SELF-ASSESSMENT TOOL FOR COMPORTMENT OF MEDICAID ALTERNATIVE BENEFIT PACKAGES WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Introduction

Medicaid Alternative Benefit Packages (ABPs) are required to comport with the Mental Health Parity and Addiction Equity Act (MHPAEA). Under MHPAEA, treatment limitations and financial requirements applicable to mental health/substance use disorder (MH/SUD) benefits cannot be more restrictive than those applicable to medical/surgical benefits.

This tool is intended to provide states with a framework for assessing the MH/SUD benefits and medical/surgical benefits in Medicaid ABPs for comportment with MHPAEA. The framework includes an assessment of treatment limitations (quantitative and non-quantitative) and financial requirements, which are defined as follows:

1. Quantitative treatment limitations include the number of visits/days covered, frequency of treatment, or other limits on duration and scope of treatment.
2. Non-quantitative treatment limitations include utilization management procedures such as prior authorization, concurrent review, medical necessity, and step therapy protocols.
3. Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket limits.

In addition, the tool includes an assessment of your state's oversight efforts to ensure comportment with parity provisions by third-parties administering MH/SUD benefits (such as managed care organizations).

This tool is designed for states to conduct a self-assessment of their ABPs. The parity analysis process is an additional step and does not replace any part of the Essential Health Benefits (EHB) design review. States should first assess the proposed ABP package for alignment with the EHB requirements laid out in the Affordable Care Act and the related regulations. Once that assessment is complete, states should analyze these parity components.

How to Use this Tool

This parity assessment tool is designed to help states systematically compare the treatment limitations and financial requirements applied to MH/SUD services with those applied to medical/surgical services. The law specifies that the treatment limitations can be no more restrictive than the "predominant" treatment limitations applied to "substantially all" medical/surgical benefits. Likewise, financial requirements can be no more restrictive than the "predominant" financial requirements applied to "substantially all" medical/surgical benefits.

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The "predominant/substantially all" test applies to benefit classifications defined in the law:[1]

1. Inpatient
2. Outpatient
3. Emergency care
4. Prescription drugs

States can use this tool to document their thought process in the parity assessment of their Medicaid ABP. This information may assist states with their State Plan Amendment for their Medicaid ABP.

This tool is intended to be flexible to accommodate individual state circumstances. If an item is 'not applicable,' please indicate NA. If more space is needed to complete a response, use as much space as necessary.

Before states begin their parity assessments, we recommend two preliminary steps:

1. As noted above, this tool is based on the MHPAEA benefit classifications. However, the MHPAEA benefit classifications do not align fully with the EHB categories. States should start by thinking through the definition of the benefit classifications relative to these two systems and briefly lay out an approach in the worksheet below.

MHPAEA Benefit Classification	MH/SUD Benefits	Medical/Surgical Benefits
Inpatient		
Outpatient		
Emergency care		
Prescription drugs		
Other (specify)		

2. States should gather pertinent documentation on previous conversations with CMS concerning benefit descriptions and/or limitations. For example, if a state has a plan amendment related to limits on therapies or prescription drugs for either medical/surgical or MH/SUD services, it may be helpful to have that information available when describing the approach to benefit limitations and implications for comportment with parity.

[1] MHPAEA distinguishes in-network and out-of-network benefits for inpatient and outpatient services. For the purpose of assessing Medicaid APBs for comportment with parity, the benefit classification does not differentiate in-network and out-of-network benefits.

Additional Resources

To learn more about parity requirements under MHPAEA, refer to the following resources.

- Department of Labor Mental Health Parity Site: http://www.dol.gov/ebsa/mentalhealthparity/.
    - Fact Sheet: http://www.dol.gov/ebsa/pdf/fsmhpaea.pdf.
    - Frequently Asked Questions: http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html.
    - Mental Health Parity Self-Compliance Tool: http://www.dol.gov/ebsa/pdf/cagappa.pdf (see pages 81 to 88).
- CMS's State Health Official/State Medicaid Director Letter on Application of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans, January 16, 2013: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.
- SAMHSA Medicaid Handbook: Interface with Behavioral Services, August 2013: http://store.samhsa.gov/product/Medicaid-Handbook-Interface-with-Behavioral-Health-Services/SMA13-4773.
- SAMHSA Webinar Slides, October 6, 2010: http://www.samhsa.gov/HealthReform/docs/MHPAEA-Webinar10-6-10.ppt.
- Interim Final Rule on MHPAEA: http://www.gpo.gov/fdsys/pkg/FR-2010-02-02/pdf/2010-2167.pdf. (NOTE: The proposed rule was published in 2010, and has not been finalized; therefore, this does not constitute final guidance on the application of MHPAEA.)

For further information about assessing the comportment of ABPs with parity, please contact MedicaidMHPAEA@cms.hhs.gov.

FRAMEWORK FOR ASSESSING COMPORTMENT OF MEDICAID ALTERNATIVE BENEFIT PACKAGES WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

A. QUANTITATIVE TREATMENT LIMITATIONS

This section identifies what, if any, quantitative treatment limitations are applied to covered MH/SUD services. If a treatment limit is applied (such as a limit on the number of visits covered), it cannot be more restrictive than a treatment limit that applies to medical/surgical services in the same benefit classification. For the purpose of this assessment, rehabilitative therapies (such as physical therapy, speech therapy, and occupational therapy) should not be used solely for the comparison.[2] To analyze comportment of Medicaid ABPs with parity, states should consider the following questions:

Q1 Are any quantitative treatment limits being considered for MH/SUD services in the ABP design? Quantitative treatment limitations include the number of visits/days covered, frequency of treatment, or other limits on duration and scope of treatment.

☐ Yes → Go to Q1a
☐ No → Go to Q2 (Section B)

Q1a. For each of the benefit classifications specified in column 1, indicate the quantitative treatment limits proposed for MH/SUD services (column 2) and medical/surgical services (column 3).

MHPAEA Benefit Classification (column 1)	Quantitative Treatment Limit(s) Proposed for MH/SUD Services (column 2)	Quantitative Treatment Limit(s) Proposed for Medical/Surgical Services (column 3)
Inpatient		
Outpatient		
Emergency care		
Prescription drugs		
Other (specify)		

[2] Physical therapy and occupational therapy will likely not meet the "substantially all" test outlined in the regulations. If a state wishes to include these limits as a comparison for treatment limits, it should be prepared to have the underlying data to show these services account for more than 66 percent of the total services within that benefit classification.

Q1b. Are there any differences in the quantitative treatment limits proposed for MH/SUD services (column 2) and medical/surgical services (column 3)?

☐ Yes → Go to Q1c
☐ No → Go to Q2 (Section B)

Q1c. Are there services for which the quantitative treatment limits on MH/SUD services are more restrictive than the predominant limits applied to substantially all medical/surgical services?

☐ Yes → Go to Q1d
☐ No → Go to Q2 (Section B)

Q1d. The state is strongly encouraged to have limits on MH/SUD services that are the same as limits on medical/surgical services; if the state intends to have benefit limits for MH/SUD services that are more restrictive than those for medical/surgical services, please describe a reason for the differences in the quantitative treatment limits.

B. NON-QUANTITATIVE TREATMENT LIMITATIONS

This section identifies what, if any, non-quantitative treatment limitations are applied to covered MH/SUD services. If a non-quantitative treatment limit is applied (such as prior authorization or medical necessity criteria), it cannot be more restrictive than a treatment limit that applies to medical/surgical services in the same benefit classification. This section may be more complex for states where some or all of the MH/SUD services are administered under a carve-out arrangement, in which benefit structures and limitations may not align between MH/SUD and medical/surgical services. For example, medical/surgical services may use a prior authorization method, while MH/SUD services may be governed by step-therapy protocols. Where this is the case, states should note the divergence of approaches and assess the implications for parity across the different types of limitations.

To analyze comportment of Medicaid ABPs with parity, states should consider the following questions:

Q2. Does the state intend to apply any of the following non-quantitative limits on MH/SUD services?

Limitation	Yes	No	Still Deciding / Don't Know
Prior authorization techniques	☐	☐	☐
Concurrent review processes	☐	☐	☐
Specific medical necessity criteria	☐	☐	☐
Step-therapy protocols	☐	☐	☐
Other utilization management tools (Please describe)	☐	☐	☐

IF YOU SELECTED "YES" FOR ANY ITEM IN Q2, CONTINUE TO Q2A. OTHERWISE, GO TO Q3 (SECTION C).

Q2a. For each of the benefit classifications specified in column 1, indicate all the non-quantitative treatment limits proposed for MH/SUD services (column 2) and medical/surgical services (column 3).

MHPAEA Benefit Classification (column 1)	Non-Quantitative Treatment Limit(s) Proposed for MH/SUD Services (column 2)	Non-Quantitative Treatment Limit(s) Proposed for Medical/Surgical Services (column 3)
Inpatient		
Outpatient		
Emergency care		
Prescription drugs		
Other (specify)		

Q2b. Are there any differences in the non-quantitative treatment limits proposed for MH/SUD services (column 2) and medical/surgical services (column 3)?

☐ Yes → Go to Q2c
☐ No → Go to Q3 (Section C)

Q2c. Are there services for which the non-quantitative treatment limits on MH/SUD services are more restrictive than the predominant limits applied to substantially all medical/surgical services?

☐ Yes → Go to Q2d
☐ No → Go to Q3 (Section C)

Q2d. The state is strongly encouraged to have limits on MH/SUD services that are the same as limits on medical/surgical services; if the state intends to have benefit limits for MH/SUD services that are more restrictive than those for medical/surgical services, please describe the evidentiary standards used to determine this difference or other reason for the differences in the non-quantitative treatment limits.

C. FINANCIAL REQUIREMENTS

This section identifies what, if any, financial requirements are applied to covered MH/SUD services. If a financial requirement is applied (such as a deductible or copayment), it cannot be more restrictive than a financial requirement that applies to medical/surgical services in the same benefit classification. To analyze comportment of Medicaid ABPs with parity, states should consider the following questions:

Q3. Are any financial requirements being considered for MH/SUD services in the ABP design? Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket limits.

☐ Yes → Go to Q3a
☐ No → Go to Q4a (Section D)

Q3a. For each of the benefit classifications specified in column 1, indicate the financial requirements—both type and amount—proposed for MH/SUD services (column 2) and medical/surgical services (column 3).

MHPAEA Benefit Classification (column 1)	Financial Requirement(s) Proposed for MH/SUD Services (column 2)	Financial Requirement(s) Proposed for Medical/Surgical Services (column 3)
Inpatient		
Outpatient		
Emergency care		
Prescription drugs		
Other (specify)		

Q3b. Are there any differences in the financial requirements proposed for MH/SUD services (column 2) and medical/surgical services (column 3)?

☐ Yes → Go to Q3c
☐ No → Go to Q4a (Section D)

Q3c. Are there services for which the financial requirements on MH/SUD services are more restrictive than the predominant limits applied to substantially all medical/surgical services?

☐ Yes → Go to Q3d
☐ No → Go to Q4a (Section D)

Q3d. The state is strongly encouraged to have financial requirements for MH/SUD services that are the same as requirements for medical/surgical services; if the state intends to have financial requirements for MH/SUD services that are more restrictive than those for medical/surgical services, please describe a reason for the differences in the financial requirements.

D. OVERSIGHT PLANS FOR ENSURING COMPORTMENT WITH PARITY

In addition to describing the treatment limitations and financial requirements for MH/SUD and medical/surgical benefits for the ABP, CMS will want to understand the state's oversight plan for any third party administering the benefit, such as managed care organizations (MCOs) or third-party administrators. States should be explicit about any particular oversight tools they may apply to test parity and/or any specific plan management approaches that will be useful in identifying parity concerns, should they occur.

States should look at how their existing oversight and plan assessment tools can be used to identify parity issues, including contract requirements, utilization review and prior-authorization procedures, network adequacy requirements and network design, HEDIS submissions, and consumer complaint tracking. The state may also want to consider additional requirements or measures.

There are several tools and FAQs published by the Department of Labor that also may be helpful in describing the state's oversight plan. See, for example, the Self-Compliance Tool (pages 81 to 88), available at http://www.dol.gov/ebsa/pdf/cagappa.pdf.

Q4a. What contract provisions, oversight mechanisms, or reporting tools will be used to ensure compliance with parity for quantitative treatment limitations?

Q4b. What contract provisions, oversight mechanisms, or reporting tools will be used to ensure compliance with parity for non-quantitative treatment limitations?

Q4c. What contract provisions, oversight mechanisms, or reporting tools will be used to ensure compliance with parity for financial requirements?

Q4d. What mechanisms does the state intend to use that would identify parity concerns, such as consumer complaint tracking, network requirements, provider access measures, or other mechanisms?