



Webinar #2: Application of Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs

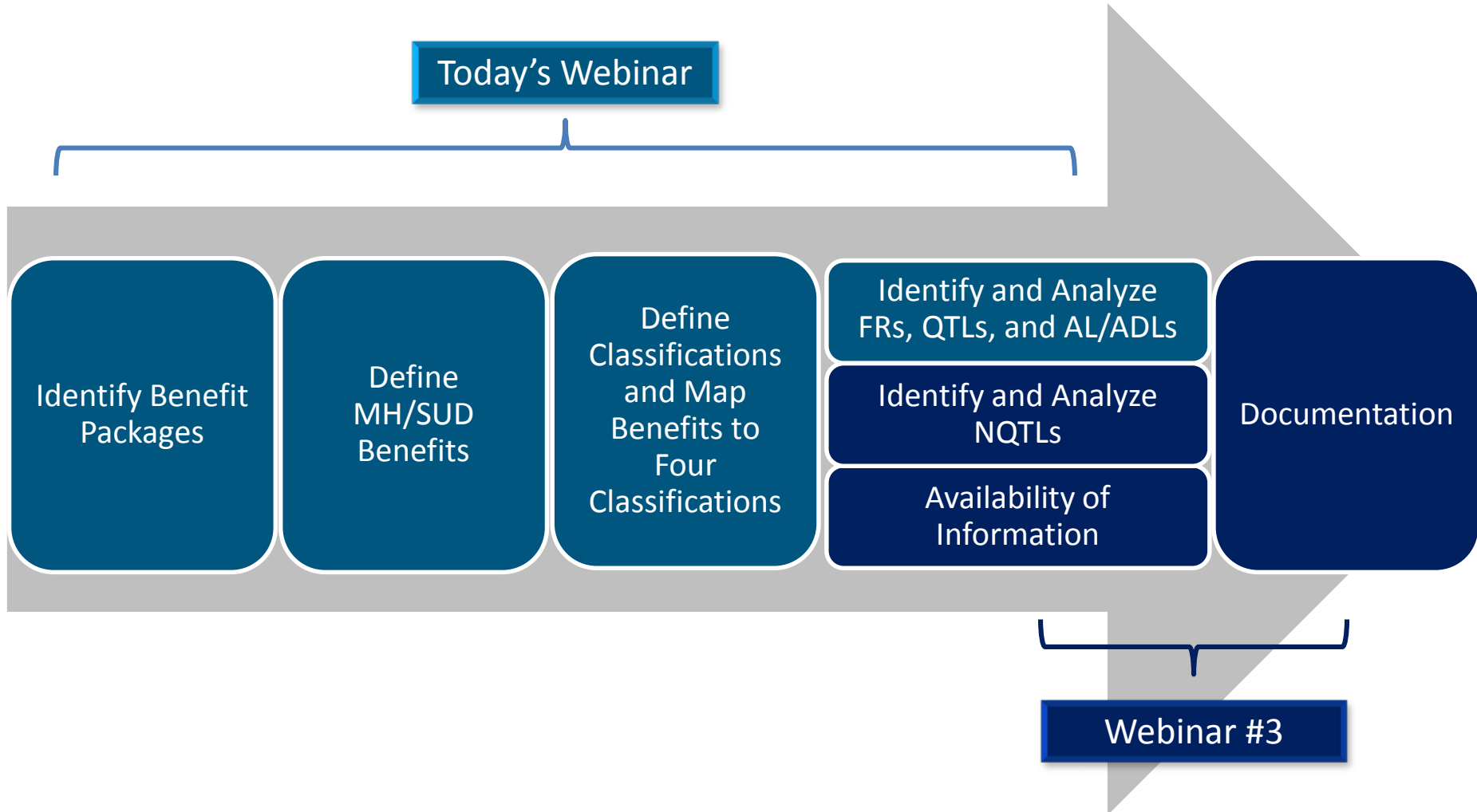
February 23, 2017

3:00-4:30pm ET

Center for Medicaid and CHIP Services



Welcome and Review






Webinar Overview

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

- ✔ Identifying Benefit Packages
 - ✔ Defining Mental Health/Substance Use Disorder (MH/SUD) Benefits
 - ✔ Defining Classifications and Mapping Benefits to Classifications
 - ✔ Identifying and Analyzing Financial Requirements (FRs) and Quantitative Treatment Limitations (QTLs)
 - ✔ Identifying and Analyzing Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)
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Webinar Overview (con't)

Webinar 3 will provide detailed information regarding the other key steps in the parity analysis:

-  Identifying and Analyzing Non-Quantitative Treatment Limitations (NQTLs)
 -  Availability of Information
 -  Documentation
-

Brief Overview of Key Requirements for this Webinar

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

-  The parity requirements for FRs, QTLs, and NQTLs apply by benefit package.
-  MH/SUD and medical/surgical (M/S) benefits must be defined consistent with a “generally recognized independent standard of medical practice.”
-  Benefits must be mapped to one of four classifications: inpatient, outpatient, prescription drugs, and emergency care.
-  FRs and QTLs applied to MH/SUD benefits cannot be more restrictive than the **predominant** FR or QTL that applies to **substantially all** M/S benefits in that same classification.
-  AL/ADLs cannot be applied to MH/SUD benefits unless AL/ADLs apply to at least one-third of M/S benefits.



Identify Benefit Packages

Identify Benefit Packages

Overview

The parity analysis for FRs, QTLs, and NQTLs is conducted by benefit package.

A benefit package is a unique set of M/S and MH/SUD benefits and/or financial requirements provided to specific eligibility categories.

- For example, Medicaid children, children in a separate CHIP program with income below a certain FPL, alternative benefit plan (ABP) adults, individuals meeting nursing facility level of care.

A benefit package includes all M/S and MH/SUD benefits regardless of the authority, including long term care services.

- For example, state plan, 1115, 1915(b)(3), 1915(c), 1915(i), “in lieu of” services, and voluntary benefits.

Identify Benefit Packages

Overview (con't)

- A benefit package may be provided using one or more delivery system(s).
- A delivery system consists of the entity or entities that administer the benefit package, such as:

Managed Care Organizations (MCOs)

Prepaid Inpatient Health Plans (PIHPs)

Prepaid Ambulatory Health Plans (PAHPs)

Fee-for-Service (FFS)

- If a benefit package is provided through multiple delivery systems, a parity analysis may be needed for each delivery system combination.

Number of Benefit Packages

Example



In this example, a different set of benefits is covered for each of the following eligibility groups/populations:

- ABP adults
- Non-ABP adults
- Medicaid children
- Children in the State's separate CHIP program
- Further, the separate CHIP applies 2 different sets of financial/ cost-sharing requirements, one for each of the 2 different income bands.
- There are **5** benefit packages in this example.

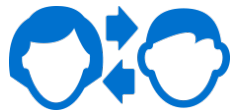
Identify Benefit Packages

Streamlining the Analysis

- 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 is not necessary to review those NQTLs more than once (unless they differ in writing or operation between benefit packages).
- Once a data collection methodology has been established for a benefit package, the data collection methodology for similar benefit packages may build on the first data collection methodology.
- If an NQTL's processes, strategies, evidentiary standards are identical for M/S and MH/SUD benefits, it is sufficient to document those processes, strategies and evidentiary standards once, indicating there is no difference for M/S and MH/SUD benefits. 10

Identify Benefit Packages: Key Considerations

Considerations for the process



Consider convening an interdisciplinary and cross-agency committee.

Considerations for the parity analysis

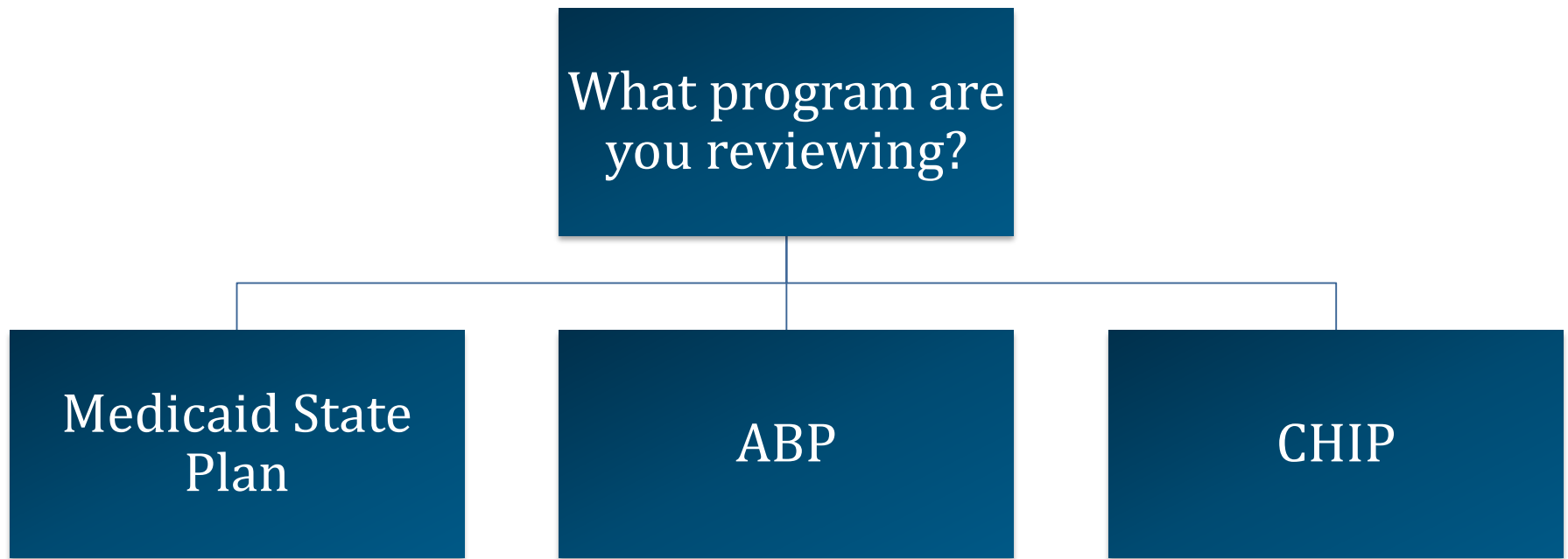


To determine the scope of the parity analysis, identify the programs (i.e., Medicaid State Plan, ABP, CHIP), benefit packages, and delivery systems that require review.

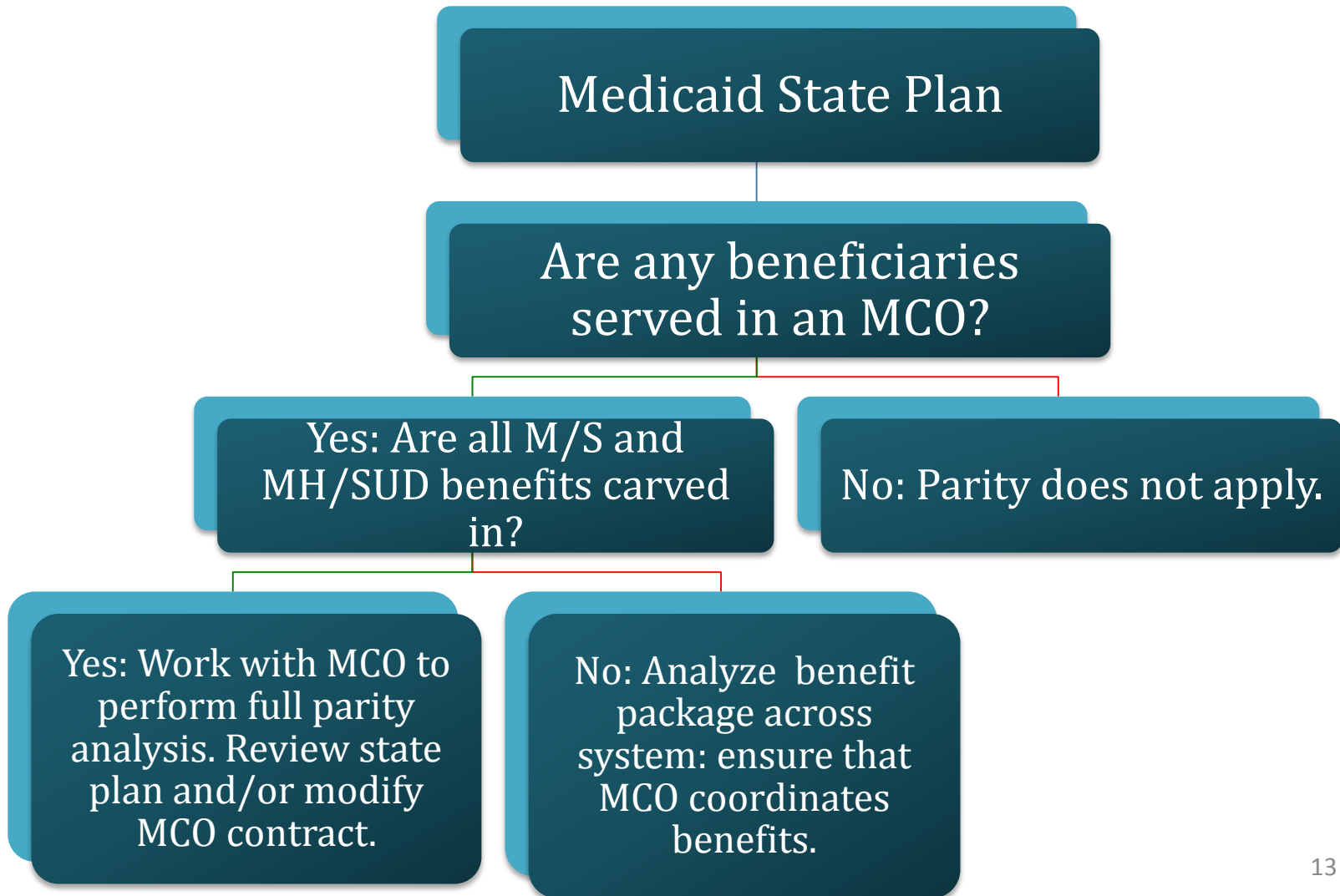


The Mapping Tool (see Roadmap Appendix A) provides a high-level overview of the state and MCO responsibilities for conducting the parity analysis. The following slides break down the Mapping Tool by program type: Medicaid state plan, ABP, and CHIP.

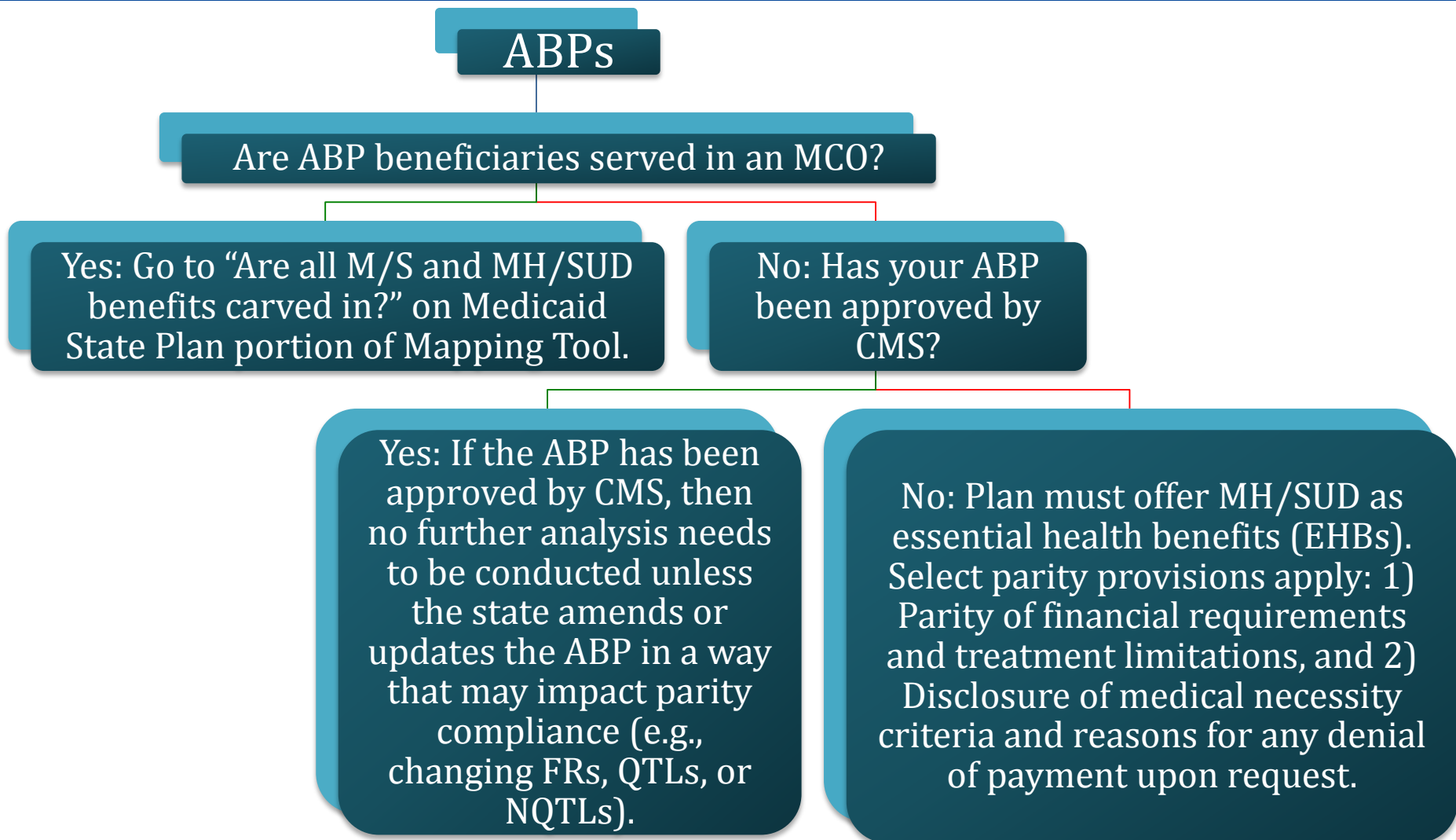
Identify Parity Requirements for Each Benefit Package



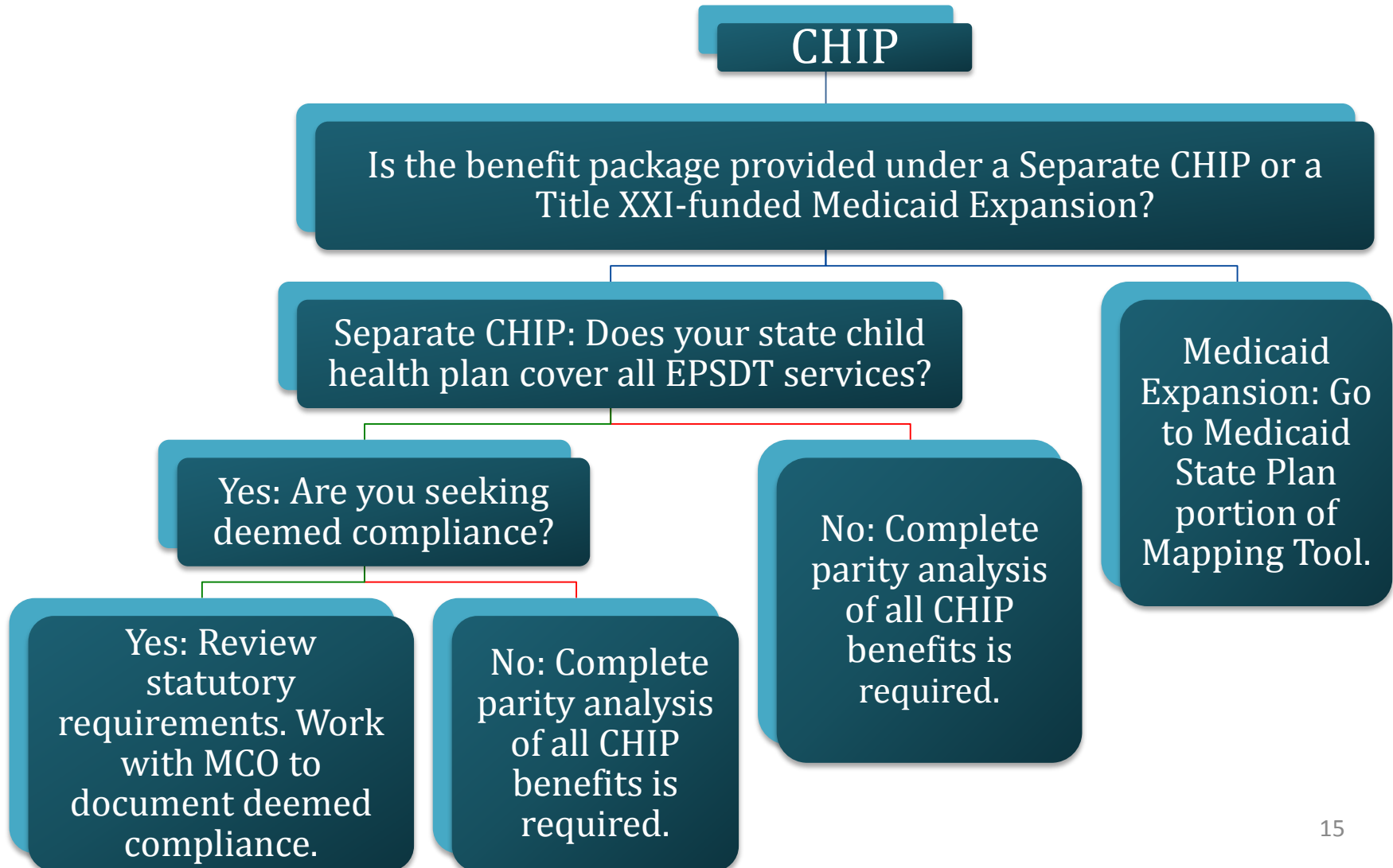
Identify Parity Requirements for Each Benefit Package: Medicaid State Plan



Identify Parity Requirements for Each Benefit Package: ABPs



Identify Parity Requirements for Each Benefit Package: CHIP





Define MH/SUD Benefits

Define MH/SUD Benefits Overview



In order to determine whether MH/SUD benefits are provided in parity with M/S benefits, the state must first identify which benefits are MH/SUD benefits and which are M/S benefits.

Define MH/SUD Benefits Overview (con't)

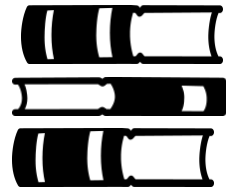
- The state must choose a “generally recognized independent standard of current medical practice” to define MH/SUD and M/S conditions.
 - Options in the rule include the most current International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM)
- A State cannot pick and choose conditions within a standard, but may use the structure of the manual to identify which conditions are MH/SUD conditions.



Define MH/SUD Benefits

Example Standards

- There may be pros and cons to the standard selected. For example:
 - The DSM includes both medical and MH/SUD conditions (e.g., medication-induced movement disorders), so additional analysis is needed to identify MH/SUD conditions.
 - ICD-10 has a separate chapter for MH/SUD conditions, but certain conditions more commonly thought of as M/S are included in the chapter (e.g., some dementias).
- A state can look to its own set of guidelines to define MH/SUD benefits, but the state guidelines must be based on a generally recognized independent standard of current medical practice.



Define MH/SUD Benefits

Key Considerations

- The selected standard determines which conditions are MH/SUD, making items and services for those conditions subject to parity requirements.



For example, State C has identified the ICD-10-CM as the standard for defining MH/SUD conditions. ICD-10 classifies anorexia nervosa as a MH condition. Therefore, nutritional counseling for treatment of anorexia nervosa is a MH benefit for State C.

Define MH/SUD Benefits

Implementation Considerations

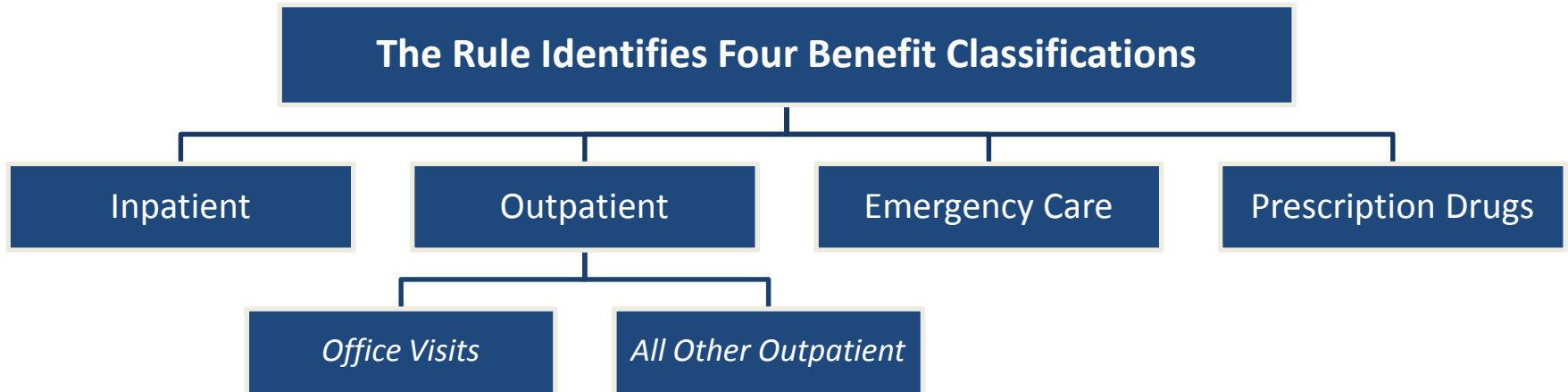
- Utilize committee members
 - State behavioral health agencies can be important sources of information on clinical and diagnostic frameworks currently used for MH/SUD.
- Include Long-Term Services and Supports (LTSS) in the definition of M/S, MH, and SUD benefits
- Create consistency
 - States will benefit from providing standardized definitions of MH, SUD, and M/S benefits across plans so that (1) all contracted MCOs understand the scope of their analytical obligations and (2) beneficiaries, who may switch plans, have access to a consistent set of MH/SUD benefits.



Define Classifications and Map Benefits to Classifications

Define Classifications & Map Benefits to Classifications

Overview



- Parity requirements for FRs, QTLs, and NQTLs apply by benefit classification.
- The rule also provides that if MH or SUD benefits are provided in any one classification, then MH or SUD benefits must also be provided in every classification in which M/S benefits are provided.



State D, which provides M/S, MH, and SUD benefits to Medicaid MCO enrollees, covers inpatient M/S and MH services but does not cover any inpatient SUD services. Consistent with the parity requirement for SUD benefits to be provided in every classification in which M/S benefits are provided, state D also must provide Medicaid benefits for inpatient SUD services.

Define Classifications & Map Benefits to Classifications

Overview (con't)

- In defining what benefits are included in a particular classification, the entity responsible for the parity analysis (i.e., the state or the MCO) must apply the same reasonable standard to M/S and MH/SUD benefits.



For example, if a state/MCO defines M/S inpatient benefits to include all benefits provided in a *hospital* setting, the state/MCO must define MH/SUD inpatient benefits to include all benefits in a *hospital* setting. It may not define MH/SUD inpatient benefits to include all benefits provided in any *facility*.

- This is because M/S inpatient benefits are defined as only those benefits that are provided in a hospital, and the *same* reasonable standard must be consistently applied to M/S and MH/SUD benefits.



A state/MCO may not assign benefits to a classification solely for the purpose of ensuring that certain FRs/QTLs/NQTLs will be applicable to the MH/SUD benefits. That would not be a reasonable standard.

Define Classifications & Map Benefits to Classifications

Implementation Considerations

- Capture the full breadth of services, whether those services are provided through MCO, PIHP, PAHP, and/or FFS.

Potential Data Sources for Complete Picture of Benefits

Plan administrators

State plans and amendments

Waivers and demonstrations

Managed care contracts

Provider policy manuals

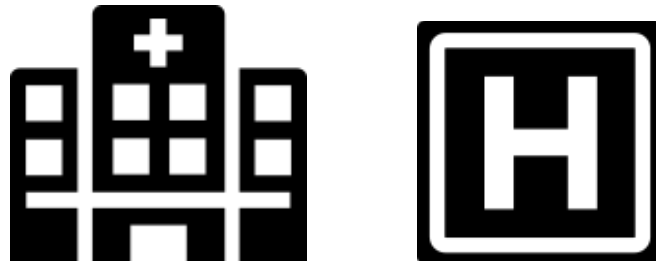
Medical necessity definitions

Member handbooks

Define Classifications & Map Benefits to Classifications

Reasonable Standards

- Possible reasonable standards for benefit classifications include:
 - How services are billed (e.g., services billed as institutional claims are defined as inpatient).
 - On the basis of the setting in which services are delivered (e.g., services delivered during an overnight stay in a hospital are defined as inpatient).
 - According to the purpose of the service (e.g., facility-based services designed to avoid institutionalization are defined as inpatient).



Questions





Identify and Analyze FRs and QTLs

FRs and QTLs

Definitions

Financial requirements (FRs)

Payment by beneficiaries for services including copayments, coinsurance, and deductibles.

Quantitative treatment limitations (QTLs)

Limits on the scope or duration of a benefit that are expressed numerically. This includes day or visit limits.

FRs and QTLs

Two-Part Test

- The State (or MCO) must identify and analyze FRs and QTLs for each benefit package, by classification, using a two-part, cost-based test:

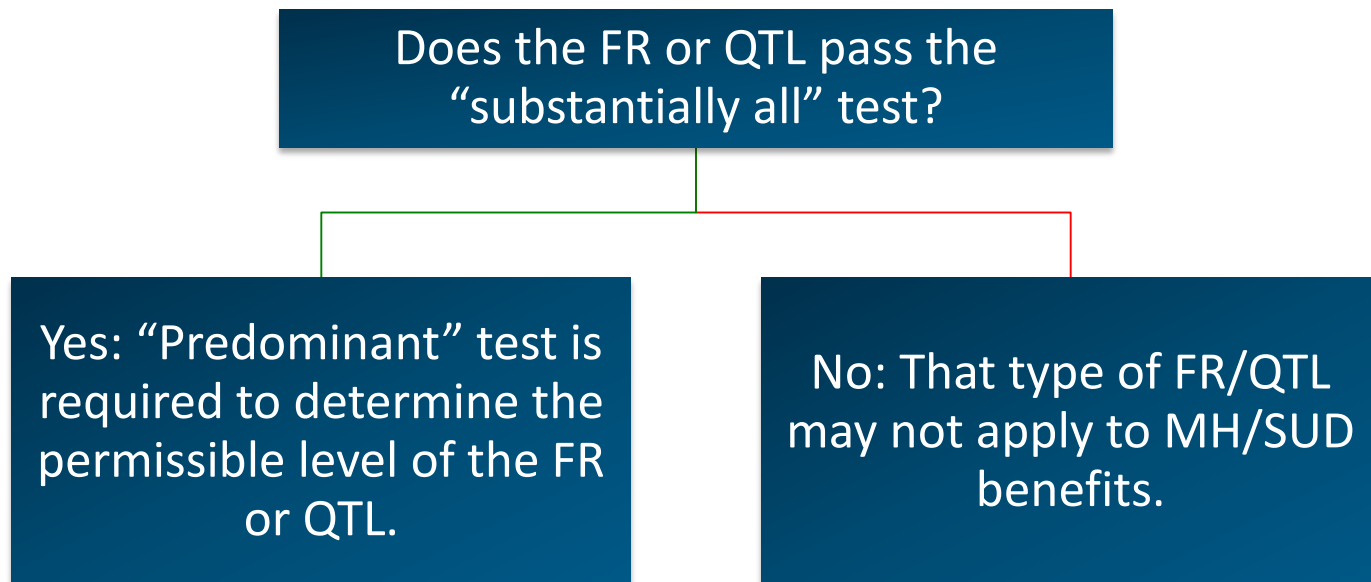
FRs and QTLs applied to MH/SUD benefits cannot be more restrictive than the *predominant* financial requirement or treatment limitation of that type applied to *substantially all* M/S benefits in that same classification.

- The State/MCO does not have to perform the two-part test for classifications where there are no FRs or QTLs applied to any MH/SUD benefits.

FRs and QTLs

Substantially All Test

- The “substantially all” test requires a type of FR (e.g., copayment) or QTL (e.g., day limit) to apply to at least two-thirds (i.e., substantially all) of the expected payments in a year for all M/S benefits in the same classification.



FRs and QTLs

Substantially All Test: Example A



An MCO limits residential treatment for SUD (which is mapped to the inpatient classification) to 90 days a year (a QTL), and most M/S services in the inpatient classification are subject to either a 90-day or 120-day limit.

- Total projected M/S payments in the inpatient classification for the applicable benefit package and time period are \$5,000,000.
- Of the \$5,000,000, \$4,000,000 is projected for payments with day limits.
- This passes the substantially all test because at least two-thirds of all inpatient M/S benefits in the applicable classification for that benefit package have a day limit.

FRs and QTLs

Substantially All Test: Example B



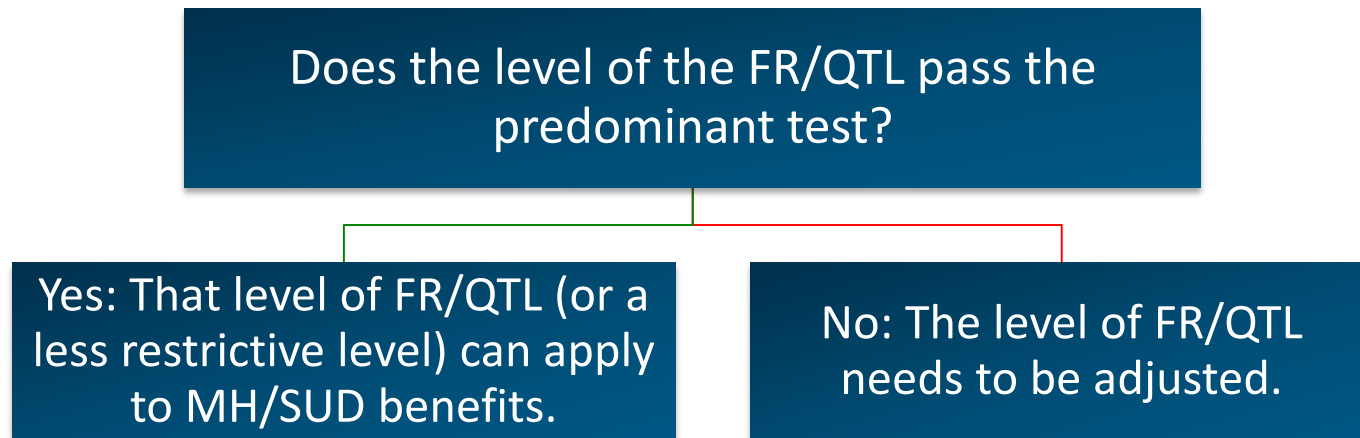
An MCO limits residential treatment for SUD (which is mapped to the inpatient classification) to 90 days a year, and the only day limit that exists on inpatient M/S benefits is for inpatient rehabilitation. It is unlikely that the 90-day limit will pass the substantially all test (i.e., at least two-thirds of inpatient M/S benefits must have a day limit) because only a very limited M/S benefit has any day limit.

- If a QTL does not pass this first part of the test, the QTL cannot be applied to residential treatment for SUDs, regardless of level.

FRs and QTLs

Predominant Test

- If the type of FR or QTL passes the substantially all test, then the predominant test is required to determine the permissible level of the FR or QTL.
- To pass the “predominant” test, the level (or magnitude) of the type of FR (e.g., **\$5** copayment) or QTL (e.g., **90** day limit) must apply to more than one-half (i.e., the predominant amount) of the payments for M/S benefits in the same classification that are subject to that type of FR or QTL.



FRs and QTLs

Predominant Test Example

Using the same facts as example A, the MCO looks at the projected payments for M/S benefits in the inpatient classification for the benefit package subject to the applicable level of QTL (90-day limit).

Inpatient M/S Benefit	Day Limit	Projected M/S Payments	Does a Day Limit Pass the Substantially All Test?	Does the Level of Day Limit Pass the Predominant Limit?
Skilled nursing facility	None	\$1,000,000	NA	NA
Hospice	90-day limit	\$750,000	Yes ($\$4,000,000 / \$5,000,000 = 80\%$)	No ($\$750,000 / \$4,000,000 = 18.75\%$)
Inpatient hospital	120-day limit	\$3,250,000	Yes ($\$4,000,000 / \$5,000,000 = 80\%$)	Yes ($\$3,250,000 / \$4,000,000 = 81.25\%$)
Inpatient M/S benefits with a day limit	NA	\$4,000,000 ($\$750,000 + \$3,250,000$)	NA	NA
Inpatient classification total for M/S benefits	NA	\$5,000,000	NA	NA

FRs and QTLs

Exceptions

Generally, the classifications cannot be subdivided. However, there are two exceptions:



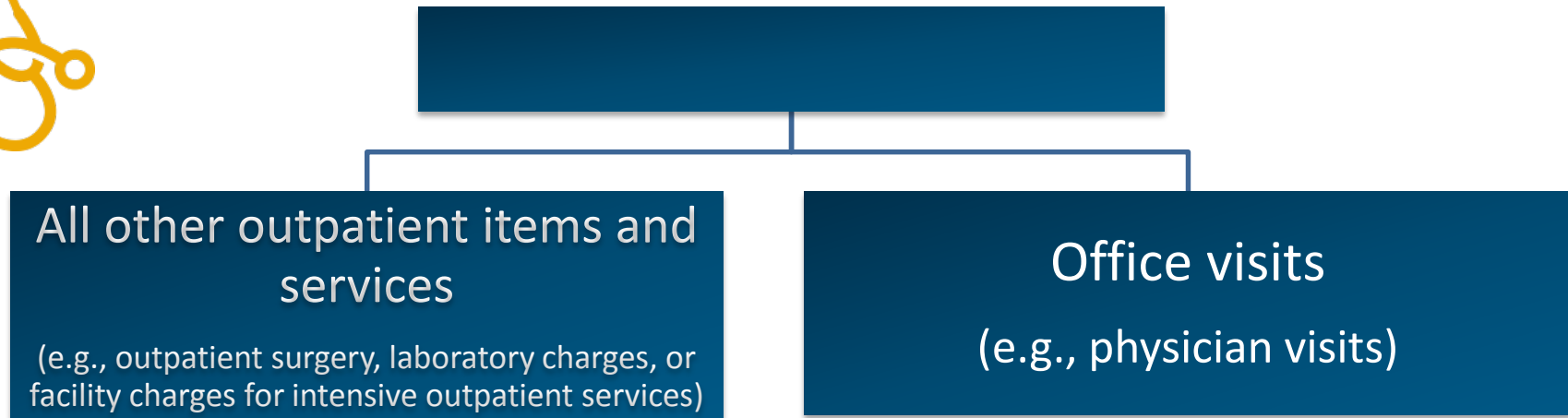
Outpatient subclassification



Prescription drug tiers

FRs and QTLs

Outpatient Subclassification



- Once the subclassification is used, no FR or QTL may be applied to MH/SUD benefits in a subclassification that is more restrictive than the predominant FR or QTL that applies to substantially all M/S benefits in the subclassification.
- Additional information on the outpatient subclassification, including examples, can be found in section 5.2.3 of the Toolkit.

FRs and QTLs

Prescription Drug Tiers



- A state, MCO, PIHP, or PAHP may apply different levels of FRs to different tiers of prescription drugs if:
 - The tiers are based on reasonable factors (such as costs, efficacy, generic versus brand name, or mail order versus pharmacy pick-up/delivery); and
 - Those factors are applied consistent with NQTL requirements and without regard to whether a drug is generally prescribed for MH/SUD or M/S conditions.

FRs and QTLs

When Cost Analysis is Not Needed



A state/MCO (as applicable) does not have to perform the cost analysis if it is possible to determine the results of two-part test without it.

FRs and QTLs

When Cost Analysis is Not Needed (con't)

Cost analysis is not needed:


- If no FRs or QTLs apply to MH/SUD benefits in a particular benefit package or classification.
- If no FRs or QTLs apply to M/S benefits in a particular benefit package or classification, no FRs or QTLs can apply to MH/SUD benefits in that benefit package or classification.
- If the same FR or QTL applies to all benefits in a classification, the State/MCO can conclude, without conducting a cost analysis, that the FR/QTL can apply to MH/SUD benefits in that classification.
- If the type of FR/QTL that applies to MH/SUD benefits in a particular classification only applies to a limited portion of M/S benefits in the same classification, then the State/MCO can conclude, without conducting the cost analysis, that no FRs/QTLs can apply to MH/SUD benefits in that classification.



For instance, in Example B above the only day limit on inpatient M/S is for inpatient rehabilitation.


FRs and QTLs

Cumulative FRs


- The Medicaid and CHIP parity regulations define *cumulative financial requirements* as FRs “that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums.”
- This type of financial requirement is allowed under the parity rules, but the state, MCO, PIHP, or PAHP cannot apply separate cumulative financial requirements to M/S and MH/SUD benefits in a classification
 -  For example, an out-of-pocket (OOP) maximum for M/S outpatient benefits and a separate OOP maximum for MH/SUD outpatient benefits.
- Separately accumulating QTLs are permissible if they pass the two-part “substantially all and predominant” test.

FRs and QTLs

Determining the Amount of Payments

- To do the cost analysis, the State/MCO must determine the dollar amount of all payments for M/S benefits in the classification (for the applicable benefit package) expected to be paid during a specific year.
 - The final rule says that “any reasonable method” may be used to determine the dollar amount expected to be paid for M/S benefits.
 - In order to be reasonable, data specific to the benefit package being evaluated must be used to make projections for the dollar amounts expected to be paid during the relevant period.
-  If such data are not available or sufficient, then data from other, similarly structured benefit packages for similar populations can be used, as long as the data are adjusted to be comparable to the benefits and population being assessed to conduct the analysis.

FRs and QTLs: Determining the Amount of Payments (con't)

- Total dollar amounts consist of all combinations of MCO, PIHP, PAHP and FFS payments for M/S benefits in a classification expected to be paid in a contract year.
 -  For instance, if a benefit package includes M/S benefits that are provided by an MCO and FFS, total M/S payments for the MCO and FFS for M/S benefits for that benefit package must be used to project the total M/S dollar amounts in each classification for that benefit package.

FRs and QTLs

Key Considerations



Develop the necessary data sets

- States with multiple delivery systems may need to coordinate across both claims and encounter data.
- The state Medicaid Management Information System (MMIS) fiscal agent may be a helpful resource for developing data sets that can be used to perform the cost analyses.



If needed, consider convening a data subgroup to prepare and align data

- State staff and point people from managed care plans (MCOs, PIHPs, and PAHPs) may find it helpful to convene as a subgroup.
- The subgroup can develop standards for data queries and data sets.
- These standards can facilitate clear comparisons across benefit packages.

Questions





Identify and Analyze AL/ADLs

Identify and Analyze AL/ADLs

Definition

Aggregate lifetime dollar limit (AL)



Dollar limitation on the total amount of specified benefit that may be paid.

Annual dollar limit (ADL)

Dollar limitation on the total amount of specified benefits that may be paid in a 12-month period. This includes dollar limits that apply on a monthly basis.

Identify and Analyze AL/ADLs

Overview

- The State/MCO must identify and analyze AL/ADLs using a cost-based test (can use any reasonable method to determine expected dollar amounts).
 - The rule prohibits the application of AL/ADLs to MH/SUD benefits unless dollar limits apply to at least one-third of M/S benefits.
-  For example, State D has a separate CHIP program with a \$50,000 annual dollar limit on inpatient treatment for SUD. There are no annual dollar limits on any M/S services in the CHIP program.
-  State D must remove the annual dollar limit on inpatient treatment for SUD if it continues to have no annual dollar limits for any M/S benefits in the CHIP program.

Identify and Analyze AL/ADLs

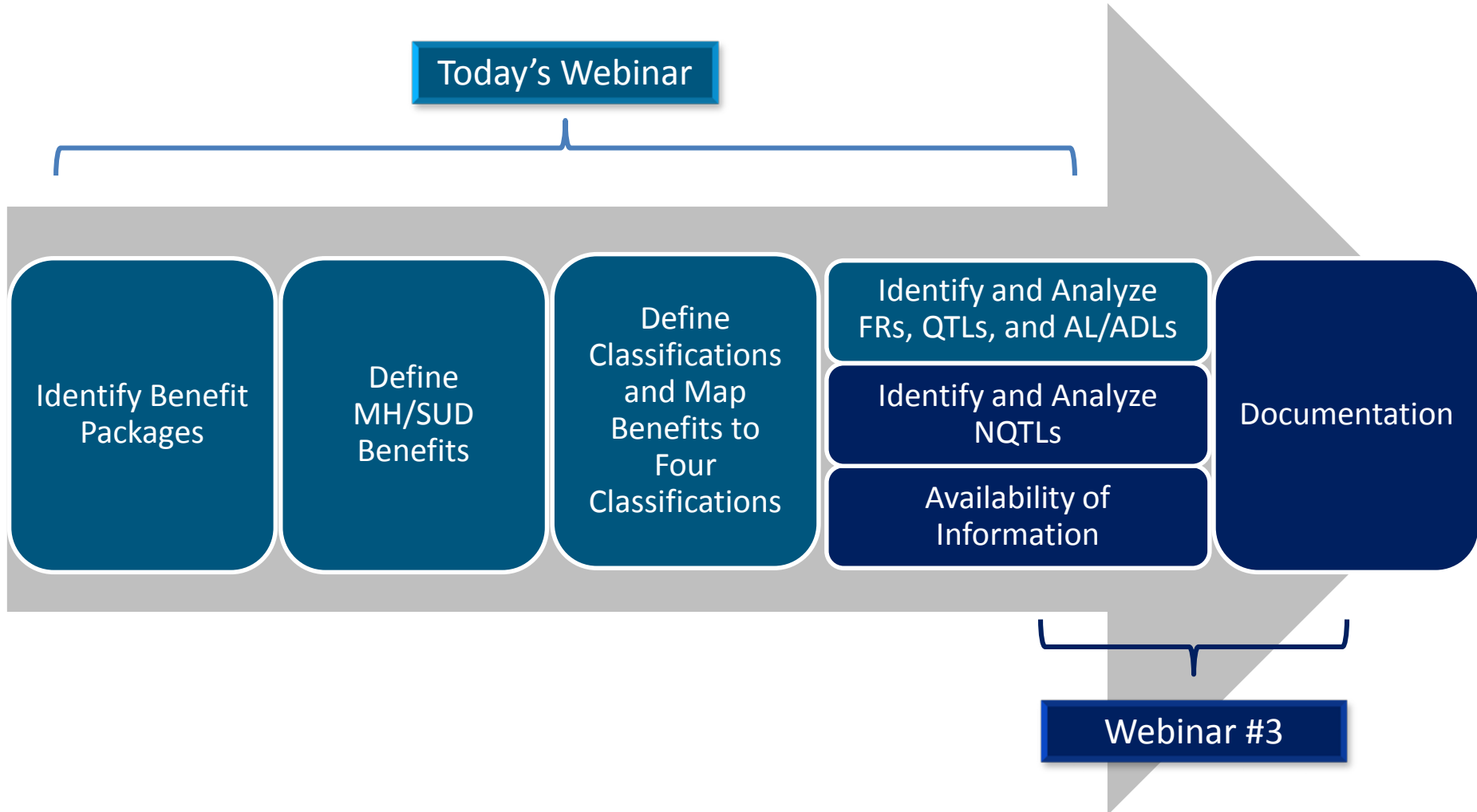
Overview (con't)

- If an AL/ADL applies to between one-third and two-thirds of M/S benefits, an AL/ADL may be applied to MH/SUD benefits if it is no more restrictive than the weighted average of the limit applied to the M/S benefit.
- If an AL/ADL applies to at least two-thirds of M/S benefits either:
 - Apply the AL/ADL to both the M/S and MH/SUD benefits subject to the limit without distinguishing between the M/S benefits and MH/SUD benefits, or
 - Apply an AL/ADL on MH/SUD benefits that is no more restrictive than the AL/ADL on M/S benefits.



Wrap Up

Steps to be Covered in Webinar 3



Additional Resources

- [Parity Compliance Toolkit](#)
 - Full web address:
<https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>
- [Parity Implementation Roadmap](#)
 - Full web address:
<https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-roadmap.pdf>
- SAMHSA Parity Policy Academies
 - Two parity policy academies to occur from February 2017 through August 2017
- Upcoming Webinar
- Additional TA opportunities
- TA Mailbox
 - Email: parity@cms.hhs.gov

Questions



Additional Questions?

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

parity@cms.hhs.gov

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