is finalizing these provisions as proposed.

4. Special Rules for Multi-Tiered Prescription Drug and Other Benefits

The MHPAEA regulations allow plans under certain circumstances to apply different levels of financial requirements to different tiers of prescription drugs and still satisfy the parity requirements. CMS proposed to allow Medicaid MCOs, PIHPs, PAHPs, ABPs, and CHIP state plans to subdivide the prescription drug classification into tiers based on reasonable factors and without regard to whether a drug is prescribed for medical/surgical benefits or for MH/SUD benefits.



CMS also proposed—similar to the MHPAEA regulations—to permit a sub-classification for office visits but prohibit other sub-classifications, such as separate sub-classifications for generalists and specialists. After the sub-classifications are established, a Medicaid or CHIP plan may not impose any financial requirement or quantitative treatment limitation on MH/SUD benefits in any sub-classification that is more restrictive than the predominant requirement or limitation that applies to substantially all medical/surgical benefits in the sub-classification. Unlike the MHPAEA regulations, the proposed rule did not include using network tiers for the purposes of the parity analysis because network tiers are less common in Medicaid plans.

CMS removed the provision to deem compliance with §§438.910(d)(3) and 457.496(d)(5) of this rule (regarding parity requirements for access to out-of-network providers) where an MCO, PIHP, PAHP, or CHIP state plan is found to be in compliance with the provider network standard found in §438.206(b)(4). The provisions regarding multi-tiered prescription drug benefits and other benefits at §§438.910(c)(2), 440.395(b)(3)(ii), 457.496(d)(3)(ii) are finalized as proposed.

D. Cumulative Financial Requirements (§§438.910(c)(3), 440.395(b)(3)(iii), 457.496(d)(3)(iii))

CMS proposed that cumulative financial requirements be defined as financial requirements that determine whether and to what extent benefits are provided based on accumulated amounts, such as deductibles. Similar to the MHPAEA rule, CMS proposed that any separate cumulative financial requirement not be permitted for entities subject to CMS’s proposed requirements. However, treatment limitations will be permitted to accumulate separately for medical/surgical and MH/SUD services as long as they comply with the general parity requirement. MCOs, PIHPs, and PAHPs will be able to maintain separate treatment limitations, provided that such limitations for MH/SUD benefits are no more restrictive than the predominant limitation applied to substantially all medical/surgical benefits in a given classification.

CMS is finalizing these provisions as proposed.

E. Compliance with Other Cost-Sharing Rules (§438.910(c)(4))

CMS emphasized that all financial requirements included in a parity analysis must also be in compliance with existing cost-sharing rules for Medicaid and CHIP, as well as with the requirements of the proposed rule. CMS proposed to reiterate the requirement with a cross-reference to the cost-sharing rules applicable to MCOs, PIHPs, and PAHPs.

CMS received no comments on this proposal and is finalizing these provisions as proposed.



F. NQTLs (§§438.910(d), 440.395(b)(4), 457.496(d)(4))

Medicaid and CHIP state plans may impose a variety of limits affecting the scope or duration of benefits that are not expressed numerically (NQTLs). CMS proposed to prohibit the imposition of any NQTL to MH/SUD benefits unless certain requirements are met. For states using a non-managed care delivery system for their ABPs and CHIP, CMS proposed that the state may only impose an NQTL on a mental health benefit in any classification if it has written and operable processes, strategies, evidentiary standards, or other factors used in applying the NQTL that are comparable to or less restrictive than any processes used in applying the limitation for medical/surgical services in that classification. This is similar to the requirement under the MHPAEA regulations.

CMS also proposed that a managed care delivery system providing access to out-of-network providers for MH/SUD benefits use the same processes for providing access to out-of-network providers for medical surgical benefits within the same classification. CMS noted that MCOs, PIHPs, and PAHPs may use network tiers in developing NQTLs. In the proposed rule, CMS provided several examples to illustrate the operation of the requirements for NQTLs.

In the final rule, CMS notes that if questions arise about the appropriateness of criteria that are being used to apply NQTLs to MH/SUD benefits, CMS will consider whether additional sub-regulatory guidance or further rulemaking is needed.

CMS will provide technical assistance to states regarding what constitutes an NQTL and additional examples of typical parity violations. CMS will develop educational materials about the requirements of parity for Medicaid managed care, ABPs, and CHIP programs, and about effective quality control strategies to ensure that managed care contracts include provisions that reflect best practices and promote quality of care in the context of parity. CMS will also identify and promote best practices and quality control strategies for states to help MCOs ensure that their benefits and service delivery strategies adhere to the requirements of parity.

CMS has revised this final rule to require that the factors used to apply the limitation to MH/SUD benefits be “comparable to” and applied no more stringently than the factors used in applying the limitation to medical/surgical benefits in the classification. This language is in alignment with the general NQTL standard. This final rule also clarifies that the types of factors used to apply the NQTL will depend on the nature of both the NQTL and the benefit, and that in some cases it may be appropriate to use the same factors to apply the NQTL for both medical/surgical and MH/SUD benefits, whereas 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 factors that are comparable may need to be used instead.

CMS also removed the provision to deem compliance with §§438.910(d)(3) and 457.496(d)(5) of this rule (regarding parity requirements for access to out-of-network providers) where an MCO,



PIHP, PAHP, or CHIP state plan is found to be in compliance with the provider network standard found in §438.206(b)(4). CMS clarified that compliance with §438.910(d)(3) and/or §457.496(d)(5) does not affect the requirement to comply with §438.206(b)(4). CMS may provide additional guidance or technical assistance to states regarding the requirements of §§438.206(b)(4) and 438.910(d)(3) and 457.496(d)(5) if questions persist.

G. Application to CHIP and EPSDT-Deemed Compliance (§457.496(b))

The CHIP Reauthorization Act (CHIPRA) applies mental health parity requirements to the entire “state child health plan,” including any MCOs that contract with the state CHIP. The proposed rule provided that, for individuals receiving EPSDT services through the CHIP state plan, the state will be deemed to meet parity requirements for financial requirements and treatment limitations. However, states that apply NQTLs to EPSDT services must ensure that these limitations are applied consistent with the intent of the MHPAEA.

In response to comments, CMS is modifying §457.496(b) of the final regulation to provide that, to be deemed compliant with the mental health parity requirements under §457.496, a state must elect in its state plan to cover all EPSDT services required under §1905(r) of the Act, as well as meet the informing and administrative requirements under §1902(a)(43) of the Act and the approved state Medicaid plan. CMS is also adding new language to require that the child health plan include a description of how the state will comply with the applicable Medicaid statute and the requirements of this section. The exclusion of services for particular conditions or diagnoses is also not permitted under §1905(r) of the Act for individuals under 21 entitled to EPSDT services. Therefore, CMS has added a provision to preclude separate CHIPs from excluding any particular condition, disorder, or diagnosis under EPSDT benefits.

CMS is also revising the meaning of EPSDT to include references to both §§1905(r) and 1902(a)(43) of the Act. CMS is not finalizing the proposed text that referred to “expansion of Medicaid programs,” which CMS believes was confusing since the regulation applies only to separate CHIP programs. CMS also added clarity that if a state has elected in its state child health plan to cover EPSDT benefits only for certain children eligible under the state child health plan, then the state is deemed compliant with this section only with respect to such children.

CMS will develop a state plan amendment template for states to use in indicating how they will comply with the requirements of §457.496. States will also be required to affirm in their state plan that the processes, strategies, evidentiary standards, or other factors used in applying NQTLs to MH/SUD benefits are comparable to and applied no more stringently than those used in applying the limitation to medical/surgical benefits. As a part of the review process, CMS will work closely with states to ensure compliance with the parity requirements and assist states in their efforts to address any inconsistencies discovered during the review process.



Finally, in response to comments, CMS has added language to expressly provide that a separate CHIP cannot be deemed compliant with mental health parity requirements under the final regulation if it excludes benefits for a particular condition, disorder, or diagnosis.

H. Availability of Information (§§438.915, 440.395(c), 457.496(e))

Similar to the availability of information requirements under the MHPAEA regulations, CMS proposed to require MCOs, PIHPs, and PAHPs to make their medical necessity criteria for MH/SUD benefits available to any enrollee, potential enrollee, or participating provider upon request. MCOs, PIHPs, and PAHPs that distribute practice guidelines to all affected providers and enrollees upon request will be deemed to have met this proposed requirement. The proposed rules also required the MCO, PHIP, or PAHP to make available the reason for any denial of reimbursement or payment for MH/SUD services to the enrollee. Notice must also be provided to a provider and enrollee requesting a MH/SUD service that is denied or authorized in an amount, duration, or scope that is less than requested. CMS proposed that all states delivering ABP services through a non-MCO must make available to enrollees and contracting providers upon request the criteria for medical necessity determinations for MH/SUD benefits and provide enrollees the reason for any denial of such services.

CMS is providing technical assistance to states regarding the data and information that would be helpful to review to identify possible issues with plans' efforts to understand and comply with parity. CMS is finalizing these provisions as proposed.

I. Application to EHBs and other ABP Benefits (§§440.395, 440.347)

The ACA requires ABPs to provide the ten essential EHBs, including MH/SUD services, and to comply with certain parity requirements. States have the flexibility to develop different benefit packages, including services beyond the EHBs for different groups of eligible individuals, as long as each benefit package contains all of the EHBs and meets the parity requirements.

CMS will provide technical assistance to states regarding the implementation of these provisions and questions or issues that may arise. This technical assistance may include the identification and promotion of best practices, tools, and/or other assistance for analyzing ABPs for compliance with the requirements of this rule. CMS is finalizing these provisions as proposed.

J. ABP State Plan Requirements (§440.395(d))

CMS proposed adding a provision that requires a state using ABPs to provide information in the ABP state plan amendment request to assure compliance with applicable federal statutes and regulations, including MHPAEA and EHB anti-discrimination provisions.



CMS is finalizing this provision as proposed, with a different designation, at §440.395(e)(3).

K. Application of Parity Requirements to the Medicaid State Plan

Under the proposed rule, the parity requirements would apply to the benefits offered by the MCO or—if the benefits are carved out—to all benefits provided to MCO enrollees, regardless of the service delivery system. States that have individuals enrolled in MCOs and have mental health services offered through the FFS system will have the option of amending their non-ABP state plan to be consistent with these proposed regulations or offering mental health services through a managed care delivery system to be compliant with these rules. The mental health parity requirements of this proposed rule will not apply to Medicaid enrollees who only receive services through FFS. However, CMS still encourages states to provide benefits to the FFS population in a way that complies with the mental health parity requirements.

CMS will continue to provide support and technical assistance to states to strengthen coverage of MH/SUD services for all Medicaid participants even when states are not required to do so through this rule. CMS is finalizing this provision as proposed.

L. Scope and Applicability of the Proposed Rules (§§438.920(a)-(b), 440.395(d), 457.496(f)(1))

CMS proposed that the requirement that MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided will apply if a beneficiary is enrolled in an MCO. In cases in which MH/SUD services are delivered through multiple managed care delivery vehicles, CMS proposed to apply the parity provisions across the managed care delivery systems in the Medicaid and CHIP programs. MHPAEA requirements apply to the entire package of services MCO enrollees receive, whether from the MCO, PIHP, PAHP, or FFS. CMS expects states to work with their MCOs to determine the best method of achieving compliance with these proposed parity requirements for benefits provided to the MCO enrollees.

For MH/SUD benefits offered through FFS, states could use their existing state plan to achieve parity when individuals are receiving some benefits from both an MCO and FFS system. If a state does not have MH/SUD benefits in every classification in which medical/surgical benefits are provided across all authorities, then the state would have to choose either to offer these services through an MCO, PIHP, or PAHP, or amend its state plan to include these benefits.

In states where the MCO has responsibility for offering all medical/surgical and MH/SUD benefits, the MCO would be responsible for undertaking the parity analysis and informing the state about what additional changes would be needed to the MCO contract. In states where some or all of MH/SUD benefits are provided through MCOs, PIHPs, PAHPs, or FFS, the state would have the responsibility for undertaking the parity analysis across those delivery systems and



determining if the existing benefits and any financial or treatment limitations are consistent with MHPAEA. If states offer benefits through an ABP or CHIP state plan with various delivery systems, the state would need to apply the provisions of the proposed rule across the delivery systems utilized for its ABP and CHIP state plan and ensure that beneficiaries have access to MH/SUD benefits in every classification medical/surgical benefits are provided. CMS provided an example of how the rule would be applied across the delivery system in Medicaid.

CMS finalized these provisions with the following modifications:

- States have to review both medical/surgical benefits and MH/SUD benefits when completing the parity analysis.
- Information on compliance with the rule must be available on a state's website within 18 months of the publication of the final rule and updated with any change in MCO, PIHP, PAHP, or Medicaid state plan benefits.
- States must ensure that all services are delivered to the enrollees of the MCO in compliance with this rule regardless of whether the MCO covers all services or only a portion of services.
- States must indicate in their state plans the standard used when classifying benefits in their respective category as a medical/surgical, MH, or SUD benefit.

M. Scope of Services (§§438.920(c), 440.395(e)(2), 457.496(f)(2))

CMS proposed that an MCO, PIHP, or PAHP would not be required to provide MH/SUD benefits for conditions or disorders beyond the conditions or disorders that are covered as required by their contract with the state. Plans that provide benefits for one or more specific mental health conditions or SUDs would also not be required to provide benefits for additional conditions or disorders. The proposed regulations would not affect the terms and conditions relating to the amount, duration, or scope of MH/SUD benefits under the MCO, PHIP, or PAHP contract.

CMS is finalizing these provisions as proposed.

N. Increased Cost Exemption

The proposed rule did not include an increased cost exemption for MCOs, PIHPs, or PAHPs. However, CMS proposed that states will be allowed to include the cost of providing additional services or removing treatment limitations in their actuarially sound rate methodology where such costs are necessary to comply with MHPAEA parity requirements. The changes to the managed care rate setting process give states and MCOs the ability to fully comply with these mental health parity requirements by allowing flexibility to provide services compliant with the proposed regulation or remove service limits. CMS proposed that states would have up to 18



months after the date of the publication of the final rule to comply with the provisions of these regulations. CMS did not propose to permit states delivering services through an ABP or CHIP plan to apply for a cost exemption due to the mandatory delivery of EHBs and the requirement that ABPs be compliant with MHPAEA.

CMS is finalizing this provision as proposed. CMS is not including a provision in the final rule for an increased cost exemption.

O. Enforcement, Managed Care Rate Setting, and Contract Review and Approval (§§438.6(e), 438.6(n))

States must assure compliance with parity requirements when submitting ABP or CHIP state plans. CMS proposed to require the state Medicaid agency to include contract provisions involving compliance with parity requirements in all applicable MCO, PIHP, and PAHP contracts. CMS expects states to include in the MCO, PIHP, and PAHP contracts a methodology that will establish and demonstrate compliance with parity requirements, including, in some cases, developing a crosswalk with other entities that are part of the service delivery system for enrollees. This methodology would have to ensure that all Medicaid plans included in the delivery system work together to ensure that any MCO enrollee in a state is provided access to MH/SUD benefits.

If the state provides some MH/SUD benefits within its state plan, all MCO contracts must include provisions needing compliance with parity requirements because all MCO enrollees must be provided access to MHPAEA-compliant services even if the MCO itself does not provide the MH/SUD services. CMS may deny federal financial participation on expenditures for the MCO contract to the extent that the state has not documented that the contract would comply with parity requirements. If MH/SUD services are delivered outside of the MCO contract, then the state would be required to show how the MCO enrollees are provided all of the services needed to comply with this proposed rule. If the state cannot provide evidence of this compliance outside of the MCO contract, then CMS would have the ability to defer federal financial participation on the MCO contract amount until evidence of compliance is provided.

CMS is finalizing these provisions as proposed with a revision to target contract requirements on the provision—rather than the receipt—of services. CMS is planning to release subregulatory guidance around documentation that will be required to show compliance with these regulations, as well as develop tools and provide technical assistance to states in completing the parity analysis.



P. Applicability and Compliance (§§438.930, 440.395(d), 457.496(f))

CMS proposed that the rule would be effective based on the date of the publication of the final rule. However, MCOs, PIHPs, or PAHPs would have to establish compliance with this rule no later than the beginning of the contract year starting 18 months after the publication of the final rule. States would have 18 months after the publication of the final rule to ensure that their ABPs and CHIP are in compliance with the rule.

CMS is finalizing this provision with a modification that states that contracts with MCOs, PIHPs, and PAHPs to offer Medicaid services must ensure compliance with the final rule no later than 18 months after the publication of the final rule, regardless of whether the date is the start or middle of a contract year.

Q. Utilization Management

Current Medicaid regulations have requirements for the control of utilization management of inpatient services in mental hospitals. These regulations require medical and other professionals within the Medicaid agency to evaluate each beneficiary's need for admission into inpatient services in a mental hospital. After states have expressed concern that this requirement would prevent compliance in achieving parity for inpatient services at a mental hospital, CMS proposed to eliminate this requirement from existing regulations. A state could continue these evaluations but would need to ensure that the standards and processes were consistent with the provisions in this regulation regarding NQTLs when parity limits are applicable.

CMS is finalizing the removal of this requirement regarding evaluations for admission to inpatient services in a mental hospital as proposed.

R. Institutions for Mental Diseases (IMD)

The IMD exclusion is a statutory prohibition on providing Medicaid matching funds for services provided to individuals aged 21 to 64 years who are inpatients in IMDs. IMDs are defined in statute as any 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, including medical attention, nursing care, and related services. The proposed regulation did not address the IMD payment exclusion. CMS received several comments on the applicability of this regulation on CMS's IMD payment policy. CMS is not making changes to this rule on this topic.

S. Medicare-Medicaid Dual-Eligible Beneficiaries

CMS received a number of comments about individuals who are dually eligible for both Medicare and Medicaid and, specifically, the provision of both Medicare and Medicaid benefits to such beneficiaries. Mental health parity requirements under §2726 of the PHS Act do not



apply to Medicare Parts A, B, or D services covered by Medicaid MCOs, such as those covered by integrated plans for Medicare-Medicaid beneficiaries. The proposed rule noted that Medicare benefits are controlled by the Medicare statute and regulations, which are not within the scope of this rule; therefore, CMS is not including provisions in the final rule that are specific to coverage provided to Medicare-Medicaid beneficiaries.





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