



Key Takeaways:

CMS Proposed Rule: Extension of Mental Health Parity to Medicaid Managed Care Organizations, CHIP and Alternative Benefit Plans

BACKGROUND

June 11th, 2015

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. It applied to only the group commercial insurance market and Medicaid Managed Care Organizations (MCOs) upon its passage. Subsequent legislation, including the Affordable Care Act, extended its requirements to the Children's Health Insurance Plan (CHIP) and Medicaid Alternative Benefit Plans (ABPs). While final rules were issued in November of 2013 (the "Final Rule") that laid the groundwork on much of the detail related to parity implementation, Medicaid application was left uncovered. CMS said it would issue separate rules on parity application for Medicaid at a later date.

In April 2015, CMS issued these separate proposed rules implementing parity and how parity would apply to MCOs, CHIP, and ABPs, (the "Proposed Rule"). CMS based the substance of the Proposed Rule on what it deemed the differences between the commercial market and Medicaid that necessitate a modified approach. The Proposed Rule generally retains the essential requirements of the Final Rule for the commercial structure.

As you know, the Proposed Rule carries major implications for the significant percentage of Americans covered by Medicaid that suffer from MH/SUD.

Below is a summary of key takeaways from APA's response to the proposed rule.

Overall, it is our understanding that the regulators applied parity requirements to a complicated web of potential Medicaid financing structures with significant rigor and intention to broadly fulfill their mandate.

ELEMENTS OF PROPOSED RULE

PARITY ANALYSIS AND COMPLIANCE

APA's main concern is that Medicaid beneficiaries should receive the same rights and benefits as those in the private insurance market. The Proposed Rule requires proactive analysis by states, or MCOs in certain circumstances, to determine if their overall delivery system complies with the provisions of the Proposed Rule. APA urged CMS to ensure that the rules require full transparency and public disclosure from states and insurers regarding plan design and the compliance process.

EXTEND APPLICATION TO PIHPs, PAHPs, AND MEDICAID FFS

APA agreed with CMS's proposal to extend MHPAEA requirements to these non-MCO defined entities (Prepaid Inpatient Health Plans [PIHPs] and Prepaid Ambulatory Health Plans [PAHPs]). We believe this is essential to eliminating loopholes and/or potential workarounds to the requirements and intent of the statute. This is a major point that must be carried through in the final regulations.

STATE PLANS UNDER ONE MCO

Under the Proposed Rule, states that do not provide all services through an MCO would be required to provide evidence of compliance with parity, including information on any contracts with PIHPs and PAHPs. However, CMS discussed the idea of requiring that all state plan MH/SUD services be provided under MCO contracts as a way to ensure compliance. The comments reiterated our position statement against carve-outs but noted that this rule is not the vehicle to address this and stated that flexibility at this stage is better due to the rapidly changing healthcare environment. It would be more useful to thoroughly examine each arrangement to ensure that the full range of benefits is afforded to enrollees.

DUAL ELIGIBLES

APA urged CMS to address how the Proposed Rule would apply to a set of states with special arrangements that combine Medicare and Medicaid financing for dual eligibles, given that MHPAEA does not apply to Medicare.

COMPLIANCE DATE

APA strongly urged CMS to shorten the compliance time for the states. CMS proposed a compliance period of 18 months after the effective date of the final rules, which would result in a significant delay. Given that states have been aware of the MHPAEA final rules for some time, and they received notice that they must comply with the statute even in the absence of regulatory guidance, APA recommended that the time frame be shortened to 12 months (with allowance for defineable exceptions).

EXCLUSION OF LONG-TERM CARE

CMS proposed excluding all long-term care services from the definition of medical-surgical and MH/SUD services in the Medicaid and CHIP context since there is no analog in the commercial insurance market. APA strongly disagreed with this proposal and recommended that CMS provide a definition of long-term care services that delineates those types of long term care services that are subject to the parity rule.

INTERMEDIATE SERVICES

In light of recent issues in the commercial insurance markets where plans denied benefits for intermediate services (e.g., partial hospitalization and residential treatment), APA urged CMS to clearly articulate that parity applies to intermediate care services and to align the final rule with the regulations under MHPAEA where it is now understood that these services are covered.

DISCLOSURE/TRANSPARENCY AND ACCESS TO PLAN INFORMATION

It is essential that enrollees have access to their plan information, both before and after they submit claims. While the Proposed Rule require a great deal of transparency and disclosure, APA recommended that CMS clarify many details to ensure that this is maintained in practice. APA also urged CMS to ensure that enrollees have appropriate access to medical necessity criteria and other plan information.

NETWORK ADEQUACY

APA urged CMS to reemphasize that network adequacy is regarded as a non-quantitative treatment limitation under the parity rules and that states be required to provide appropriate documentation of compliance lest beneficiary access be just a promise.