



# Webinar #3: Application of Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs

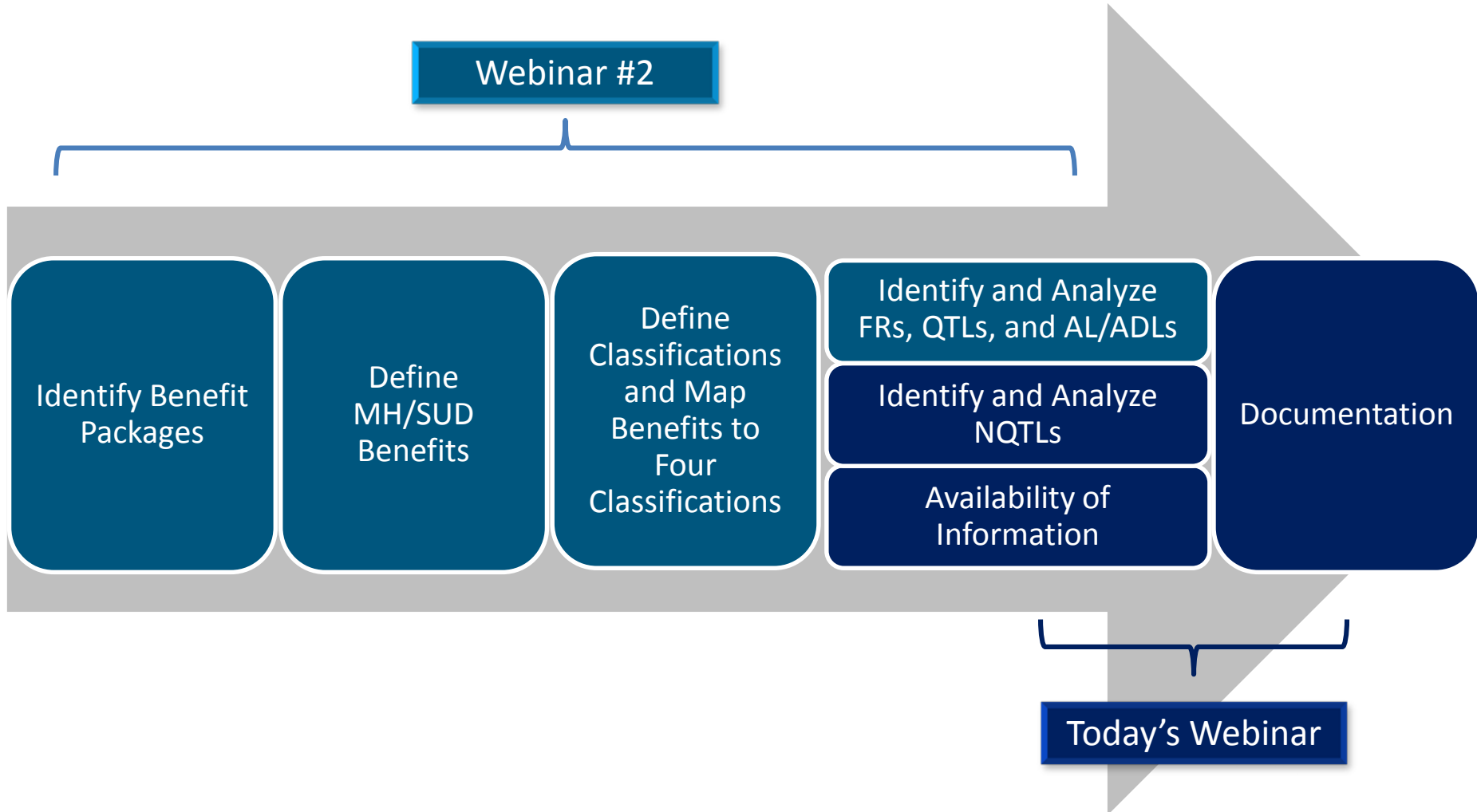
**March 9, 2017**

**3:00-4:30pm ET**

***Center for Medicaid and CHIP Services***



# Welcome and Review



# Webinar Overview

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Today's webinar will provide detailed information on the following key steps in the parity analysis:

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- ✓ Identifying and Analyzing Non-Quantitative Treatment Limitations (NQTLs)




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- ✓ Availability of Information

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- ✓ Documentation

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# Brief Overview of Key Requirements for this Webinar

The following key parity requirements will be reviewed in this webinar:

-  NQTLs cannot apply to MH/SUD benefits in any classification unless, as written and in operation, any processes, strategies, standards, or other factors used in applying the NQTL to the MH/SUD benefit are ***comparable to and applied no more stringently*** than those used in applying the same NQTL to M/S benefits in the classification.
-  The criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries and providers upon request.
-  The reason for any denial of reimbursement or payment for a MH/SUD benefit must be made available to beneficiaries.

# Brief Overview of Key Requirements for this Webinar

The following key parity requirements will be reviewed in this webinar:

-  States must submit documentation of parity compliance to CMS as part of an APB SPA, a CHIP SPA, and an MCO contract.
-  States that use an MCO to deliver some Medicaid benefits must provide documentation of compliance with parity to the general public and post this information on the state's Medicaid website by October 2, 2017.



# **Identify and Analyze Non-Quantitative Treatment Limitations (NQTLs)**

# What is an NQTL?

## Non-quantitative treatment limitations (NQTLs)

NQTLs are limits on the scope or duration of benefits, such as prior authorization or network admission standards. “Soft limits,” benefit limits that allow for an individual to exceed numerical limits based on medical necessity, are also considered NQTLs.

- Examples of NQTLs from the final rule include:
  - Medical management standards limiting or excluding benefits based on medical necessity or appropriateness criteria
  - Standards for provider admission to participate in a network and reimbursement rates
  - Restrictions based on geographic location, facility type, or provider specialty
  - Fail-first policies or step therapy protocols
  - Exclusions based on failure to complete a course of treatment



States/MCOS must identify and analyze NQTLs that apply to MH/SUD benefits.

# NQTL Requirement

The rule prohibits the application of NQTLs unless, under the policies and procedures of the state/MCO, **as written and in operation**, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are **comparable to**, and **applied no more stringently** than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification.



# The Two Parts of the NQTL Analysis

## NQTL Analysis

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graph TD; A[NQTL Analysis] --> B[COMPARABILITY]; A --> C[STRINGENCY];
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### COMPARABILITY


The *comparability* of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying the NQTL to MH/SUD benefits and M/S benefits.

### STRINGENCY

The *stringency* with which the processes, strategies, evidentiary standards and other factors (in writing and operation) are applied to MH/SUD benefits and M/S benefits.

# Comparability Example

- PIHP A's written policies and procedures state that MCO enrollees cannot obtain inpatient, out-of-state treatment for eating disorders unless there is no in-state bed available.
- Consistent with recommendations for family involvement in a national practice guideline, this limit was established to facilitate ongoing family involvement by minimizing travel distances.
- MCO Z's policies and procedures do not include limits on out-of-state treatment for M/S conditions despite comparable national practice guidelines calling for family involvement.



The NQTL (i.e., coverage limits on out-of-state inpatient treatment when an in-state bed is available) is impermissible because the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to MH/SUD benefits (e.g., in policies and procedures) *are not comparable*.

# Stringency Example

- Both PIHP A's and MCO Z's written policies and procedures exclude coverage of out-of-state inpatient treatment unless no in-state bed is available.
- But in operation, MCO Z makes exceptions to this exclusion for certain M/S conditions when an out-of-state facility is certified as a "center of excellence."

PIHP A does not make any exceptions to the policy. The NQTL is impermissible because it is more stringently applied to coverage for treatment of MH/SUD conditions (i.e., there are no exceptions to the operating policy and procedure for MH/SUD conditions) than it is to coverage for treatment of M/S conditions.



# Identifying NQTLs



The first step in conducting an NQTL analysis is to identify the NQTLs applicable to MH/SUD benefits in each classification of a benefit package.

- A list of common NQTLs can be found in the parity rule and the Parity Compliance Toolkit.
  - The parity rule does not provide an exhaustive list of NQTLs, and the State or MCO should include others in the analysis as they are identified.
- Some NQTLs (e.g., prior authorization requirements) are readily identifiable in the state plan, state manuals, policies or procedures or other documentation, but other NQTLs (e.g., certain requirements for network admission) may be embedded in delivery system operations.

# Collecting Information for Each NQTL



The second step is for the State/MCO to collect information on the processes, strategies, evidentiary standards, and other factors, in writing and in operation, used in applying the NQTL to MH/SUD **and** M/S benefits in a classification.

- It is not necessary to collect information on M/S NQTLs that do not apply to MH/SUD benefits.
- There is no required format or methodology for collecting the information necessary for an NQTL analysis.
- The toolkit includes two examples of tools that could be used for NQTL data collection.

# Collecting Information for Each NQTL

- Information for the parity analysis may include:
  - Comparability
    - Under what circumstances is this NQTL applied?
    - What is the purpose of applying this NQTL to this benefit(s)?
    - What evidence supports the assignment of this NQTL to the benefit?
  - Stringency
    - What consequences/penalties apply when the NQTL is not met?
    - How much discretion is allowed in applying the NQTL?
    - How difficult it is to meet the threshold requirement of the NQTL?

# Sample Data Collection Template






Concurrent review (in writing and in operation)	MH/SUD	M/S
<b>Comparability</b> <ul style="list-style-type: none"><li>• Processes</li><li>• Strategies</li><li>• Evidentiary standards</li><li>• Other factors</li></ul>		

# Sample Data Collection Template

Concurrent review (in writing and in operation)	MH/SUD	M/S
<b>Stringency</b> <ul style="list-style-type: none"><li>• Processes</li><li>• Strategies</li><li>• Evidentiary standards</li><li>• Other factors</li></ul>		



# Data Collection Tips

-  Determine the order for collecting information on NQTLs (e.g., MH/SUD vendors and then MCOs).
-  Educate responders (e.g., MCO, PIHP, PAHP, MH agency) about parity requirements, including identifying NQTLs, the data collection process, and the NQTL analysis.
-  Help responders identify the individuals within their organizations that can contribute to the response.
-  Allow sufficient time for entities to respond.
-  Create an expectation that data collection is an iterative process.

# Conducting the Parity Analysis



The third step, after identifying the NQTLs and collecting information on process, strategies, and evidentiary standards used, is to conduct a preliminary compliance review for each type of NQTL that applies to MH/SUD benefits in a classification.

# Analysis is Conducted by Classification

- The NQTL analysis is conducted for each type of NQTL that applies to MH/SUD benefits *in a classification*; not on a benefit-to-benefit basis.
- Considerations:
  - 💡 Parity does not require coverage of a similar M/S benefit in a classification for states to cover a MH/SUD benefit or to apply NQTLs to a unique MH/SUD benefit.
  - 💡 Each type of NQTL may be analyzed only once in a classification, regardless of the type or number of benefits it applies to.
    - It is important to identify and evaluate any differences in the processes, strategies, evidentiary standards, or other factors used in applying the type of NQTL to each benefit.

# Analysis is Conducted by Classification

## - Example

- In benefit package A, prior authorization is required for multiple inpatient MH/SUD services, two outpatient MH/SUD services (outpatient respite and ACT), and a tier of prescription drugs.



For benefit package A, prior authorization would be analyzed three times: once for inpatient, once for outpatient, and once for prescription drugs.

# Conducting the NQTL Analysis

- Does the application of the NQTL include similar components for M/S benefits and MH/SUD benefits in writing and in operation?
- Is the rationale for applying the NQTL to MH/SUD benefits supported by evidence?
- Are the differences in the application of the NQTL to MH/SUD benefits as compared to M/S benefits arbitrary?
- Are differences in the application of the NQTL to MH/SUD benefits consistent with practice guidelines?
- Is it harder to “pass” the NQTL for MH/SUD benefits than it is for M/S benefits?
- Are the consequences more severe for failing to meet the NQTL requirements as they apply to MH/SUD benefits?
- Is there a disparate impact on MH/SUD benefits (e.g., higher denial rate) as compared to M/S benefits? While not determinative of parity noncompliance, disparate impact may be a sign of non-comparable or more stringent processes, strategies, or evidentiary standards that require more analysis.

# NQTL Results do not Need to be the Same for MH/SUD and M/S Benefits

- The result of applying an **NQTL** to MH/SUD and M/S benefits does not need to be the same for the NQTL to be permissible (e.g., prior authorization may still be permissible even if denial rates are higher for MH/SUD than M/S benefits).
- Instead, compliance depends on parity of the processes, strategies, evidentiary standards, and other factors used to apply the NQTL (in writing and in operation).
  - There should not be arbitrary or discriminatory differences in how a state or MCO/PIHP/PAHP applies NQTLs to MH/SUD benefits as compared with M/S benefits.

# Streamlining NQTL Data Collection and Analysis

- Once a data collection methodology has been established for a benefit package, the data collection for similar benefit packages may only require adjustments to the original approach.
- If an NQTL's processes, strategies, and evidentiary standards are identical for M/S and MH/SUD benefits, it is sufficient to document them once in the data collection tool and indicate there is no difference for M/S and MH/SUD benefits.
- If the same delivery system administers more than one benefit package, there is likely an overlap of certain NQTLs that are embedded in the entity's operations (e.g., network admission standards, medical necessity and appropriateness criteria) between benefit packages. It may not be necessary to review those NQTLs more than once (unless they differ in writing or operation between benefit packages).

# Questions







# Availability of Information

# Availability of Information - General

The final Medicaid/CHIP parity rule includes two requirements regarding availability of information related to MH/SUD benefits:

- The criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries and affected providers upon request.
- The reason for any denial of reimbursement or payment for a MH/SUD benefit must be made available to the beneficiary.

# Availability of Information - MCOs

## Criteria for Medical Necessity Determinations:

- MCOs are deemed compliant with this requirement if the MCOs disseminate practice guidelines in compliance with the Medicaid managed care rule (42 CFR 438.236(c)).
- If the state provides MH/SUD benefits on a FFS basis to Medicaid MCO enrollees, the state is responsible for making the criteria for medical necessity determinations for MH/SUD benefits available to beneficiaries and providers upon request.

# Availability of Information – MCOs (con't.)

## Criteria for Medical Necessity Determinations:

- States are encouraged to implement strategies to make medical necessity criteria readily available to beneficiaries and providers and to require MCOs to do the same.
- States can work with MCOs, PIHPs, and PAHPs to adopt a standard approach to ensuring access to medical necessity criteria.
  - Consider a uniform disclosure standard.
  - Consider posting the information to a readily accessible website, or providing a telephone number for individuals to request more detailed criteria.

# Availability of Information - MCOs (con't.)

## Reason for Denial of Payment:

- There is no deeming provision, but if an MCO provides notices of adverse benefit determination for payment denials in accordance with managed care regulations, that would meet the requirement.
- If the state provides services on a FFS basis to Medicaid MCO enrollees, it is responsible for making the reason for any denial of reimbursement or payment for a MH/SUD benefit available to beneficiaries.
- The state should ensure that when an MCO provides the reason for any denial of reimbursement or payment for a MH/SUD benefit to an enrollee, the reason includes the applicable medical necessity criteria *as applied to that enrollee*.

# Availability of Information - ABPs

- If alternative benefit plan (ABP) benefits are provided through Medicaid MCOs, then the parity requirements for availability of information for Medicaid MCOs apply.
- If ABP benefits are provided to beneficiaries not enrolled in a Medicaid MCO, then the state is responsible for meeting the availability of information requirements for ABPs.

# Availability of Information - CHIPs

- For benefits in a separate CHIP program, the managed care entity (MCE) or the state is responsible for making the criteria for medical necessity determinations for MH/SUD benefits available to any potential or current enrollee or contracting provider upon request.
  - As with Medicaid MCOs, if the MCE complies with the requirement in the Medicaid managed care regulations regarding dissemination of practice guidelines, the MCE will be deemed compliant with the requirement to make the criteria for medical necessity determinations available to beneficiaries and providers.
- The MCE or the state must make the reason for any denial of reimbursement or payment for MH/SUD benefits available to the enrollee. These requirements are already met by complying with existing notification and disclosure requirements in CHIP regulations.

# Questions

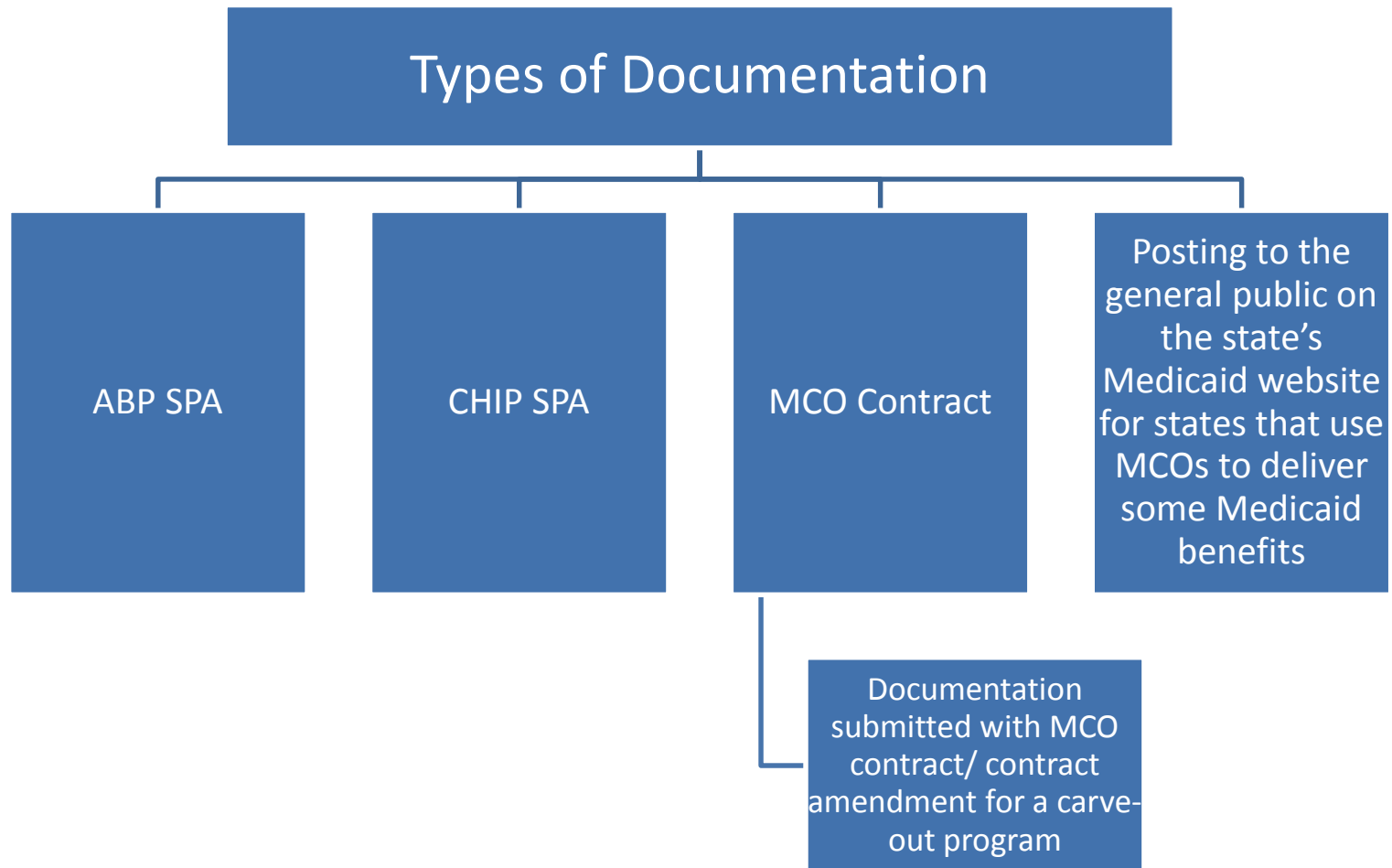






# Documentation

# Documentation of Parity Compliance



# ABP SPA

- Information in the ABP SPA:
  - Description of MH/SUD benefits, including any service limitations
  - Assurance of parity compliance based on a parity analysis
  - Assurance of EPSDT compliance for individuals under age 21 years
- CMS has already reviewed all approved ABP SPAs for parity compliance.
- CMS will review amendments to approved ABPs and new ABPs to determine compliance.
- If ABP benefits are provided through MCOs, then the State/MCO must conduct a parity analysis.

# CHIP SPA – Overview

- States with a ***Medicaid expansion*** will not need to submit a title XXI/CHIP SPA.
  - Follow all Medicaid rules related to parity
- States with a ***separate program*** must submit a title XXI/CHIP SPA.
  - May request deemed compliance with parity requirements if EPSDT is provided
    - Must meet Medicaid EPSDT statutory requirements
  - If not requesting deemed compliance:
    - Must complete a parity analysis
  - CMS will release a title XXI/CHIP state plan amendment template
  - States are encouraged to submit draft SPAs
  - SPA effective date no later than October 2, 2017

# CHIP – Requests for Deemed Compliance

- Provide certain assurances, including:
  - Consistency with all EPSDT provisions
    - 1905(r) and 1902(a)(43) of the Act
    - No exclusions of children based on condition, disorder, or diagnosis
- Specify whether EPSDT applies to all children or a subset of children.
- Supporting documents demonstrating EPSDT applies to CHIP:
  - Beneficiary handbooks or notices to families
  - Provider manuals
  - MCO contract language
  - Other

# CHIP SPA – Considerations for Deemed Compliance

- Considerations for whether deemed compliance is a viable option for a separate CHIP program:
  1. What benefits need to be changed to meet deemed compliance requirements?
  2. Does making the needed changes comport with the state goals for children's coverage?
  3. Does aligning benefit changes in CHIP with the provision of EPSDT in Medicaid result in more efficient systems?
  4. How would implementing the needed changes affect the state's process, timeline, and budget?

# CHIP – SPA Analysis When Deeming Not Requested

- Provide certain assurances related to:
  - Parity in FRs, QTLs, and NQTLs for MH/SUD benefits
  - Availability of plan infor AL/ADLs mation
- Describe:
  - Standards used to classify benefits
  - Methodology for cost based analysis related to:
    - Treatment limitations (QTLs)
    - Cost sharing (FRs)
- Approved parity SPAs for CHIP will be posted on Medicaid.gov.
  - State is also encouraged to post the parity analysis results for its entire delivery system on its website



# Documentation for Benefits Delivered to MCO Enrollees



# Documentation for MCO Enrollees

- All MCO contracts will be reviewed by CMS regional offices for parity compliance.
  - Comprehensive MCOs must conduct the parity analysis, fulfill parity requirements in contracts, and submit documentation to the state as required by the state
    - For separate CHIPs, when all benefits are provided through an MCO, there is flexibility for either the State or the MCO to conduct the parity analysis
  - CMS regional offices review and approve MCO contracts in accordance with the standards in the [State Guide to CMS Criteria for Medicaid managed Care Contract Review and Approval](#) document.

# Documentation for MCO Enrollees – Availability of Information

- Documentation required to be in all contracts:
  - The criteria for medical necessity determinations for MH/SUD benefits are made available to beneficiaries and affected providers upon request.
  - The reason for any denial of reimbursement or payment for a MH/SUD benefit are made available to the beneficiary.

# Documentation for MCO Enrollees - Analyses Across Delivery Systems

- If any benefits are carved out (i.e., services provided to MCO enrollees through a PIHP, PAHP, or FFS), the State must submit documentation of parity compliance to accompany submission of the MCO contract to CMS.
  - Documentation must demonstrate compliance with each of the parity requirements in 42 CFR part 438
- It is recommended that states post similar documentation on their website.

# Documentation: Coverage in Each Classification

- Documentation providing a description of covered M/S, MH, and SUD benefits by each classification.
- Whether the State plan covers MH and SUD benefits in each classification in which there is a M/S benefit or if the State added a MH or SUD benefit to the benefit package to meet the parity requirement.

# Documentation: Definition of MH/SUD and Benefit Classifications and Mapping

- Definition of M/S, MH, and SUD benefits:
  - State's definition of M/S benefits, MH benefits, and SUD benefits, including the standard used to define M/S, MH, and SUD benefits
  - Benefits included under each benefit type (M/S, MH, and SUD)
- Classification of benefits into the inpatient, outpatient, emergency care, and prescription drug classifications:
  - Definition of each benefit classification
  - The M/S, MH, and SUD benefits in each classification

# Documentation: FRs and QTLs

- Financial requirements (FRs) and Quantitative Treatment Limitations (QTLs):
  - How the parity requirements for FRs and QTLs applied to MH/SUD benefits are met for each benefit package
    - Met if the State documents there are no FRs or QTLs for MH/SUD benefits
  - If FRs or QTLs are applied to MH/SUD benefits, documentation by benefit package that:
    - Lists each covered MH/SUD benefit within each classification and the applicable type and level of FR or QTL
    - Lists each covered M/S benefit within each classification and the applicable type and level of FR or QTL

# Documentation: FRs and QTLs (con't.)

- If FRs or QTLs are applied to MH/SUD benefits, documentation by benefit package that summarizes:
  - For each type of FR that applies to MH/SUD benefits in a classification, the results of the two-part test.
  - For each type of QTL that applies to MH/SUD benefits in a classification, the results of the two-part test. For example, see table A on next slide.
  - It is not necessary to document the FRs or QTLs that were removed.

# Documentation: FRs and QTLs

## Example Table A

Benefit Package: XYZ

Classification	M/S Projected Payments	Subject to Annual Day Limitation					
		Substantially All Test			Predominant Test		
		\$	%	Pass (Y/N)	\$	%	Level
Inpatient	\$5,000,000	\$4,000,000	80%	Y	\$3,250,000	81%	120 days

The following MH/SUD benefit(s), and corresponding limit, for the applicable benefit package and benefit classification pass the two-part parity test:

- Inpatient treatment for substance use disorders: 120 annual day limit
- Residential treatment for substance use disorders: 150 annual day limit



# Documentation: FRs and QTLs (con't.)

- A narrative explanation of the State's methodology including:
  - A description of the methodology used to perform the parity analysis for each type and level of FR and QTL applied to a MH/SUD benefit.
  - A description of the data, steps, and assumptions used to calculate the projected payments in each applicable classification for the applicable time period.

# Documentation: Cumulative FRs

- Cumulative FRs:
  - Show that no cumulative FR for MH or SUD benefits in a classification accumulates separately from any cumulative FR for M/S benefits in the same classification.

# Documentation: Prescription Drug Tiers

- If different levels of an FR apply to different tiers of prescription drug benefits, document:
  - The reasonable factors applied to assign drugs to the tiers.
  - That the factors were applied in a comparable manner without regard as to whether a drug is generally prescribed for M/S or MH/SUD conditions.

# Documentation: ALs and ADLs

- If a single AL or ADL is applied to all M/S and MH/SUD benefits OR a separate AL or ADL applies to MH/SUD benefits:
  - Provide documentation that more than 2/3 of M/S benefits are associated with the AL or ADL.
- If an AL or ADL is imposed on MH/SUD benefits that is no lower than the weighted average of ALs or ADLs applied to M/S benefits:
  - Provide documentation that between 1/3 and 2/3 of all M/S benefits are associated with ALs or ADLs and the calculation that determined the amount of the AL/ADL applied to MH/SUD benefits.

# Documentation: NQTLs

- How the State collected information regarding the processes, strategies, evidentiary standards and other factors used in applying each NQTL to M/S and MHSUD benefits, in writing and in operation.
- How the State evaluated each NQTL for compliance with the parity requirements for NQTLs.
- The State's documentation must include, for each benefit package, documentation:
  - Listing all NQTLs applicable to MH/SUD benefits.
  - Describing how each NQTL applied to MH/SUD benefits meets the parity requirements of comparability and stringency for associated processes, strategies, evidentiary standards, and other factors.

# Documentation to the General Public

- States that use an MCO to deliver some Medicaid benefits must provide documentation of compliance with parity to the general public and post this information on the State's Medicaid website by October 2, 2017.
- May include the same type of information as the documentation required with submission of an MCO contract/contract amendment for a carve out but in a user-friendly format.

# Updating Documentation

- Documentation must be updated when there is a change that impacts parity compliance. For example:
  - Change to benefit package (e.g., adding MH/SUD benefits subject to limits or adding or removing M/S benefits that may impact the FR, QTL, AL/ADL or NQTL test)
  - System delivery change
  - Change to FRs/QTLs, AL/ADLs and/or NQTLs



# Considerations for Ongoing Compliance and Monitoring



# Ongoing Compliance and Monitoring

- Key considerations:
  - Leverage existing oversight and plan assessment tools to monitor:
    - Managed care plan reporting requirements
    - Network adequacy and access requirements
    - HEDIS submissions
    - Consumer complaint processes

# Ongoing Compliance and Monitoring (con't.)

- Key considerations:
  - Establish communication pathways for interested parties, for example:
    - Bulletins
    - Policy guides
    - Discussions with key stakeholders
    - Opportunity for public comment



# Wrap Up

# Additional Resources

- Parity Compliance Toolkit
  - [Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs](#)
- Parity Implementation Roadmap
  - [An Implementation Roadmap for State Policy Makers Applying Mental Health and Substance Use Disorder parity Requirements to Medicaid and Children's Health Insurance Programs](#)
- SAMHSA Parity Policy Academies
  - Two parity policy academies to occur from February 2017 through August 2017
- State Technical Assistance
- TA Mailbox
  - Email: [parity@cms.hhs.gov](mailto:parity@cms.hhs.gov)

# Questions



# Additional Questions?

Please send additional questions to the mailbox dedicated to this rule:

[parity@cms.hhs.gov](mailto:parity@cms.hhs.gov)

While we cannot guarantee individualized responses, inquiries will inform future guidance and presentations.