Mental Health Parity Overview

Presented by
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Health Policy Forum
May 19, 2025

MDHHS
Michigan Department of Health & Human Services

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College of Human Medicine
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Learning Objectives

1. What is Mental Health Parity
2. Basic Requirement of MHPAEA
3. OIG Report On CMS Monitoring of Parity
4. What Does this Actually Mean?
5. How is this Enforced
6. Ongoing Monitoring Requirements
7. Questions????

What is Mental Health Parity?

MHPAEA rules differ for Medicaid and Commercial Coverage:

The Centers for Medicare and Medicaid Services (CMS) promulgated the regulations for implementing MHPAEA for Medicaid managed care (42 CFR Part 438, Subpart K and 42 CFR Part 440). These were initially published in 2016 and then updated n 2024. The Department of Treasury, Internal Revenue Service promulgated the regulation for implementing MHPAEA for Commercial Insurance (26 CFR Part 54). These were initially published in 2013, which were updated in 2020.

Someone else will address the commercial coverage, I understand Medicaid. One significant complicating factor when working with the commercial coverage application of MHPAEA is the impact of plan size, i.e. covered lives.

MHPAEA rules differ for Medicaid and Commercial Coverage

I believe Joseph Sullivan from the Michigan Department of Insurance and Financial Services will address the commercial coverage implications of MHPAEA. But do understand that there are differences.

Basic Requirements of Mental Health Parity?

The Mental Health Parity and Addiction Equity Act 2008 (MHPAEA):

First thing to understand is that Parity is about not being more restrictive with MH/SUD services then with M/S services. MHPAEA does not require that plans include specific benefits, MH/SUD or M/S. It also does not prevent limits, it only requires that these limits be no more restrictive nor more stringently applied to MH/SUD than to M/S benefits. The ACA defined "Essential Health Benefits"

All services are mapped to one of four classifications:

- Services are classified by what they are addressing, ICD 10 is the evidentiary standard
- Classifications: Inpatient, Emergency Services, Pharmacy, Outpatient

Limitations include:

- Annual Dollar Limits and Aggregate Lifetime Limits,
- Financial Requirements (Co-Pays and Deductibles etc.),
- Quantitative Treatment Limitations (20 session limit etc.) and Non-Quantitative Treatment Limitations

Worth noting: Non-Quantitative Treatment Limitations (NQTLs) are the trickiest.

- Medical Management Standards or UM including prior authorizations
- Formulary design for prescription drugs
- Standards for provider admission to participate in a network, including reimbursement rates
- Refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective
- Conditioning benefits on completion of a course of treatment
- Restrictions based on geographic location, facility type, or provider specialty
- Standards for providing access to out-of-network providers

OIG Review of CMS Monitoring of States Parity

- OIG reviewed eight (8) states, four (4) where the State was required to do the Parity Assessment and four (4) where the MCO's managed the entire benefit and therefore were responsible for the Parity Assessment.
- Issue 1: Was necessary contract language in contracts by October 2, 2017 – all eight were "NO" but all eight also have it in current contracts.
- Issue 2: For the four states that were required to complete Assessment, was it completed and posted to website by October 2, 3017 – all four were "NO" but all four now have it completed and posted (Two states (AZ and TX) sought and obtained extensions, NY did a multiyear plan)

OIG Report – Summary of Findings

- CMS did not provide adequate oversight of States' compliance with parity requirements or their posting of this information on state websites.
- CMS provided guidance to States related to compliance with MH/SUD parity requirements and, as part of the review of States' MCO contracts, determined whether contracts contained required provisions. However, CMS did not review whether States added MH/SUD provisions to MCO contract by the compliance date.
- Further, CMS did not always maintain documentation of its communications with States to address noncompliance identified in States' parity analyses.
- Additionally, the selected States did not provide adequate oversight and monitoring of MCO's compliance with MH/SUD parity requirements.

OIG Report – Recommendations

- improve its oversight of States' compliance with MH/SUD parity requirements, including:
  - strengthening its follow-up procedures, including regular communication with States, to verify that States perform parity analyses across their MH/SUD delivery systems;
  - requiring States in which MCOs are responsible for the parity analysis to submit information MCOs provided regarding compliance with parity requirements to CMS for its review as part of the contract approval process and, if necessary, seeking additional regulatory authority to do so;
  - following up with any States that have identified any noncompliance with parity requirements to verify that the States have taken actions to address the noncompliance; and
  - maintaining documentation of its communications with States related to compliance with MH/SUD parity requirements and actions taken to correct any identified deficiencies; and

OIG Report – Recommendations

- require States to improve their monitoring of MCOs' ongoing compliance with MH/SUD parity requirements by:
  - modifying State policies and procedures for reviewing MCOs' compliance with contract provisions to include written procedures for reviewing compliance with MH/SUD parity requirements,
  - requiring MCOs to update parity analyses when benefits change or deficiencies are corrected,
  - requiring newly added MCOs to conduct parity analyses, and
  - conducting follow-up in a timely manner with MCOs that have identified noncompliance with parity requirements to verify that the MCOs take corrective actions to address the noncompliance.

What Does This Actually Mean

- Michigan conducted a Parity Assessment in 2017, completing the written summary and corrective action plan in April 2018. The report is still on the MDHHS website.
  - Most significant findings involved the utilization management, prior authorization processes for mental health and substance use disorder services:
    - The evidentiary standard in use was largely interpretation of the Medicaid Provider Manual and not a nationally recognized standard. PIHPs decided to utilize MCG standards for inpatient and "traditional" outpatient (acute care services). For most other services (LTSS) the PIHPs agreed to use the Level of Care Utilization System (LOCUS) to support medical necessity and service authorization processes. This tool was currently in use, but not for the authorization process. Children with SED – The PIHPs decided to utilize the Devereux Early Childhood Assessment (DECA), the Preschool and Early Childhood Functional Assessment Scale (PECFAS), and the Child and Adolescent Functional Assessment Scale (CAFAS) to support medical necessity and service authorization processes. These scales were in use, but not consistently used for authorization.
  - Services to Persons with I/DD
    - PIHPs currently use the Supports Intensity Scale, a nationally standardized instrument, to document needed levels of supports and services for individuals with I/DD.
    - Standardized authorization guidelines, utilizing the Supports Intensity Scale to inform level of care authorizations, will used by the PIHPs.
  - There was also a co-pay for certain psychotropic drugs. This was found to be non-compliant and was discontinued
  - Various language in the Medicaid Manual was changed to avoid confusion

What Does This Actually Mean

- Michigan has not updated the Parity Assessment since 2018
- For states in which a plan manages both M/S and MH/SUD, the plans are responsible for conducting the assessment
- For states in which M/S and MH/SUD are managed by different systems, the state is responsible for conducting the assessment
- The OIG Report found that CMS had not adequately monitored states' compliance with these requirement
- Anytime a new service/benefit is added, the Parity Assessment is to be updated. This is also true if new managed care entities are added
- Michigan has added many new services since 2018 and the MHP landscape has changed
- CMS issued new rules in 2024 adding ongoing monitoring requirements and annual reporting
- Michigan is currently working on an updated Parity Assessment (2025) and ongoing monitoring requirements
- CMS published a reporting template for public comment, results of the public comments and final version have not yet been published

How Is This Enforced?

- As noted, additional rules promulgated in 2024
- Annual Reporting now required
- Final details not yet available
- Current Administration may take different approach
- MDHHS is committed to Parity for MH and SUD services
- As part of the 2025 Parity work, ongoing monitoring process are also being reviewed and strengthened as appropriate

Ongoing Monitoring Requirements

CMS Informational Bulletin, dated June 12, 2024, states:

"Therefore, CMS reiterates to States that they must effectively oversee their Medicaid managed care and separate CHIP programs and comply with regulatory requirements at 42 CFR § § 438.3(n) and subpart K and 457.496(d). 10,11 These regulations require States to ensure that all services delivered to enrollees of an MCO or a separate CHIP program are in compliance with Federal parity requirements, including that financial requirements,12 such as coinsurance or copayments, and treatment limitations imposed on MH or SUD benefits may not be more restrictive than those applied to substantially all medical or surgical benefits in the same classification of benefits."

Recommendation in the OIG Report, March 2024:

- Require States to improve their monitoring of MCOs' ongoing compliance with MH/SUD parity requirements by:
  - Modifying State policies and procedures for reviewing MCOs' compliance with contract provisions to include written procedures for reviewing compliance with MH/SUD parity requirements,
  - Requiring MCOs to update parity analyses when benefits change or deficiencies are corrected,
  - Requiring newly added MCOs to conduct parity analyses, and
  - Conducting follow-up in a timely manner with MCOs that have identified noncompliance with parity requirements to verify that the MCOs take corrective actions to address the noncompliance.

Questions?

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