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Obstacles And Opportunities Within CMS Mental Health Rule

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Last month, the Centers for Medicare & Medicaid Services finalized rules implementing mental health parity requirements for Medicaid and the Children's Health Insurance Program (CHIP).[1] While the basic parity standards in the final rules mirror those in the commercial market, application of parity to Medicaid and CHIP presents unique issues, challenges and opportunities.


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Background

In 1996, Congress passed the Mental Health Parity Act of 1996 (MHPA), Pub. L. No. 104-204, which requires parity in aggregate lifetime and annual dollar limits on mental health benefits and medical/surgical benefits for certain commercial group health coverage. In 2008, Congress added new mental health parity requirements through the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), Pub. L. No. 110-343. The MHPAEA requires parity in the treatment limitations and financial requirements for mental health benefits, as compared to medical/surgical benefits, and extends the parity requirements to substance use disorder services. The Affordable Care Act subsequently extended these parity requirements to plans in the individual market.[2]

These parity laws do not apply to Medicaid state plan fee-for-service benefits. However, they do apply to Medicaid managed care organizations (MCO), Medicaid alternative benefit plans, and CHIP.[3]

In November 2013, the U.S. Departments of Treasury, Labor and Health and Human Services published final mental health parity rules for commercial plans, but these rules do not apply to Medicaid or CHIP.[4] On April 10, 2015, CMS proposed mental health parity rules to Medicaid and CHIP.[5] Last month, CMS finalized those rules, largely as originally proposed.

General Standards and Requirements

The basic mental health parity standards and requirements in Medicaid and CHIP mirror those that apply to commercial plans.

Like the commercial rules, the Medicaid/CHIP rules prohibit the application of any "quantitative

treatment limitation" or "financial requirement" to mental health and substance use disorder (MH/SUD) benefits "that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees."[6] The key terms are defined as follows:

- Three-fourths classifications of benefits: inpatient, outpatient, emergency care and prescription drugs.

- Three-fourths type of limit/requirement: a copayment, visit limit, deductible or anything else that limits access or is a financial requirement for the service.

- Three-fourths substantially all of the benefits: the type of limit/requirement covers at least two-thirds of the benefits in the classification (measured by the amount of plan payments for benefits).

- Three-fourths predominant level: the magnitude of the limit/requirement (e.g., dollar amount of the copayment) applies to more than 50 percent of the benefits subject to that type of limit/requirement.

For example, a $5 co-payment can be applied to outpatient MH/SUD services only if more than two-thirds (substantially all) of all of outpatient (classification) medical/surgical benefits are subject to a copayment (type), and over half of the copayments charged for outpatient medical/surgical services are equal to or greater than $5 (making $5 the predominant requirement of the copayment type).

The provisions of the Medicaid rules governing "nonquantitative" treatment limitations are also similar to those that apply in the commercial market. Specifically, the "processes, strategies, evidentiary standards or other factors used in applying the nonquantitative treatment limitation to" MH/SUD benefits must be "comparable to," and "applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the limitation for medical/surgical benefits in the classification."[7]

The Medicaid/CHIP rules also include the special rules for multitiered prescription drug benefits and outpatient services:

1. Multitiered prescription drug benefits: Different financial requirements for different tiers of prescription drugs are permissible if they are based on "reasonable factors" (e.g., cost, efficacy, generic versus brand and mail order versus retail) and determined in compliance with the standards for nonquantitative treatment limitations described below, without regard to whether the drug is generally prescribed for MH/SUD treatments as opposed to medical/surgical treatments.

2. Subclassifications for outpatient services. The outpatient classification may be split into two sub-classifications: office visits and other outpatient services. Requirements and limits in these sub-classifications will comply with the MHPAEA if they are not more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same subclassification.[8]

Finally, the Medicaid/CHIP rules mirror the commercial rules in prohibiting "cumulative financial requirement for [MH/SUD] benefits in a classification that accumulates separately from any established for medical/surgical benefits."[9]

Issues and Challenges in Applying Parity to Medicaid and CHIP

Although the basic parity standards mirror those in the rules governing commercial plans, applying parity to Medicaid and CHIP presents unique issues and challenges, and CMS's final Medicaid/CHIP rules include provisions that are not relevant to the commercial market.

Scope of Application to Medicaid and CHIP

While the statute specifies that the mental health parity requirements apply generally to all commercial plans, they do not apply to all Medicaid coverage. As mentioned above, the parity laws do not apply to Medicaid state plan fee-for-service benefits; they only apply to Medicaid MCOs, Medicaid alternative benefit plans and CHIP.[10] In addition, the statute deems CHIP coverage and alternative benefit plan coverage to be compliant with parity if that coverage offers the comprehensive "early and periodic screening, diagnostic and treatment" package of benefits for children.[11]

In the final rules, CMS expands application of the mental health parity requirements beyond what MHPAEA requires. Specifically, while the statute provides that "[e]ach [Medicaid MCO] shall comply with" mental health parity,[12] CMS's regulations apply parity to any services delivered to any MCO enrollee, not just services actually delivered by an MCO.[13] For example, in states that carve out MH/SUD benefits from the scope of their MCO contracts, and deliver those MH/SUD fee-for-service, those fee-for-service benefits are now subject to the parity rules. CMS acknowledges that the statute does not apply the parity requirements to Medicaid services not delivered through an MCO (or an alternative benefit plan), but asserts that it has the authority to expand application of the parity requirements under its general authority to require "methods of administration" that it determines are "necessary for the proper and efficient operation of the [Medicaid state] plan."[14]

Applying the mental health parity rules to services delivered through two different delivery systems creates a significant administrative challenge for states and Medicaid MCOs. As commenters noted, "the various delivery system arrangements that states use will become significantly more complex and difficult to administer."[15] For example, some states will need to ensure that copayments, medical management standards, network tier design, and other financial requirements and treatment limits are comparable between medical/surgical benefits offered through an MCO and MH/SUD services paid fee-for-service by the state. It remains to be seen how states will handle this complexity, but it could drive more states into folding their MH/SUD benefits into the package of services covered by MCOs, to avoid the administrative headache of reconciling the limits and requirements in two different delivery systems.[16]

Consistent with CMS's effort to maximize the scope of the mental health parity requirements, the final rules do not extend MHPAEA's statutory cost exemption to Medicaid and CHIP. Under the statute, group and individual market plans are exempt from the mental health parity requirements if compliance would result in a two percent increase in costs in the first year of application or a one percent increase in years thereafter.[17] Although the mental health parity requirements apply to Medicaid MCOs and CHIP "in the same manner as such requirements apply to a group health plan,"[18] CMS did not include a cost exemption in the Medicaid or CHIP rules applying mental health parity.

CMS takes the position that a cost exemption is unnecessary because the MCOs do not bear the cost of compliance, and a cost exemption for alternative benefit plan a coverage is inappropriate "due to the mandatory delivery of [essential health benefits] and the requirement that [alternative benefit plans] be compliant with MHPAEA." CMS's decision to decline to include the cost exemption in the Medicaid and CHIP rule means that states and MCOs will need to comply with the mental health parity requirement regardless of the cost of compliance.

Finally, in the preamble to the final rule, CMS makes clear that services delivered through "Section 1115 demonstrations"* must comply with the parity requirements, if those services are delivered to MCO enrollees or if those services are part of alternative benefit plan or CHIP coverage. CMS also states that it will not waive of the mental health parity requirements in a Section 1115 demonstration.[19]

**Section 1115 demonstrations are Medicaid programs in which CMS waives compliance with certain federal requirements to allow states to experiment with innovative health care delivery ideas and models.*

Institutions for Mental Diseases

Since the inception of the Medicaid program in 1965, federal law has prohibited states from making payments for services for adults aged 22 to 64 in "institutions for mental diseases" (IMD), which are defined as any institution with more than 16 beds that is "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases."[20] This has meant that inpatient mental health services for adults are generally covered and paid for outside of the Medicaid program.

It is hard to reconcile this longstanding IMD exclusion with the mental health parity requirements. For example, Medicaid's IMD exclusion appears to be a nonquantitative treatment limitation (a restriction on "facility type"), but Medicaid does not have a similar restriction with respect to medical/surgical benefits.

CMS has long been aware of this tension, and it was expressly raised by commenters in response to the proposed rule. CMS responded that the IMD exclusion is "beyond the scope of this regulation," and that the agency believes "[t]he full range of covered services, including MH/SUD services, could be provided to beneficiaries when they are in facilities that are not IMDs."[21] This appears to mean that CMS will evaluate parity by what is available and paid for by Medicaid, and not include the services that have traditionally been provided outside Medicaid. Nor does CMS explain how specifically states and MCOs can comply with both the IMD exclusion and the requirement that any restrictions on "facility type" be comparable to, and applied no more stringently to, MH/SUD benefits compared to medical/surgical benefits.

Long-Term Services and Supports

Commercial health care plans generally do not cover long-term services and supports, such as nursing facility care or home- and community-based services for individuals with disabilities. In contrast, Medicaid is the largest payor of long-term services and supports in the U.S.

In a reversal from its original proposal, CMS in its final rule extended application of mental health parity to long-term services and supports.[22] CMS indicates that it decided to apply the rules to long-term care for several reasons, including the important role Medicaid plays as the largest payor of health care

for individuals with MH/SUD; the risk that excluding long-term services could result in more restrictive limits and requirements for long-term services for individuals with MH/SUD; and the difficulty in formulating clear standards to distinguish long-term services from other health care services.[23]

The extension of parity to long-term services and supports means that, for individuals enrolled in an MCO, an alternative benefit plan or CHIP enrollees, states must pay for and cover long-term services and supports needed for individuals with mental health issues and substance use disorders in generally the same way that they cover those services for individuals with physical or intellectual disabilities.

However, application of parity requirements to long-term services and supports raises a host of questions, especially with the continued exclusion of one type of inpatient facility (IMDs) specializing in MH/SUD for much of the adult population. The preamble references both institutional services (skilled nursing and inpatient rehabilitation), as well as some state plan noninstitutional services (home health and personal care), but it does not expressly indicate whether the rule also extends to Section 1915(c) home- and community-based services, which by their nature seem ill-suited for comparison to nonwaiver medical services. CMS intends to provide additional guidance on this subject, which hopefully will provide some clarity for states and MCOs about how these rules will impact their coverage policies.

Timetable for Compliance

As explained above, complying with the mental health parity requirements will be an enormous administrative undertaking for many states and MCOs. For that reason, CMS has provided an extended timetable for demonstrating compliance. Although the rules are effective 60 days after the date of their publication, i.e., on May 31, 2016,[24] states have until Oct. 2, 2017, to comply.[25]

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[1] 81 Fed. Reg. 18390 (March 30, 2016).

[2] ACA §§ 1001(2), 1311(j), 1563(c)(4).

[3] See Social Security Act (SSA) §§ 1932(b)(8), 1937(b)(6), 2103(c)(6).

[4] See 78 Fed. Reg. 68240 (Nov. 13, 2013).

[5] 79 Fed. Reg. 19418 (April. 10, 2015).

[6] See 42 C.F.R. § 438.910(b)(1) (emphasis added); accord 42 C.F.R. § 440.395(b)(2); 42 C.F.R. § 457.496(d)(2).

[7] § 438.910(d); § 440.395(b)(4); § 457.496(d)(4). Examples of nonquantitative treatment limitations

include medical management standards, length of treatment approvals, drug formulary design, network tier design, among others. In the final rulemaking, CMS clarifies that "soft benefit limits" — i.e., benefit limits that an individual may exceed based on a medical necessity finding — are subject to the nonquantitative treatment requirements, not the quantitative treatment requirements, even if the soft limits are quantitative. 81 Fed. Reg. at 18393.

[8] § 438.910(c)(2); § 440.395(b)(3)(ii); § 457.496(d)(3)(ii).

[9] § 438.910(c)(3); § 440.395(b)(3)(iii); § 457.496(d)(3)(iii).

[10] See Social Security Act (SSA) §§ 1932(b)(8), 1937(b)(6), 2103(c)(6).

[11] § 440.395(c).

[12] SSA 1932(b)(8).

[13] 42 C.F.R. § 438.6(n); 42 C.F.R. § 438.920.

[14] SSA § 1902(a)(4).

[15] 81 Fed. Reg. at 18411.

[16] 81 Fed. Reg. at 18411.

[17] See 42 U.S.C. § 300gg-26(c)(2).

[18] SSA § 1937(b)(6), 2103(c)(6); see also § 1932(b)(8),

[19] 81 Fed. Reg. at 18414.

[20] 42 C.F.R. § 435.1010.

[22] 81 Fed. Reg. at 18423.

[22] 42 C.F.R. § 438.900; § 440.395(a); § 457.496(a).

[23] 81 Fed. Reg. at 18392-93.

[24] 81 Fed. Reg. at 18390.

[25] 42 C.F.R. §§ 438.920(b)(1), 438.930, 440.395(e)(4), 457.496(g).