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Centers for Medicare & Medicaid Services (CMS)
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CMS–2333–F

Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act[i] (MHPAEA) of 2008; the Application of Mental Health Parity Requirements

Action: Final Rule
Effective Date: May 31, 2016
Overview: This final rule addresses the application of MHPAEA parity requirements to: (1) **Medicaid managed care organizations (MCOs)** as described in section 1903(m) of the Social Security Act (SSA)[ii]; (2) **Medicaid benchmark and benchmark-equivalent plans** (referred to in this rule as Medicaid Alternative Benefit Plans[iii] (ABPs)) as described in section 1937 of the Act; and (3) **Children's Health Insurance Program (CHIP)** under title XXI of the Act. Under section the SSA, Medicaid MCOs, ABPs, and CHIP plans are required to comply with the requirements of the MHPAEA to the same extent that those requirements apply to a health insurance issuer that offers group health insurance. The rule does not apply to Medicaid state plan beneficiaries who are not enrolled in an MCO. These final rules incorporate these requirements into regulation.

Section	Title	Provision Summary
§438.900, §440.395, §457.496	**Definitions**	The definitions of terms in the final rule include most terms included in the MHPAEA final regulation[iv]. The final rule adds terms unique to the Medicaid program. **Long-term Services and Supports (LTSS)**–LTSS 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 intends to provide additional information to states regarding the application of parity to long term service. **Identification of Medical/Surgical and MH/SUD Conditions**–CMS believes the state and not CMS should identify which conditions are considered medical/surgical and MH/SUD conditions. The final rule provides states guidance regarding generally recognized independent standards of current medical practice to determine what conditions are medical surgical, mental health, and substance use disorders. **Treatment Limits**–States and MCOs may impose quantitative treatment limits for MH/SUD benefits, so long as they aren't more restrictive than the predominant limits applied to medical/surgical benefits in each classification. The rule allows states to apply quantitative treatment limits to services regardless of the type of practitioner that renders either a medical/surgical service or MH/SUD service so long as the parity requirements are met. **Utilization Review, Prior Authorization, and Concurrent Review**–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 om applying the limitation for medical/surgical benefits in the classification. **Definitions of Medical/Surgical, Mental Health, and Substance Use Disorder Services**–Revises the definitions of medical/surgical, mental health, and substance use disorder services so that they include, rather than exclude, long-term care services.

§438.905 & §457.496(c)	**Parity Requirements for Aggregate Lifetime and Annual Dollar Limits**	If a regulated entity applies an *aggregate lifetime* or *annual dollar limit* to between one-third and two-thirds of all medical/surgical benefits, it must either impose no aggregate lifetime or annual dollar limits on MH/SUD benefits, or impose and aggregate lifetime or annual dollar limit on MH/SUD benefits that is no more restrictive than the average limit for medical/surgical benefits. This final rule neither sanctions nor prohibits aggregate lifetime and annual dollar limits. This rule merely provides the standards for applying parity requirements to these limits if the limits are otherwise authorized. **Coverage Unit**–CMS did not include a definition of "coverage unit" in this rule because Medicaid and CHIP programs, the coverage unit will always be the individual beneficiary, regardless of marital or family status. **Medicaid ABPs**–Regardless of whether services are delivered in managed care or nonmanaged care arrangements, all Medicaid ABPs (including benchmark equivalent and secretary-approved benchmark plans) and CHIP plans are statutorily required to meet the financial requirements and treatment limitation components of mental health parity provisions in the Public Health Service Act (PHS).
§§438.910, 440.395(b), and 457.459(d)	**Parity Requirements for Financial Requirements and Treatment Limitations**	
	Clarification of Terms	CMS proposed to modify the classifications of benefits set forth in the regulations that were adopted by HHS in the 2010 MHPAEA final rule. CMS proposes in the Medicaid and CHIP rule that parity requirements for financial requirements and treatment limitations be applied on a classification by classification basis. CMS is also proposing that the term "type" would refer to financial requirements and treatment limitations of the same nature. Different types of financial requirements and treatment limitations include copayments, copayments, coinsurance, annual visit limits, and episode visit limits. CMS is proposing that a financial requirement or treatment limitation must be compared only to requirements and limitations of the same type within a classification. Finally, CMS is proposing the term "level" to refer to the magnitude (such as the dollar, percentage, day, or visit amount) of the financial requirement or treatment limitation.
	General Parity Requirement for Financial Requirement and Treatment Limitations	CMS is proposing to eliminate the in-network and out-of-network distinctions for the inpatient and outpatient classifications: I. Inpatient II. Outpatient III. Emergency care IV. Prescription Drugs These four classifications in the final rule are the only classifications to be used for the purpose of applying the parity requirements of MHPAEA to Medicaid and CHIP. These classifications must be used for all financial requirements and treatment limitations to the extent that a MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), ABP or CHIP provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of financial requirement or treatment limitation) for benefits in the classification. This 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 package. CMS proposes that the classification of benefits should relate to how states construct and manage their Medicaid benefits.

		CMS is allowing the applicable regulated entity (the MCO, PIHP, or PAHP, or state in connection with the ABP and CHIP) to assign intermediate level services to any of the classifications listed, but require that assignment to those classifications be done using the same standards for both medical/surgical services and MH/SUD services, and be reasonable. CMS is not proposing any specific rules for classification of long-term care (LTC) services. The final rule allows the regulated entity to assign LTC services to any of the four listed classifications. **Definition of the Four Classifications of Services**–State health insurance laws may define the terms describing the four classifications of services, and in the event these terms are not defined, CMS expects each regulated entity within a state to define these classifications in a similar manner. Each managed care plan or the state in connection with ABP or CHIP, must apply these terms uniformly for both medical/surgical benefits and MH/SUD benefits. **Intermediate and Long-term Care Services**–The final rule applies parity requirements to all intermediate and LTC services. Medical necessity determinations for LTC services or other services are a nonquantitative treatment limitation[v] (NQTL) that must comply with the requirements of the final rule. The parity analysis does not require a 1-to-1 comparison of MH/SUD service to medical/surgical service, but instead requires that a NQTL may not be imposed for a MH/SUD benefit in any classification unless certain criteria were applied as explained in the rule. CMS may develop further guidance or will provide technical assistance as needed in relation to the development of medical necessity criteria as described in the final rule. **State Licensure Laws**–The rule clarifies that mental health parity requirements under the final rule do not apply to state licensure laws and will not affect clinical determinations and processes regarding medical necessity, such as the intensity of services that are medically necessary for an individual, are subject to NQTL.
	Applying the General Parity Requirements to Financial Requirements and Quantitative Treatment Limitations (§§438.910(c), 440.395(b)(3), and 457.456(d)(3))	The final rule prohibits a MCO, PIHP or PAHP (in connection with coverage provided to an MCO enrollee), or ABP state plan (when used in a nonmanaged care assignment), or CHIP state plan or MCE 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 " requirement or limitation of that type applied to "substantially all" medical/surgical benefits in the same classification. **Quantitative Treatment Limits**–The portion of medical/surgical benefits in a classification[vi]subject to a financial requirement or quantitative treatment limitation would be based on the dollar amount of all payments for medical/surgical benefits in the classification expected to be paid during a specific year. For **MCOs, PHIPs and PHAPs**, this means dollar amounts for payment during a contract year. For **ABPs and CHIP state plans**, this means dollar amounts for the year starting the effective date for approved ABP or CHIP state plan; effective dates for these plans will vary based on the date the ABP or CHIP state plan was approved 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 PHIPs and PAHPs are used in conjunction with MCOs) must determine the total amount projected to be expended to determine the two-thirds threshold. **Quantitative Treatment Limitation on Inpatient MH/SUD Services**–With regard to the level of the quantitative treatment limitation on inpatient MH/SUD services, the MCO may maintain its 30-day limit because 100 percent of all inpatient medical/surgical benefits are also subject to a 30-day limit, making it the predominant level. **Outpatient MH/SUD Services**–The MCO may not maintain a limit on visits per year if the visit limitation is not the predominant level (that is, it does not apply to at least 50 percent of the medical/surgical benefits in the classification subject to the visit limit), in this case the MCO would have to either remove the visit limits altogether on outpatient MH/SUD services or increase

		the visit limitation to at least 50 percent per year to align with the least restrictive level of visit limits on outpatient medical/surgical benefits. **Emergency Services**–Because there are currently unlimited emergency visits under the medical/surgical benefits, the MCO would need to maintain unlimited visits for emergency services for MH/SUD, and would not be able to impose any limits on MH/SUD unless limits were also imposed on medical/surgical services and these limits were consistent with parity requirements.
	Special Rules for Multi-Tiered Prescription Drug Benefits and Other Benefits (§§438.910 (c)(2), 440.395(b)(3)(ii), and 457.496(d)(3)(ii))	The final rule permits plans under certain circumstances to apply different levels of financial requirements to different tiers of prescription drugs and still satisfy the parity requirements. Regulated entities are allowed to subdivide the prescription drug classification into tiers based in reasonable factors and without regard to whether a drug is generally prescribed for medical/surgical benefits or for MH/SUD benefits. The MHPAEA final regulations permit a sub-classification for office visits, separate from other outpatient items and services.
§438.910 (c)(3), §440.395(b)(3)(iii), and §457.496(d)(3)(iii)	**Cumulative Financial Requirements**	– CMS is proposing that separate cumulative financial requirements (separate for mental health, substance use or medical/surgical) will not be permitted for entities subject to our proposed requirements (namely, MCOs, PIHPs and PAHPs in connection with coverage provided to MCO enrollees, and in ABP and CHIP). – CMS is also proposing to permit quantitative treatment limitations to accumulate separately for medical/surgical and MH/SUD services as long as they comply with the general parity requirement.
§438.910(c)(4)	**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[vii]. – CMS is emphasizing that all financial requirements included in MHPAEA analysis must also be in compliance with both existing cost-sharing rules and the requirements of this final rule.
§440.395(b)(4), and §457.496(d)(4) and (d)(5)	**Non-quantitative Treatment Limitations (NQTLs)**	▪ Prohibits the imposition of any nonquantitative treatment limitations (NQTL) to MH/SUD benefits unless certain requirements are met. ▪ **A NQTL may not be imposed for MH/SUD benefits in any classification unless**, under the terms of the plan (or health insurance coverage) 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 (processes, strategies, evidentiary standards, or other considerations used in determining limitations on coverage of service) used in applying the limitation for medical surgical/benefits in the classification. ▪ **States that are using a nonmanaged care delivery system** for their ABPs and CHIP, the state (through its ABP and CHIP state plan) may only impose a NQTL on a MH/SUD benefit in any classification if it has written and operable processes, strategies, evidentiary standards or other factors used in applying—to MH/SUD benefits in that classification—the NQTL that are comparable to or less restrictive and applied no more stringently than any processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical services in that classification. ▪ **The phrase** "**applied no more stringently" requires** that any processes, strategies, evidentiary standards, or other factors that are comparable on their face be applied in the same manner to medical/surgical benefits and MH/SUD benefits. ▪ **Out-of-Network Coverage**–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 regulated entity is unable to provide them in-network. Requires that the factors used in determining access to out-of-network providers for MH/SUD benefits 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 acts of benefits.

- **An NQTL 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.
- **Resources and Technical Assistance**–CMS plans to provide technical assistance to states regarding the implementation of these provisions along with new 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.
- **The final rule removes the provision to deem compliance** with NQTL related to its application to out-of-network providers, CHIP, and EPSDT.
- **States are strongly encouraged to consider changes** to the state plan benefit package to comport with the mental health parity requirements of section 2726 of the Public Health Service Act[viii], which imposes certain requirements on group health plans and health insurance issuers who provide both medical/surgical and MH/SUD benefits:
- **Aggregate Lifetime Limits.**–
  - **No Lifetime Limit.—**If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on MH/SUD benefits.
  - **Lifetime Limit.**—If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable lifetime limit''), the plan or coverage must either—
    (i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to MH/SUD benefits and not distinguish in the application of the limit between the benefits; or
    (ii) not include any aggregate lifetime limit on MH/SUD benefits that is less than the applicable lifetime limit.
  - **Annual Limits**.—[ES1]
  - **No Annual Limit**.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.
  - **Annual Limit**.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable annual limit''), the plan or coverage must either—
    (i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to MH/SUD benefits and not distinguish in the application of the limit between the categories of benefits; or
    (ii) not include any annual limit on MH/SUD benefits that is less than the applicable annual limit.
  - **Financial Requirements and Treatment Limitations**.—Plan or coverage shall ensure that the financial requirements and treatment limitations applicable to MH/SUD benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements or treatment limitations that are applicable only with respect to MH/SUD benefits.
  - **Availability of Plan Information**.—The criteria for medical necessity determinations made under the plan with respect to MH/SUD benefits must be made available by the plan administrator in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial or coverage determination under the plan of reimbursement or payment for services with respect to MH/SUD benefits in the case of any participant or beneficiary must, on request or as otherwise required, be made available by the plan administrator to the participant or beneficiary in accordance with regulations.

		– **Out-of-Network Providers**.—In the case of a plan or coverage that provides both medical and surgical benefits and MH/SUD benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage must provide coverage for MH/SUD benefits provided by out-of-network providers in a manner that is consistent with the statute. – **Authorization for Outpatient Mental Health Service**—Any requirements for prior authorization, concurrent review, or other NQTLs that are applied when a beneficiary begins receiving outpatient mental health services under fee for service (FFS) would be subject to the general parity analysis given this beneficiary is enrolled of an MCO. – **Utilization Review Requirements**—The use of concurrent review for MH/SUD services in a classification would have to be based on processes, strategies, evidentiary standards or other factors that are comparable to and applied no more stringently than those used by the plan to determine when to use concurrent review for a medical service in the same classification. Some acceptable factors may include variability in outcomes and lower predictability in length of stay. – **MH/SUD Medications**—CMS is not prohibiting the use of all quantitative or nonquantitative treatment limits for MH/SUD medications. MHPAEA does not mandate the coverage of specific treatments, services, or drugs, and instead governs the limitations imposed on benefits that are offered. – **Provider Reimbursement**–Regulated entities are permitted to consider a wide array of factors in determining provider reimbursement methodologies and rates for both medical/surgical services and MH/SUD services, such as: 1. Service type 2. Geographic market 3. Demand for service 4. Supply of providers 5. Provider practice size 6. Medicare reimbursement rates 7. Training, experience and licensure of providers The NQTL provisions require that these or other factors be applied comparably to and no more stringently than those applied for medical/surgical services.
§457.496(b)	**Parity for MH/SUD Benefits in CHIP Programs Covering EPSDT**	**Deeming of Compliance for Separate CHIP Programs** ▪ CMS is proposing to deem a separate CHIP compliant with mental health parity requirements if the state provides **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** in accordance with section 1905(r) of the Social Security Act (SSA)[ix]. ▪ To be deemed compliant with the mental health parity requirements separate CHIP programs are required to fully provide EPSDT benefits in accordance with the requirements of the Social Security Act. CMS, feeling this was not adequately addressed in the proposed rule, has modified the final rule to reflect that compliance with these requirements is also necessary for a separate CHIP to be deemed compliant with parity provisions. ▪ CMS is adding new language to the final rule requiring the child health plan to include a description of how the state will comply with the applicable Medicaid statute and the requirements of the final rule. ▪ They have also added a provision to preclude separate CHIPs from excluding any particular condition, disorder or diagnosis under EPSDT benefits. ▪ **In evaluating whether a state is fully compliant** with the statutory requirements governing EPSDT benefits with respect to children enrolled in the separate CHIP, **CMS plans to consider** whether there are any outstanding compliance **issues associated with the state's provisions of EPSDT in its Medicaid program.**

		▪ States that elect to apply any type of NQTLs under their separate program must ensure that such limits are consistent with EPSDT requirements. CMS plans to closely review states' NQTLs to ensure that they meet deemed compliance standards. ▪ Finally, 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, the state is deemed compliant with this section only with respect to these children. ▪ **State Plan Amendment Template–CMS will develop a state plan amendment (SPA) template for states** to use in indicating how they will comply with the requirements pertaining to §457.496 of the Final Rule, Parity in Mental Health and Substance Use Disorder Benefits. ▪ **State Attestation–CMS anticipates asking states** that report providing EPSDT to attest that the full EPSDT benefits being offered to children in the separate CHIP, in accordance with the requirements in the SSA. ▪ **Affirmation in State Plans**–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. ▪ **States Not Fully Compliant with EPSDT Benefits**—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 this 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** these factors are comparable to and applied no more stringently than those used in applying NQTLs to medical/surgical benefits in the same classification. CMS will develop a state plan template to facilitate this analysis. ▪ **Clarification of what medically necessary services separate CHIP programs are required to provide through EPSDT**–As stated in the preamble of the final rule, EPSDT is a required Medicaid benefit for categorically needy individuals under age 21 that entitles these individuals to medically necessary service, as described in section 1905(a) of the SSA[x], to treat physical or mental illnesses or conditions, whether or not these services are otherwise covered under the Medicaid state plan. **To be deemed compliant with the parity requirements** of the final regulations governing state plans providing EPSDT, the coverage of EPSDT under a separate CHIP requires the same scope of coverage that a child covered by Medicaid would receive—that is, CMS is saying that a CHIP enrollee would have to be entitled to all benefits and services described in the SSA if medically necessary and consistent with the act. ▪ **CMS does comment on page 18406 of the preamble** that its believes including a list of specific services that are required to be provided under EPSDT is "outside the scope of this regulation." ▪ **Revisions to the Definition of EPSDT Benefits**–CMS finalizes the rule with a revision to the definition of EPSDT benefits to specify that they should mirror the statutory requirement in Title XXI which addresses Mental Health Services Parity within CHIP regarding deemed compliance. Additional changes to proposed definitions clarify the standards that must be met to be deemed compliant, including the provision of all EPSDT benefits, and compliance with requirements for providing EPSDT benefits in accordance the SSA. Additional language was incorporated to clarify that the state plan must also include a description of how the state will comply with the EPSDT deeming requirements.
§438.915, §440.395(d), §457.496(e)	**Availability of Information**	▪ **Disclosure of Reasons for Adverse Determinations**—MHPAEA final regulations require that the reason for any denial under a group health plan or health insurance coverage of reimbursement or payment for services for MH/SUD benefits in the case of any participant or beneficiary be made available, upon request or as otherwise required. It is CMS' intent to apply the same disclosure requirements regarding availability of information in a similar manner to MCOs and to PIHPs and PAHPs that provide coverage to MCO enrollees, and to CHIP programs. ▪ **Extension of Requirements to Alternative Benefit Plans (ABPs)–**CMS is intending to use the authority granted under the SSA to extend denial disclosure requirements to ABPs, as well as those ABPs with services delivered through MCOs, PIHPs

		and all PAHP. All states delivering ABP services through a non-MCO must make available to beneficiaries and contracting providers on request the criteria for medical necessity determinations for MH/SUD benefits. ▪ **Deeming Compliance with Disclosure Requirements**–MCOs, PIHPs, and PAHPs must make their medical necessity criteria for MH/SUD benefits available to any enrollee, potential enrollee or contracting provider upon request. MCOs, PIHPs and PAHOs found to be in compliance with the final rules governing managed care plan adoption of practice guidelines subject to MHPAEA[xi] to all affected providers, and, upon request to enrollees and potential enrollees, will be deemed to meet the requirement. ▪ CMS believes that the requirements in the rule requiring that information be made readily available could be interpreted to include posting information on the website as a means of dissemination. States are encouraged to post information regarding practice guidelines. ▪ **Denial Rates**–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. Data regarding denial rates across classifications will be important information for states to analyze and determine if there are potential issues with complying with the rules and taking corrective action when appropriate with their MCO's, PIHPs, or PAHPs. ▪ **Stakeholder Involvement**–While CMS does not require states to develop stakeholder engagement processes regarding their efforts, CMS is encouraging states to undertake these efforts and to include stakeholders as much as possible. ▪ **Enrollee Notification of Changes in Benefits**–The final rules require that enrollees be notified at the time of enrollment and also at any time a change to the benefits or processes[xii] are changed.
§440.395(c), §440.395(e)(1)	**Application to Essential Health Benefits (EHBs) and Other ABP Benefits**	▪ States have oversight responsibility for ensuring parity in ABPs, similar to their responsibility for ensuring parity in managed care contracts. ▪ New SPA applications that are submitted to create ABPs will be reviewed by CMS to determine if the plan complies with the final rule.
§440.395(e)(3)	**ABP State Plan Requirements**	▪ CMS is requiring states using ABPs to provide sufficient information in the ABP state plan amendment to ensure and document compliance with parity provisions. ▪ Where ABPs are provided on a FFS basis, the regulation would require states to provide sufficient information in the ABP state plan amendment request to ensure and document compliance with parity requirements. ▪ CMS will review the plan amendment to assure compliance with parity requirements and EHB anti-discrimination provisions.
*****	**Application of Parity Requirements to the Medicaid State Plan**	▪ The provisions of section 2726 of the PHS Act that are incorporated through sections 1932 and 1937 of the act **do not apply directly to the benefit design for Medicaid fee-for-service and non-ABP state plan services**. ▪ Under the proposed rule, **the requirements would apply to the benefits offered by the MCO** (or, as discussed above, if benefits are carved out, to all benefits provided to MCO enrollees regardless of service delivery system) **but did not apply:** 1. to all Medicaid state plan benefit designs, or 2. for states that did not use an MCO at all in connection with delivery of services, the proposed rule at § 438.900 through § 438.930 [xiii]**would not have been applicable**. ▪ CMS is encouraging states to provide state plan benefits in a way that comports with mental health parity requirements of the Public Health Service Act (PHS). ▪ **The provisions of the SSA impose parity requirements in limited cases.** Only permitting CMS to encourage states to take actions in applying parity to MH/SUD benefits for FFS beneficiaries. ▪ **States can choose** to maintain these services on a FFS basis in their state plan and make the necessary changes to their state plan to comply with the final regulation. Nothing in this final regulation prohibits states from including additional MH/SUD services in their state plan or in managed care arrangements.

		▪ Parity requirements apply to the entire package of services MCO enrollees receive, whether from the MCO, PIHP, PAHP, or FFS. ▪ **Carve-out Services**–If states carve out some MH/SUD services from the MCO contract and furnish those services by PIHP, PAHPs, or through FFS, CMS is applying the parity requirements to the entire package of services MCO enrollees receive. ▪ **Multiple Delivery Systems**–In states where MH/SUD benefits are provided across multiple delivery systems (including FFS), states are required to review the full scope of benefits provided to MCO enrollees to ensure compliance with the parity requirements. ▪ **Achieving Compliance**–CMS expects states to work with their MCOs (or PIHPs and PAHPs) to determine the best method of achieving compliance with parity requirements for benefits provided to the MCO enrollees. Without limitation the final rule requires all states, regardless of how services are delivered to MCO enrollees, have the responsibility to ensure that the program is in compliance with these requirements. ▪ **MH/SUD Benefits Offered through FFS**–States would not necessarily be required to amend their non-ABP state plan to meet parity requirements, but could use their existing state plan or waiver services to achieve parity when individuals are receiving some benefits (whether MH/SUD or medical/surgical) from a MCO and also some benefits through FFS (or through PIHPs or PAHPs)). If a state did not have MH/SUD benefits in every classification in which medical/surgical benefits are provided across all authorities, the state would have to choose either to offer these services through a MCO, PIHP or PAHP or amend its state plan (or a waiver of its state plan) to include these benefits to achieve compliance with state responsibilities as outlined in the rule[xiv]. ▪ **To avoid incentivizing carve-outs**–CMS is requiring that id [ES2]MH/SUD state plan services are provided to MCO enrollees through a PIHP, PAHP, or under FFS Medicaid (because services are carved out of the MCO contract scope), MCO enrollees will still receive the MHPAEA parity protections with respect to MH/SUD state plan services.
§438.920(a) and (b), §440.395(e)(2), and §457.496(f)(1)	**Scope and Applicability of the Final Rule**	▪ Commenters specifically questioned the applicability of the final parity rule to **Section 1115 Demonstration and other Waiver authorities**. CMS believes the parity requirements are necessary to provide adequate protections for beneficiaries enrolled in demonstration and Waiver programs. They have also clarified that they will not approve any waivers of the parity requirements in the final rule in request for an 1115 Waiver. ▪ **Parity Analysis**–CMS is finalizing the rule to require states to perform the parity analysis when the MCO is not providing all MH/SUD services to Medicaid beneficiaries, this is the scope and intent of the regulation text requiring states to review all services to ensure compliance with the rule and implicit in the requirement for the state to provide documentation of the compliance. 1. The **state may use third parties** to gather information and make preliminary parity analysis on its behalf. States will be held accountable for answering any questions regarding the analysis and ultimately for its accuracy and completeness. 2. The **state must provide documentation** supporting compliance with these rules when submitting MCO contracts to CMS for review and approval. 3. **States must be aware** of the timeframes and requirements imposed on MCOs by the statute when they are providing all medical/surgical and MH/SUD benefits. States will be responsible for overseeing the delivery of benefits in a manner that is compliant with the final rule, including implementing any appropriate contract changes. **States should be sure to include contract provisions** in their MCO contracts in these cases to be sure they get the necessary reporting during the 18-month implementation period. 4. **CMS is offering to assist states in the development of contract language to achieve these goals if necessary during the 18-month transition period.** CMS will also provide technical assistance and tools for states and MCOs that clarify expectations around the types of documentation that must be submitted with the MCO contracts and ABP state plan

		amendments to demonstrate compliance with parity. CMS will use the submitted documentation as part of their MCO contract review and approval process. ▪ **Availability of Compliance Information to the Public**–CMS has changed the dates by which states must provide information from 18-months from the effective date of the final rule to 18-months from the publication date of the final rule. States must make documentation available to the public about compliance, this means that states must report how they are complying in order to document compliance. CMS believes that the use of a web site operated by the state is consistent with managed care rules.
§438.920(c), §440.395(e)(2), §457.496(f)(2)	**Scope of Services**	▪ States are required to provide coverage of all drugs that meet the definition of covered outpatient drugs when these drugs are prescribed for medically accepted indications, including those indicated for the treatment of mental health conditions and substance use disorders. ▪ State Medicaid FFS programs and Medicaid managed care plans have the discretion to establish certain utilization management techniques that include preferred drug lists and prior authorization processes for the coverage of covered outpatient drugs. ▪ If a state is using a PIHP, PAHP or FFS benefits to comply with the final rules, the MCO should not also have to provide additional benefits on the basis that its contract, on its own, does not comply with the requirements.
	Increase Cost Exemption	▪ MCOs must be paid on an actuarially sound basis, which would include the cost of adding services or removing or aligning treatment limitations in managed care benefits are necessary to comply with mental health parity requirements. ▪ States have the ability to make changes to their capitation payments during the course of the contract year to account for unexpected changes in benefits, costs, and utilization if they find that the assumptions included in the initial rate development are different than actual experience. ▪ The final rule authorizes states, in instances where they choose not to change their state plan, to include the cost of services that are necessary to comply with the final rule but are beyond what is specified in the state plan into the development of actuarially sound rates. ▪ States may also choose to use a risk mitigation strategy in their rates the first year(s) that the additional benefits are added to MCO, PIHP, or PAHP contract. This would ensure that any over-or under-payments are reconciled at the end of the year and give the state a more accurate sense of the utilization of services for future years of rate setting.
§438.6(e), and §438.6(n)	**Enforcement, Managed Care Rate Setting & Contract Review and Approval**	▪ CMS is working with a contractor to develop technical assistance materials, and they are available to states during the transition period if states would like to discuss their plans for compliance and possible contract language. ▪ CMS will be reviewing associated and relevant documents submitted by the state including the review of the MCO contracts, and SPA documents, as well as any documentation of the parity analysis the state has done to determine that their system and or/ benefit design meet the requirements of the rule. ▪ States will be the primary oversight entity to ensure that services are delivered in compliance with the final rule. ▪ If questions or confusion persist about the requirements of the rule for pediatric populations, CMS may provide tools or guidance to respond to those questions. ▪ CHIP and ABP programs that include full coverage of EPSDT, in the same manner as regular Medicaid coverage, will be deemed compliant with the final rule in accordance with the statutory authority. ▪ CMS will review a state's assurance carefully as a part of the CHIP or ABP SPA review process to ensure compliance with all EPSDT requirements, including the methods and procedures for implementing the EPSDT benefit. ▪ **Pre-condition to Managed Care Contract Approval**–Where there are services outside of the MCO contract, the state is required to show how the MCO enrollees are expected to receive all the services needed to comply with the requirements in the final rule. States would be able to do this by providing evidence of the other services provided through a FFS system, or included in contracts with other types of managed care entities such as through a PIHP or a PAHP. CMS would expect

		that the state provide the analysis that shows services provided through the MCO meet the requirements of the final rule. **It is CMS' intent that this demonstration be a precondition to their approval of the MCO contract.** ▪ **If the state cannot show evidence of compliance outside of the MCO contract**, then the state has not demonstrated that the contract complies with parity requirements and CMS will not approve the contract until evidence of compliance has been provided. **CMS may defer claims for FFP in expenditures for capitation rates paid** based on unapproved MCO contracts in this circumstance. ▪ **Reduction or Restriction in Benefits**–If a state chooses to reduce or restrict the amount, duration or scope of covered medical/surgical services it must do so through an amendment to its state plan (SPA). When reducing benefits in the state plan, a state must meet sufficiency requirements, so any reduction in medical/surgical benefits must be reviewed and approved by CMS. Consistent with the experience they have seen in the commercial market around reductions of benefits, CMS believes that states will not typically choose to go through the SPA process to reduce medical/surgical benefits in order to make it easier for MCO coverage to meet the requirements of the rule.
§438.930, §440.395(d), §457.496(f)	**Applicability and Compliance**	▪ CMS is finalizing the rule with a modification to the proposed text. The proposed rule required compliance no later than the beginning of the contract year starting 18 months after the date of publication of the final rule. Because of a potential to allow a plan an additional period of up to 12 months beyond the expected compliance date, the language was changed to require implementation no later than 18 months after the date of publication of the final language.
	Utilization Control	▪ This final rule removes the Medicaid regulation at § 456.171 which prescribed requirements for medical and other professionals within the Medicaid agency evaluating the need for admission of each applicant or beneficiary into inpatient services in a mental hospital. The Medicaid agency was required to review and assess the hospital's medical, psychiatric, and social evaluations. There was not a similar requirement for the Medicaid agency to review the hospital's evaluation of each applicant's or beneficiary's need for medical/surgical admissions. As a result, this requirement presented a challenge to achieving parity for inpatient services rendered in a mental hospital.
	Institutions of Mental Disease	▪ The IMD exclusion is a statutory prohibition on providing Medicaid matching funds for services provided to individuals aged 21 to 64 who are inpatients in an Institution for Mental Diseases (IMD). 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. This exclusion has been in place since Medicaid was established in 1965 and was based on amendments to the statute that predated Medicaid and prohibited cash assistance payments for services for individuals in IMDs.
	Medicare-Medicaid Dual Eligible Beneficiaries	▪ CMS lacks the statutory authority to apply the final rule to Medicare benefits. They will, however, provide technical assistance to states enrolled in the CMS Financial Alignment Initiative that are implementation a capitated model as needed about how to structure and assess those plans for compliance with MHPAEA.

[i] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

[ii] **TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS: Payment to States.** https://www.ssa.gov/OP_Home/ssact/title19/1903.htm

[iii] **Alternative Benefit Plans (ABPs)–**States have the option to provide alternative benefits specifically tailored to meet the needs of certain Medicaid population groups, target residents in certain areas of the state, or provide services through specific delivery systems instead of following the traditional Medicaid benefit plan.https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/alternative-benefit-plans.html

[iv] https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf

[v] **Non-quantitative Treatment Limitations-(NQTL)–**limits on the scope or duration of treatment that are not expressed numerically (such as medical management techniques like prior authorization).

[vi] **Quantitative Treatment Limits**–Quantitative treatment limitations are numerical, such as visit limits and day limits.

[vii] **§ 438.108 and part 457, subpart E**

[viii] http://housedocs.house.gov/energycommerce/phsa027.pdf

[ix] The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and
(B) which shall at a minimum include—
(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
(ii) a comprehensive unclothed physical exam,
(iii) appropriate immunizations (according to the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines) according to age and health history,
(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
(v) health education (including anticipatory guidance).
(2) Vision services—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.
(3) Dental services—
(A) which are provided—
(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.
(4) Hearing services—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.
(5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.

[x] https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

[xi] Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements: (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. (2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees. (3) Are adopted in consultation with contracting health care professionals. (4) Are reviewed and updated periodically as appropriate.

[xii] https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol4/pdf/CFR-2015-title42-vol4-sec438-10.pdf

[xiii] §438.900 Meaning of terms, §438.905 Parity requirements for aggregate lifetime and annual dollar limits, §438.910 Parity requirements for financial requirements and treatment limitations, §438.925 Availability of information, §438.920 Applicability, and §438.930 Compliance dates.

[xiv] §438.920(a)–*MCOs, PIHPs, and PAHPs*. The requirements of this subpart apply to each MCO, PIHP, and PAHP offering services to enrollees of a MCO, in States covering medical/surgical and MH/SUD services under the State plan. These requirements regarding coverage for services that must be provided to enrollees of an MCO apply regardless of the delivery system of the medical/surgical, MH/SUD under the State plan.
(b) *State responsibilities*. (1) In any instance where the full scope of medical/surgical and MH/SUD services are not provided through the MCO, the State must review the MH/SUD and medical/surgical benefits provided through the MCO, PIHP, PAHP, and fee-for service (FFS) coverage to ensure the full scope of services available to all enrollees of the MCO complies with the requirements in this subpart. The State must provide documentation of compliance with requirements in this subpart to the general public and post this information on the State Medicaid Web site by October 2, 2017. Such documentation must be updated prior to any change in MCO, PIHP, PAHP or FFS State plan benefits. (2) The State must ensure that all services are delivered to the enrollees of the MCO in compliance with this subpart.