South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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MEDICAID BULLETIN

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TO: **All Providers**

SUBJECT: **Application of the Mental Health Parity and Addiction Equity Act (MHPAEA)**

The South Carolina Department of Health and Human Services (SCDHHS) is issuing this bulletin for guidance on the application of MHPAEA in Medicaid.

History and Background
Starting in 1996, Congress enacted several laws designed to improve access to mental health and substance use disorder services under health insurance or benefit plans that provide medical/surgical benefits.

The Mental Health Parity Act of 1996 (MHPA, Pub.L. 104-204) addressed aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits offered by group health plans (or health insurance coverage offered in connection with such plans). The Balanced Budget Act of 1997 (BBA, Pub.L. 105-33) added sections 1932(b)(8) and 2103(f)(2) of the Act to apply certain aspects of MHPA to Medicaid managed care organizations (MCOs) and CHIP benefits.

MHPAEA extended the MHPA requirements to substance use disorder benefits in addition to mental health benefits. MHPAEA also added new requirements regarding financial requirements and treatment limitations in addition to the limitations on aggregate annual and lifetime dollar limits.

In 2009, section 502 of CHIPRA amended section 2103(c) of the Act by adding paragraph (6), which incorporates, by reference, provisions added to section 2705 of the Public Health Service Act (PHSA) by MHPAEA. Consequently, the mental health and substance use disorder parity requirements of MHPAEA apply to coverage under a CHIP state plan in the same manner MHPAEA applies to group health plans.

The Affordable Care Act (Pub.L. 111-148) expanded the application of MHPAEA to benefits in Medicaid non-managed care benchmark and benchmark-equivalent state plan benefits pursuant to section 1937 of the Act (referred to in this letter as Medicaid Alternative Benefit plans) (see section 2001(c)(3) of the Affordable Care

Act, adding section 1937(b)(6)). The application of MHPAEA to Medicaid non-managed care Alternative Benefit plan benefits was effective on March 23, 2010. Also effective as of that date, Medicaid Alternative Benefit plans that are benchmark-equivalent plans must include mental health and substance abuse services as a basic service (see section 2001(c) of the Affordable Care Act).

Requirements
MHPAEA's requirements include:

- Financial requirements that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements that are applied to substantially all medical/surgical benefits. The statute defines "predominant" as the most common or frequent of such type of limitation or requirements.
- There are no separate cost sharing requirements that apply only to mental health or substance use disorder benefits.
- Treatment limitations that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- The criteria for medical necessity determinations with respect to mental health or substance use disorder benefits are made available to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits is made available within a reasonable timeframe to participants and beneficiaries upon request.
- If a plan or coverage provides out-of-network coverage for medical/surgical benefits, it provides out-of-network coverage for mental health or substance use disorder benefits.

On February 2, 2010, the Departments of Health and Human Services, Labor, and the Treasury (the Departments) published an Interim Final Rule (IFR) under MHPAEA. The IFR is applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010. In the IFR, the Departments interpreted the statutory requirement precluding more restrictive treatment limitations for mental health or substance use disorder benefits to apply to both quantitative and non-quantitative treatment limitations. Examples of quantitative treatment limits include a limit on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Examples of non-quantitative treatment limits that were identified in the IFR include preauthorization requirements and medical management standards.

Application of MHPAEA Requirements to Managed Care Organizations
The CMS noted in its November 2009 SHO letter that mental health and substance use disorder parity requirements apply to MCOs (defined in section 1903(m) of the Act) that contract with the state to provide both medical/ surgical and mental health or substance use disorder benefits. In light of Medicaid regulations that direct states to reimburse MCOs based only on state plan services, CMS will not find MCOs out of compliance with MHPAEA to the extent that the benefits offered by

the MCO reflect the financial limitations, quantitative treatment limitations, nonquantitative treatment limitations, and disclosure requirements set forth in the Medicaid state plan and as specified in CMS approved contracts. However, this does not preclude state use of current Medicaid flexibilities to amend their Medicaid state plans or demonstrations/waiver projects to address financial limitations, quantitative treatment limitations, nonquantitative treatment limitations, and disclosure requirements in ways that promote parity.

Any additional or alternative treatment limitations put in place by the MCO, however, must comply with mental health and substance use disorder parity requirements. For example, MCOs must meet the following requirements:

- Medical management techniques used by the MCO, such as pre-authorization requirements, which are applied to mental health or substance use disorder benefits must be comparable to and applied no more stringently than the medical management techniques that are applied to medical/surgical benefits.
- Any benefits offered by an MCO beyond those specified in the Medicaid state plan also must be compliant with MHPAEA.
- In accordance with MHPAEA and federal Medicaid managed care regulations at 42 CFR 438 Subpart F, the criteria for medical necessity determinations made under the plan for mental health or substance use disorder benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contracting provider upon request. The reasons for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits must be provided to plan participants and beneficiaries upon request within a reasonable time.
- When out-of-network coverage is available for medical/surgical benefits, it also must be available for mental health or substance use disorder benefits. States are responsible for assessing their contracts with all MCOs that offer medical and surgical benefits and mental health or substance use disorder benefits, to ensure that plans comply with the provisions of MHPAEA as set forth above.

In addition to MCOs, which are statutorily-defined, CMS has, by regulation, recognized entities known as Prepaid Inpatient Hospital Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). These entities provide a more limited set of state plan services (in some instances through a carve-out arrangement). CMS urges states with these arrangements to apply the principles of parity across the whole Medicaid managed care delivery system when mental health and substance use disorders services are offered through a carve-out arrangement. CMS intends to issue additional guidance that will address this issue and will continue to consider additional regulatory changes that may be necessary to properly implement MHPAEA.

MCOs that are not in compliance with the parity requirements described above should take steps to come into compliance with those requirements. Pursuant to MHPAEA, SCDHHS is reviewing all policies and contracts and will be making

changes as needed to meet the MHPAEA requirements. Any changes as a result of this review will be issued via Medicaid Bulletins and/or revisions to provider manuals.

Thank you for your continued support of the South Carolina Medicaid program.

/s/
Anthony E. Keck
Director