Toward Equality for Texans with Mental Illness and Substance Use Disorders: *A status report on implementing new federal parity protections*

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Introduction

All Texans deserve high-quality health care, whether it's for a physical ailment or a mental health or substance use issue.

In health insurance, the term "parity" describes the equal treatment of mental health (MH) conditions and substance use disorders (SUD) in insurance plans, when compared to coverage for medical or surgical (M/S) health care. When a plan has parity it means that, for example, if an insurer provides unlimited doctor visits for a condition like diabetes, then the insurer should also provide unlimited doctor's visits for mental health conditions like depression or schizophrenia. On December 2, 2017, Texas Medicaid was scheduled to come into compliance with new parity protections required under federal rules. HHSC has created a new web home for this area of policy, and in upcoming reports CPPP will review the newly-posted analyses. This brief explains the new protections and Texas' process to implement them.

The evolution of federal parity protections

Parity protections are not new in Medicaid. Federal law on parity has been evolving since 1996 and was first applied to Medicaid Managed Care Organizations[i] in 1998 (see Table 1). On March 29, 2016, the Centers for Medicare and Medicaid Services (CMS) released final federal rules that extend parity protections to Medicaid MCOs, Medicaid Alternative Benefit Plans (ABPs) and the Children's Health Insurance Program (CHIP). Medicaid ABPs are plans that states may choose to offer to meet the needs of specific populations, such as adults covered under Medicaid Expansion (Texas Medicaid does not currently offer any of these plans).

The CMS rule on Medicaid and CHIP parity is designed to align as much as possible to rules issued to implement the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA). The parity rule was designed to create consistency across the different insurance markets, including Medicaid and CHIP, employer-sponsored insurance, and the Health Insurance Marketplace. According to the CMS rule, states were to be in compliance by October 2, 2017, but Texas got a two-month extension (discussed below).

Table 1: MH/SUD Parity Protections Timeline		
Year	Federal Law or Rule	Summary
1996	Mental Health Parity Act (MHPA)	Narrow in scope, some health plans, SUD benefits excluded
1998	Balanced Budget Act (BBA)	Extends 1996 MHPA protections to Medicaid MCOs and CHIP
2008	Mental Health Parity and Addiction Equity Act (MHPAEA)	Full MH/SUD parity protections apply to health plans offered by large employers
2009	Children Health Insurance Program Reauthorization Act (CHIPRA)	2008 MHPAEA parity protections apply to CHIP
2010	Affordable Care Act (ACA)	2008 MHPAEA parity protections extended to most private insurance plans
2016	Medicaid MCOs, ABPs and CHIP parity final rule	2008 MHPAEA law and regulations are extended to Medicaid MCOs, ABPs and CHIP

What is required under the CMS rule?

Medicaid parity rules require that everyone who receives services through MCOs, ABPs or CHIP be provided MH/SUD benefits that comply with parity. The rules require each state Medicaid agency to perform a "parity analysis" – to review both medical and surgical health benefits and MH/SUD benefits offered under insurance plans to determine compliance with the parity protections. States had to make information related to compliance available online within 18 months of the rule's publication, by the beginning of October 2017, including any updates made to Medicaid benefits. The regulations also extend parity protections to long term care services for MH/SUD in the same manner that they are applied to other services.

Key provisions in the CMS Rule

Medicaid MCOs are required to meet federal parity requirements (see text box on next page). Separate CHIP programs and ABPs must also meet federal parity requirements.

- States must include any additional costs of providing additional services or removing treatment limitations in their payment rate methodology for affected managed care plans. The rules allow states to increase the Medicaid payment rates, launch additional services, and eliminate treatment limits without a formal change to the Medicaid State Plan (the contract states have with federal Medicaid that details how their program operates).
- MCOs, ABPs and CHIP have to make available the criteria for medical necessity determinations with respect to MH/SUD benefits upon request to consumers and providers.
- MCOs, ABPs and CHIP must also make available to the consumer the reason for any denial of reimbursement or payment for services with respect to any MH/SUD benefits.
- States that don't provide full Early and Periodic Screening, Diagnosis, and Treatment coverage (EPSDT) in CHIP, as in Texas, must complete a parity analysis to ensure compliance with federal parity requirements. State CHIP programs that provide full coverage of EPSDT services will be deemed in compliance with parity.

Parity in Texas Medicaid

The Texas Health and Human Services Commission (HHSC) has been working with its 19 Medicaid and CHIP MCOs for more than a year—with technical assistance from both CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA)—to conduct parity analyses and ensure compliance with CMS rules. Originally the CMS deadline for states to comply with the parity rule was October 2, 2017; however, Texas received a two-month extension due to Hurricane Harvey. By December 2, 2017, HHSC should have provided documentation of compliance with parity requirements to CMS, posted compliance-related information on the Texas

FEDERAL PARITY REQUIREMENTS

Requirement: Financial requirements and treatment limitations associated with MH/SUD benefits are no more restrictive or applied more stringently than those associated with medical and surgical benefits

Two types of treatment limitations

Quantitative Treatment Limitations (QTLs): financial requirements like deductibles and copayments, or limits on the number of visits

Non-quantitative Treatment Limitations (NQTLs): limits to the type of treatment, treatment settings, and duration of treatment covered by a health plan (for example, requiring a patient to try and fail on one type of treatment before getting the prescribed treatment; or requiring a recommended treatment to be reviewed and approved as medically necessary in advance)

Medicaid website, and ensured that all services delivered by MCOs or CHIP were compliant with parity requirements.

HHSC identified three separate benefit packages – these are benefits provided to a specific population group like children and adults - and conducted a parity compliance analysis on each separately.

The three benefit packages are: EPSDT (comprehensive benefits provided to children in Medicaid's STAR, STAR Health, Star Kids), adult Medicaid (provided to adults through STAR, STAR PLUS), and CHIP. HHSC created a list of all covered benefits in each benefit package. HHSC staff then categorized benefits as MH/SUD and/or medical/surgical, and also assigned each benefit to one or more of four benefit classifications: inpatient, outpatient, emergency room and prescription drugs. This process created a standardized list of benefits and their classifications that MCOs and HHSC could use in their parity analyses.

By Dec. 2 HHSC should have completed the parity analysis for quantitative treatment limits, and the 19 MCOs should have completed their analysis for non-quantitative treatment limits (NQTLs, see box, "Federal Parity Requirements",) using a tool provided by HHSC. In the parity analysis for Medicaid MCOs and CHIP, NQTLs are defined as the processes, strategies and evidentiary standards used to determine a treatment limitation that is not quantifiable. When conducting the parity analysis, MCOs must document that an NQTL applied to MH/SUD benefits is comparable and applied no more stringently than when it is applied to medical/surgical benefits within each of the four benefit classifications. HHSC provided a tool to MCOs to conduct the analysis and demonstrate parity compliance. NQTLs are allowable if they are applied equally to both sets of benefits.

<u>NQTLs analyzed in Texas Medicaid/CHIP</u>

HHSC identified the following seven types of NQTLs and required MCOs to conduct a separate parity analysis for each utilized by the plan:

- *Prior authorization*: requirement to obtain an MCO authorization prior to receiving a service.

HHSC DEFINITIONS FOR NQTL ANALYSIS

- **Processes**: what, when and how a treatment limitation is applied to a benefit
- **Strategies**: the purpose or rationale behind the treatment limitation
- **Evidentiary standards**: specific standard or evidence to support the use of the treatment limitation

- *Concurrent review*: evaluation by an MCO of the ongoing medical necessity of care currently being provided.
- *Medical necessity criteria*: evaluating the evidentiary standards, guidelines, and/or processes used to determine whether care is medically necessary or appropriate. Criteria that are above and beyond those imposed by the Texas Medicaid Provider Procedure Manual (TMPPM) or by an evidence-based clinical decision-making tool are of special interest.
- *Fail-first policies*: refusal to cover a higher-cost therapy until a lower-cost therapy proves ineffective. Also known as "step therapy"
- *Level of Engagement/Degree of Progress***:** conditioning access to a benefit on determination of an individual's level of engagement in or compliance with a treatment and/or the degree of progress the individual is making while accessing a particular benefit.
- *Probability of Improvement***.** The process of assessing whether an individual is likely to benefit from treatment before allowing access to the benefit.
- *Network Participation and Reimbursement***:** the processes and criteria that plans may use to determine whether to admit a provider into a network.

As is required by CMS parity rules, HHSC had to post findings from its parity analysis on a public website by December 2. HHSC and MCOs had to implement any needed changes to the state plan, Medicaid Provider Procedure Manual, managed care contracts, MCO policies and practices, etc. by this same date.

Conclusion

All Texans deserve high-quality health care, whether it's for a physical ailment or a mental health or substance use issue. The HHSC parity analysis and MCO changes that may flow from it are important but still very early steps toward eventually realizing the great promise that mental health parity laws and regulations hold. It will be important for all behavioral health stakeholders to monitor and engage in the next steps in implementation of the Medicaid and CHIP final parity rule, to ensure that more Texans gain equal access to mental health and other health care services needed to achieve recovery.

Read more at http://bettertexasblog.org/category/health-care/mental-health/

[i]MCO is the term used by Medicaid for any kind of managed care health plan used to deliver Medicaid benefits. In Texas virtually 100 percent of Medicaid enrollees get their care through Health Maintenance Organizations (HMOs) that contract with the state, as opposed to the Medicaid program actually receiving claims for health care and paying care providers.