South Carolina Department of Health and Human Services Medicaid MHPAEA Assessment

Findings and Recommendations

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KEY ABBREVIATIONS

ACA…….. Affordable Care Act
AL……... Aggregate lifetime
ADL…… Annual dollar limits
ASAM…….. American Society of Addiction Medicine
CHIP…… Children's Health Insurance Program
CI……..… Crisis Intervention
CMS…… Centers for Medicare & Medicaid Services
EHB…… Essential Health Benefit
EQRO……... External Quality Review Organization
FR……..…… Financial Requirements
HMA……... Health Management Associates, Inc.
ICD-10-CM..…… International Classification of Diseases
LIP……. Licensed Independent Practitioner's
MCO……. Managed care organization
MH…… Mental Health
MHPAEA……..…… Mental Health Parity and Addiction Equity Act of 2008
M/S..……. Medical/surgical benefits
NQTL…….. Non-quantitative treatment limitations
PSS……. Peer Support Service
QIO……... Quality Improvement Organization
QTL……. Quantitative treatment limitations
SCDHHS……..…… South Carolina Department of Health and Human Services
SUD……..… Substance Use Disorder

INTRODUCTION

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The MHPAEA requires insurers and plans to guarantee that all financial requirements (i.e., deductibles, co-pays), as well as caps and limitations on benefits, be no more restrictive for mental health (MH) services than for medical and surgical counterpart coverages under the same plan.

The Affordable Care Act (ACA) built upon the MHPAEA by including MH services as an essential health benefit (EHB) and mandating that parity rules apply to individual and small group markets. On March 30, 2016, Centers for Medicare & Medicaid Services (CMS) finalized the MH and substance use disorder (SUD) parity rule for Medicaid and the Children's Health Insurance Program (CHIP) effective May 31, 2016.

This report presents South Carolina Department of Health and Human Services (SCDHHS)' analysis of the State's Medicaid and Children's Health Insurance Program's (CHIP) compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act.

South Carolina's Medicaid and CHIP programs are operated by the South Carolina Department of Health and Human Services (SCDHHS). Most Medicaid-covered MH/SUD services in South Carolina are provided through capitated managed care organization (MCO) arrangements under the state's Medicaid managed care program, Healthy Connections. However, the full scope of covered MH/SUD services are provided through multiple service delivery systems, including a few services that are carved out of managed care and provided through fee-for-service delivery systems. As required by 42 CFR § 438.920(b), SCDHHS understands that, because of its mixed delivery system, it must maintain responsibility for the full scope of the benefits provided to MCO enrollees to ensure compliance with 42 CFR Part 438.

SCDHHS generally requires MCOs to furnish benefits, including MH/SUD benefits, in accordance with the Medicaid State Plan, administrative rules, department policy, and provider manuals. This report summarizes the results of a comprehensive evaluation of the Medicaid fee-for-service delivery system, a risk assessment of the SCDHHS Medicaid State Plan and associated policy framework, and a meta-analysis of benefits managed through MCO contractors to document compliance and/or identify potential parity issues that require corrective action.

EXECUTIVE SUMMARY

This report provides an evaluation of the South Carolina Department of Health and Human Services (SCDHHS) Medicaid program's compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act (ACA). The assessment focused on ensuring parity in financial requirements, quantitative treatment limitations (QTLs), and non-quantitative treatment limitations (NQTLs) between mental health/substance use disorder (MH/SUD) and medical/surgical (M/S) services.

Key findings include:

- **Financial Requirements**: The Department's elimination of cost-sharing as of July 1, 2024, achieved compliance with parity requirements for financial requirements.
- **Quantitative Treatment Limitations (QTLs)**: While benefit limitations exist, they are treated as "soft limits" allowing exceptions based on medical necessity. This approach complies with parity requirements.
- **Non-Quantitative Treatment Limitations (NQTLs):** This represents the most significant risk of non-compliance with parity requirements. The study identifies next steps to collect the appropriate information and/or take required action to ensure NQTLs are being applied in ways that ensure comparability and equivalent stringency in several areas.
- **Oversight of Managed Care Organizations (MCOs):** The external quality review (EQR) process found that all MCOs complied with parity requirements, though some MCOs required ongoing monitoring for potential risks, such as provider network adequacy and appeal rates.

SCDHHS remains committed to ensuring equitable access to services and will continue to refine its processes and policies to maintain compliance with federal parity requirements.

PROCESS OVERVIEW

SCDHHS recognizes and appreciates the importance of MHPAEA and subsequent parity final rules and strives to document compliance and identify any necessary strategies to remediate gaps in compliance. To assist the State in this MHPAEA compliance evaluation process, Health Management Associates, Inc. (HMA) was engaged to define and structure the State's review and evaluation process. The subsequent analysis is designed to be consistent with available CMS resources, including the "Parity Compliance Toolkit: Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs"[1] and "Self-Compliance Tool for Compliance with MHPAEA."[2]

The key steps included:

1. Identifying all benefit packages to which parity requirements apply.
2. Determining which covered benefits are MH/SUD benefits and which are medical/surgical (M/S) benefits.

[1] Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs. 2017. https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf

[2] Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA). https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool-mental-health-parity.pdf

3. Classifying benefits into the four benefit classifications (i.e., inpatient, outpatient, prescription drugs, and emergency care) and determine which classification MH/SUD and M/S benefits are aligned with.
4. Identifying and testing each aggregate lifetime (AL) and annual dollar limits (ADL) for compliance with parity requirements.
5. Identifying and testing each financial requirement and other quantitative treatment limits applied in a classification for compliance with applicable parity requirements.
6. Identifying and testing each non-quantitative treatment limitation in a classification, by benefit package, for compliance with applicable parity requirements.
7. For applicable benefits, ensuring appropriate mechanisms are in place to ensure MCOs comply with parity requirements.

This report is organized according to this framework, to illustrate the state's approach to each step of the parity analysis process.

BENEFIT GROUPINGS

To determine whether MH/SUD benefits are provided in parity with M/S benefits, the state must identify a consistent approach to determining which benefits are considered MH/SUD benefits and which are M/S benefits. The federal statute and regulations do not identify specific conditions as MH/SUD or M/S conditions; instead, it is incumbent upon the State to choose a specific standard for identifying and defining which conditions are considered MH/SUD conditions and which are considered M/S conditions, so that services are categorized and classified, and all parity analyses are conducted consistently. State definitions of mental health conditions and substance use disorders are required to be consistent with generally recognized independent standards of current medical practice. (See 42 CFR §438.900 and 42 CFR §457.496(a).)

For evaluating and ongoing monitoring of MHPAEA compliance, the State will utilize the ICD-10 CM to define and differentiate between MH/SUD and M/S conditions and facilitate the identification of MH/SUD and M/S benefits. Based on this approach the state's definitions of MH/SUD and M/S services are presented in **Figure 1** below.

Service Types	Definition
MH/SUD	Any item or service used to treat a primary ICD-10-CM diagnosis of F01-F99 is regarded as a MH/SUD benefit with the following exclusions: • Mental disorders due to known physiological conditions (F01 to F09), • Intellectual disabilities (F70 to F79), and • Pervasive and specific developmental disorders (F80 to F89).

M/S	Any item or service used to treat a primary ICD-10 diagnosis that is **not** within the F01- F99 range is considered a M/S benefit

Figure 1: Definitions of MH/SUD and MS.

DEFINING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Parity regulations require states to conduct their parity analyses across four benefit classifications: (1) inpatient, (2) outpatient, (3) prescription drugs, and (4) emergency care. Regulations permit states latitude with respect to the placement of benefits in each classification, but the standard for assigning a benefit to a classification must be identical for MH/SUD and M/S benefits. Grouping benefits into classifications allows for like-for-like comparisons for testing all application financial requirements, quantifiable treatment limitations, and non-quantifiable treatment limitations. If benefits are provided for M/S in any of the four treatment classifications, then parity regulations require that benefits for MH/SUD conditions must also be available in those classifications (42 CFR § 438.910(b)(2)).

Classifying Benefits into Benefit Types

For purposes of this analysis, the state applied the definitions in **Figure 2** below to classify M/S and MH/SUD benefits:

Classification	Description
Inpatient	All covered services provided to a patient who has been formally admitted to a hospital or long-term care facility and is receiving room, board, and professional services in the institution on a continuous, 24-hour-a-day basis. Inpatient services include all treatments, pharmaceuticals, equipment, tests, and procedures provided during an inpatient treatment episode.
Outpatient	Services provided to a patient who is evaluated or treated at a hospital emergency department, medical clinic, diagnostic center, or other appropriate medical facility who is not receiving room, board, and professional services on a 24-hour-a-day basis. Outpatient services include all treatments, equipment, tests, procedures, and clinician-administered pharmaceuticals provided during an outpatient treatment episode.
Emergency	All covered items or services rendered in an emergency department or to stabilize an emergency/crisis in a non-inpatient setting.

Prescription Drugs	Covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy.

Figure 2: Benefit classification descriptions.

SCDHHS leveraged the state plan and associated policy manuals to create a comprehensive catalog of benefits. These benefits were then mapped to the appropriate categories based on the definitions above. **Appendix 1** contains a benefit map that illustrates how Healthy Connections benefits were mapped to for purposes of this analysis. The exercise highlights that SCDHHS covers MH/SUD benefits in every classification in which there is a M/S benefit. SCDHSS recognizes the need to work with our MCO partners to ensure consistent application of definitions and service mapping in order to produce comparable parity reporting.

FINANCIAL REQUIREMENTS

Financial Requirements (FRs)

FRs include coinsurance, deductibles, copayments, out-of-pocket maximums, or similar requirements aligned with a service. The parity rules require that any financial requirements that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements and quantitative treatment limits that apply to substantially all M/S benefits (see 42 CFR § 438.910). Additionally, parity rules also prohibit cumulative FRs for MH/SUD benefits in a classification that accumulates separately from any established for M/S benefits in the same classification and define the conditions whereby aggregate lifetime or annual dollar limits are applied, when permissible.

As of this year, SCDHHS policy prohibits the imposition of FRs on any benefit. Effective for dates of service on and after July 1, 2024, all services are covered without cost-sharing. This policy change removed all requirements for co-payments and applies to all Healthy Connections Medicaid members, thereby ensuring compliance with parity regulations.

Aggregate Lifetime (AL) and Annual Dollar Limits (ADL)

SCDHHS does not impose AL or ADL on MH/SUD services in any benefit classifications. Given that SCDHHS does not impose this type of treatment limitation, the state determined that it is in compliance with parity regulations.

QUANTITATIVE TREATMENT LIMITATIONS

Quantitative treatment limitations (QTLs) are limits on the scope or duration of a benefit that are expressed numerically, including limits on the number of days or visits. The parity rule requires that any QTLs that apply to MH/SUD benefits should be no more restrictive than the predominant QTLs that apply to substantially all M/S benefits in the same classification.

SCDHHS' Medicaid State Plan and complementary individual provider manuals do include a range of benefit limitations within the MH/SUD service package (see examples in Figure 3 below); however, any service identified with a benefit limitation, such as number of visits, can be exceeded if meeting medical necessity or other criteria. SCDHHS will continue to monitor the application of State-defined limits for MH/SUD services to ensure that they are properly applied as "soft limits." Notably, CMS guidance indicates that soft limits, or benefit limits that allow for an individual to exceed numerical limits for M/S or MH/SUD benefits on the basis of medical necessity are to be considered NQTLs. As such, a further examination of these soft limits is included in the relevant section below.

Given that there are no hard caps in place, the study found that SCDHHS is in compliance with parity requirements governing QTLs.

Service	Classification	Benefit Limitation	Additional Policy Context
Community Mental Health	Outpatient	Maximum billable units for all services are outlined on the provider portal.	There may be clinical exceptions to the service limits when the number of units or encounters allowed may not be sufficient to meet the complex and intensive needs of a beneficiary. On these occasions, requests for frequencies beyond the service limits may be submitted directly to SCDHHS for approval.
Crisis Intervention (CI) Service	Outpatient	Telephonic interventions are limited to a maximum of four units per day.	After the second CI, medical necessity needs to be determined before rendering any other service.
Peer Support Service (PSS)	Outpatient	PSS shall not exceed 12 units per day, and private providers must submit documentation for prior authorization beyond 216 units' total. Private providers may render PSS for up to 216 units (or 56 hours), approximately 90 days of services if rendered twice	Providers will be required to submit documentation as to the medical necessity for continued services. This shall include the following: • Assessment • Plan of Care • Service notes from the last 30 days of Peer Support Services • Any additional documentation that may support need for continued

		per week, without prior authorization.	services (i.e., recent hospital discharge information, information related to a recent relapse, noted significant life stressors which may place the individual at risk for hospitalization or relapse, etc.).
Licensed Independent Practitioner's (LIP) Rehabilitative Services	Outpatient	Medicaid fee-for-service beneficiaries must receive prior authorization from a Quality Improvement Organization (QIO) that establishes the number of authorized visits.	If the number of visits authorized is deemed inadequate to address the identified goals, reauthorization of services will be required.

Figure 3: Sample of identified benefit limitations and associated guidance indicating they are to be treated as "soft limits."

NON-QUANTITATIVE TREATMENT LIMITATIONS

Non-quantitative treatment limitations (NQTLs) are limits on the scope or duration of benefits that are generally not expressed numerically. The final Medicaid/CHIP parity regulations include an illustrative list of NQTLs sufficient to provide an understanding of the nature of an NQTL, but the list is not exhaustive. The list includes the following:

- Medical management standards limiting or excluding benefits on the basis medical necessity or medical appropriateness, or on the basis of whether the treatment is experimental
- Formulary design for prescription drugs
- Standards for provider admission to participate in a network, including reimbursement rates
- Refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective
- Conditioning benefits on completion of a course of treatment
- Restrictions based on geographic location, facility type, or provider specialty
- Standards for providing access to out-of-network providers

Parity regulations prohibit states and MCOs from imposing an NQTL on MH/SUD benefits in any classification unless, under the policies and procedures of the state or MCO, as written and in operation, any processes, strategies, and evidentiary standards used in applying the NQTL to MH/SUD benefits are comparable to, and applied no more stringently than, the processes, strategies, and evidentiary standards used in applying the NQTL to M/S benefits.

In determining whether the NQTL complies with parity requirements, the study applied a three-part approach:

1. Reviewed documentation for all benefits, including reviewing the state plan, Medicaid provider manuals, and member and provider handbooks to identify NQTLs applicable to MH/SUD benefits in each classification of a benefit package.

2. To the extent NQTLs were identified, the study evaluated the *comparability* of the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to MH/SUD benefits and M/S benefits using a template that was completed by the applicable departmental subject matter expert.

3. Using the same template, the study evaluated the *stringency* with which the processes, strategies, evidentiary standards, and other factors were applied to MH/SUD benefits and M/S benefits.

The template included a range of questions informed by sample tools outlined in the CMS Webinar "Application of Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs."[3]

In reviewing documentation and holding internal discussions the study identified several NQTLs that have been grouped into four categories with the definitions noted in Figure 4 below:

NQTL Type	Definition
Concurrent review	Policies encouraging the state/plan to review the treatment provided while the member is in the hospital or receiving outpatient services to ensure they are receiving the right care based on their specific health care needs. This can mean that the state/plan reviews the type of care, the need for that care, and the place of care.
Prior authorization	Policies requiring providers to obtain approval of a health care service or medication before the care is provided.

[3] See "Webinar #3: Application of Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs." 9 March 2017. https://www.medicaid.gov/medicaid/benefits/downloads/parity-webinar-030917.pdf

Medical necessity	Policies requiring plans or providers to take steps to establish that a service meets accepted medical standards; is needed to diagnose or treat an illness, injury, condition or disease; is clinically appropriate; is not primarily for the convenience of the patient or provider; and is not more costly than an alternative service.
Probability of Improvement / Written Treatment Plan	Policies indicating that for coverage of certain benefits the plan/provider requires documentation indicating the likelihood that the treatment will result in improvement or achievement of certain goals. This subsection also covers policies that require a written treatment plan or plan of care before the services can be provided or within a particular time after services have been provided.

Figure 4: NQTL Definitions

The subsections that follow examine the findings for each of the identified NQTL categories to evaluate whether the information provided indicated that the plan was applying NQTLs in a manner that complied with parity requirements.

Concurrent Review

The study identified requirements for concurrent review for inpatient MH/SUD and M/S services. The rationale for applying concurrent review is rooted in existing state and federal requirements, including those that mandate SCDHHS and MCOs to operate a utilization management (UM) program that ensures beneficiaries have appropriate access to specialty mental health services.[4] The UM program must evaluate medical necessity, appropriateness, efficacy, and efficiency of services prospectively, such as through prior or concurrent authorization review. Additionally, MCOs must establish associated policies and procedures, including "[m]echanisms to ensure consistent application of review criteria" and "[d]ata collection processes and analytical methods used in assessing utilization of physical and Behavioral Health Services."[5]

Based on the review of policies and practice, the rationale for applying concurrent review requirements was comparable across MH/SUD and M/S services. Both leveraged consistent review types, with some differences in the team responsible for conducting the reviews that account for admission status; and review criteria, including the utilization of independent standards of practice (i.e., InterQual and ASAM criteria). The study did identify the need to conduct comparative analysis to ensure that concurrent review was being applied comparably and with equivalent stringency. SCDHHS will work with its internal business intelligence team, as well as its QIO partner, to identify methods to gather

[4] 42 C.F.R. § 438.210 (a)(4), (b)(1),(2)
[5] See MCO Contract, Section 8.2, page 110.

and analyze data on how concurrent review specifically, and NQTLs generally, are applied in practice. This includes working with key internal staff across functional areas to establish procedural comparability, as well as a review of utilization data, outcomes analysis (e.g., patient access, appeals, etc.)

Based on review of the comparability and stringency of processes, strategies and evidentiary standards, the study finds this NQTL to be compliant with Parity requirements. SCDHHS recognizes the need to develop additional processes to ensure the degree of consistently and objectivity with which stakeholders apply the criteria in decision-making.

Prior Authorization

The study identified requirements for Prior Authorization (PA) of services in both the inpatient and outpatient classification across several MH/SUD and M/S services. As discussed above with respect to Concurrent Review, PA policies and procedures are a key part of federally required UM program designed to evaluate medical necessity. The study identified other potential factors that triggered the application of PA, including identified occurrences of misuse or excessive utilization. Multiple methods are used to identify potential utilization anomalies. These include:

- **Utilization analytics** to monitor potential patterns of underutilization and overutilization, e.g., an unusually high volume of a specific procedure being requested by certain providers or for specific populations.
- **Program integrity analyses** to identify anomalies or other indicative patterns with a high probability of fraud, waste, or abuse.
- **Review of member complaint data** to identify potential systemic inefficiencies or overly restrictive application of prior authorization that hinders access to care.

The study did note that several behavioral health services were identified as a high risk of overutilization, including Medicaid Targeted Case Management (MTCM), Licensed Independent Practitioners (LIP) Rehabilitative Services, and Rehabilitative Behavioral Health Services (RBHS). SCDHHS initially operated these services in a low control environment that was designed to maximize beneficiary access to providers. However, this led to significant jumps in the number of private behavioral health providers, increases in services provided, and associated spikes in claims payments. SCDHHS then took needed steps, including the application of prior authorization requirements and implementing a moratorium on additional TCM and RBHS providers to mitigate fraud, waste, and abuse risk and ensure the quality of the provider pool. Though well intentioned, the use of these tools requires a close examination to promote compliance with parity regulations.

Recently, SCDHHS has worked in partnership with CMS to roll back some of these intensive utilization management efforts, including sunsetting the moratorium that prohibited new providers from enrolling as the private RBHS provider type or MTCM providers; updating enrollment requirements for LIP and

RBHS providers; and revising revalidation requirements for LIP, MTCM, and RBHS providers.[6] Notably, PA criteria remain in place for these services. Although the associated provider manuals were updated to streamline some PA requirements, including reducing the amount of attendant documentation, the requirements for continued service prior authorization remain highly detailed. The process includes the most recent 90-day progress summary, a current individualized plan of care, the Quality Improvement Organization PA request form, and the Parent/Caregiver/Guardian Agreement to Participate in CSS form. Comparable M/S services did not require similarly stringent documentation requirements, thereby representing a potential compliance risk.

Based on review of the comparability and stringency of processes, strategies and evidentiary standards, the study found that this NQTL is compliant with Parity requirements. SCDHHS will take steps to work with MCOs to ensure appropriate application of the PA criteria described in the relevant provider manuals.

Medical Necessity Reviews

All Medicaid benefits, irrespective of delivery system, are universally subject to medical necessity requirements pursuant to state and federal regulation.[7] The use of medical necessity determinations can lead to non-compliance with parity requirements if the state/MCOs medical management program, as written and in operation, is not comparable with or applied more stringently to MH/SUD benefits than for M/S benefits in the same classification. The study reviewed policies, contractual documents, and internal procedures to determine whether the medical necessity was being uniformly applied across all services.

Pursuant to the MCO Contract, a service is "medically necessary" when the following conditions apply:

1. It is essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid Managed Care Member; and
2. Is provided at an appropriate facility and at the appropriate level of care for the treatment of the Medicaid Managed Care Member's medical condition; and
3. Is provided in accordance with generally accepted standards of medical practice.

Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition.

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[6] Medicaid Bulletin #23-058. New LIP and RBHS Provider Enrollment Requirements; New LIP, MTCM and RBHS Revalidation Requirements. November 27, 20023. https://www.scdhhs.gov/communications/new-lip-and-rbhs-provider-enrollment-requirements-new-lip-mtcm-and-rbhs-revalidation#:~:text=Sunsetting%20the%20RBHS%20Provider%20Type,1%2C%202024.

[7] S.C. Code Regs. § 126-425 - Beneficiary Utilization

The study found that the processes, strategies and evidentiary standards used in applying the definition of medically necessity to MH/SUD benefits were comparable to the evidentiary standards used in administering the M/S benefits in the same classifications. In the operationalization of medical necessity guidelines, the QIO leverages recognized independent standards of practices, such as InterQual and American Society of Addiction Medicine (ASAM), consistently across services. The study notes that in some cases, when reviewing medical necessity without specific clinical criteria the QIO may rely on "QIO criteria." In these cases, the QIO will primarily rely on a comprehensive assessment of the patient's medical record, utilizing their clinical expertise to determine if the provided care was "reasonable and necessary" based on accepted standards of practice, considering the patient's diagnosis, condition, and treatment plan. This process does require clinical judgment, which must be carefully overseen to ensure continued fidelity to QIO processes as well as equitable results for members.

SCDHHS actively monitors member complaints and other data trends (e.g., service denial, grievance, and appeal rates) to identify anomalies or trends that could be indicative of an incorrect application of SCDHHS policy. However, SCDHHS recognizes the need for additional efforts to ensure the in-practice comparability of medical necessity reviews across MH/SUD and M/S services, including working with the QIO to ensure comparable application of procedures (e.g., steps, timeliness, and requirements) and tools to support equitable application of the procedures (e.g., inter-rater reliability assessments, quality control reports, etc.).

Based on review of the comparability and stringency of processes, strategies and evidentiary standards, the study found this NQTL to be compliant with MH Parity requirements. SCDHHS will take steps to work with the QIO to review internal processes and enhance data reporting to ensure comparable application of the medical necessity definition and associated processes.

Probability of Improvement/Written Treatment Plan

The study identified services in both the inpatient and outpatient classification across several MH/SUD and M/S services that required the member to be expected to benefit from the intervention and/or the development of an individualized, comprehensive treatment plan before providing the service. In many cases, these requirements are rooted in regulatory requirements. For example, inpatient psychiatric services for individuals under age 21 requires a certification of need and individualized plan of care.[8] However, federal MHPAEA regulations do list "exclusions based on failure to complete a course of treatment" as part of an illustrative, non-exhaustive list of NQTLs.[9] Subsequent CMS publications, including guidance for "warning signs" of NQTLs that require

[8] 42 C.F.R. § 441.152-155.
[9] 26 CFR 54.9812-1(c)(4)(ii); 29 CFR 2590.712(c)(4)(ii); 45 CFR 146.136(c)(4)(ii); and 147.160.

additional analysis to determine parity compliance include discussions of differential application of the likelihood for improvement and requirements for written treatment plans.[10]

In its review of policies and their application the study noted general equivalence in the comparability and stringency of the processes, strategies, and evidentiary standards used in the application of the NQTL. The requirements, which are most prevalent in outpatient rehabilitative therapies—both for MH/SUD and M/S services—align with standards of care by ensuring that services are medically necessary and tailored to the unique needs of each individual, thereby promoting effective and goal-oriented treatment. However, the study did note some potential differences in factors that triggered the application of the NQTL that could represent a compliance risk. These include a focus on excessive utilization and identified occurrences of misuse for certain services (e.g., RBHS), that were applied to MH/SUD, but not M/S services.

SCDHHS is undertaking several initiatives that will assist in improved monitoring of NQTLs, including the consistent application of probability of improvement and/or written treatment plan provisions. One strategy is to leverage the existing internal Quality Improvement Committee, which brings together key agency staff from different functional areas of the agency to take a systematic, comprehensive, and data-driven approach to improve the quality of services and outcomes. Including parity as a focus of this committee will work to address one of the key systemic challenges identified in the review of NQTLs; namely, the lack of cross-cutting organizational structures that allow the Department to gain an enterprise view of parity compliance between the two service categories (MH/SUD and M/S).

Additionally, the study found that SCDHHS is working closely with the QIO in new ways, including holding quarterly Local Quality Improvement Committee meetings with the Acentra Health Quality Team. The committee is responsible for establishing and maintaining an operation excellence program that includes quality, training, compliance, and oversight of the program.

Based on review of the comparability and stringency of processes, strategies and evidentiary standards, the study finds that this NQTL is compliant with parity requirements. SCDHHS will take steps internally to ensure that the processes and strategies that trigger the application of the NQTL are being consistently applied across outpatient MH/SUD and M/S services.

MANAGED CARE SUMMARY AND FINDINGS

Approach

SCDHHHS engages in a multi-faceted approach to ensuring parity compliance among its MCOs. Elements of the approach are described in Figure 5 below.

[10] Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/mhapeachecklistwarningsigns.pdf

Approach	Description
Contract Compliance	The MCO Contract and associated Policy and Procedure Manual include requirements to comply with parity requirements.
Readiness Review	SCDHHS reviews MCO policies and procedures to ensure compliance with parity requirements.
Ongoing Monitoring	SCDHHS reviews the provision of medically necessary services to ensure compliance with specified manuals and regulations (including the MHPEA).
External Quality Review	EQR conducts an annual mental health parity assessment of each MCO, including reviewing QTLs, NQTLs, and identifying the relative strengths and weakness of the plans.
Financial Requirement Review	SCDHHS' rate setting actuary has traditionally included a workbook to collect information necessary to complete the substantially-all and predominance tests for financial requirement as part of its Annual Rate Survey.

Figure 5: Approach to parity compliance oversight

In addition to the above, SCDHHS is also beginning to implement additional checks to promote adherence to the policies established in the provider manuals, including appropriate application of prior authorization and other potential NQTLs. The process involves creating a random sample of providers who are billing against the applicable provider manual, reviewing claims and associated documentation requirements, and following up with the member to validate receipt of the service at the reported/billed cadence. Although this process has the potential to identify parity compliance issues, the study found that the manuals prioritized for early stages of the review process were predominantly related to the BH/SUD services. This prioritization was not due to an increased expectation of fraud, waste, and abuse, but because of SCDHHS' effort to fundamentally redesign its array of covered behavioral health services, including implementation of new services. Nevertheless, it is recommended that SCDHHS will revisit its prioritization approach to ensure an appropriate balance that adheres to the letter and spirit of the MHPAEA.

In compiling this report, SCDHHS nor its vendor HMA sought to engage in redundant information gathering activities that had already been completed as part of another oversight workstream. Instead, the subsections that follow are intended to summarize each oversight approach and any relevant findings.

Contract Compliance

SCDHHS's SFY2024 MCO contract includes a provision requiring that MCOS "[r]emain in compliance with federal parity regulations." Though not explicit to parity requirements, the contract includes a number of provisions that are collectively designed to ensure that MCOs are intentional in the delivery

and oversight of all medically necessary behavioral health services. These include the assurance of timely access to and provision, coordination, and monitoring of behavioral health services, as well as the implementation of data collection processes and analytic methods to assess utilization of behavioral health services.

The associated Managed Care Policy and Procedure Guide released October 2024 also requires each MCO to "assist SCDHHS and SCDHHS' External Quality Review Organization [EQRO] in the identification of Provider and Beneficiary data required to carry out the annual review." This review includes the "review and collection of information that assists in the review of MCO compliance with all Mental Health Parity Requirements."

Readiness Review

SCDHHS uses a contract readiness review process to assess whether a potential contractor is fully prepared to fulfill the terms of the contract by meeting necessary administrative, staffing, policy, and service delivery standards required to serve Medicaid beneficiaries in the state. This includes building a robust provider network, inclusive of behavioral health and substance use disorder treatment providers and complying with parity requirements. Specifically, to demonstrate readiness plans must "Submit an analysis of the Applicant's compliance with the Mental Health Parity and Addiction Equity Act of 2008 as it applies to this Contract. The Applicant further affirms that it shall provide to the Department upon request, evidence of such compliance with the requirements of 42 CFR 438.3(n)(2), 42 CFR 438.3(e)(1)(ii), and 42 CFR 438 Subpart K, and any steps taken to comply with the Mental Health Parity and Addictions Equity Act including EQRO evaluation."

The readiness review process is conducted by SCDHHS' EQRO after SCDHHS has obtained, reviewed, and approved all required submissions and activities for operational readiness. The EQRO will review operations and note any deficiencies. If any are identified the MCO is required to submit a Plan of Correction to SCDHHS.

Additionally, SCDHHS has closely followed CMS' development of templates and associated instructional guides for documenting compliance with Mental Health Parity and Addiction Equity Act requirements. They are currently working to establish processes for completing the State FFS Benefit Template, as well as requiring our MCOs to submit the Managed Care Plan Template once they are finalized by CMS. These processes will ensure that SCDHHS is minimizing the submission of duplicate information and collecting information in a standardized format that promotes an effective review and analysis of information and compliance with parity requirements.

Ongoing Monitoring

To ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and other relevant regulations, SCDHHS conducts a thorough review of the provision of medically necessary Behavioral Health Services. This review involves evaluating the state's Medicaid documentation rules, policies, and procedures to confirm that services are provided in accordance with established criteria. The process includes regular audits and assessments of service delivery, documentation, and billing practices to ensure they meet federal and state standards. Any discrepancies or non-compliance

issues identified during the review are addressed through corrective action plans, which may involve additional training for providers, policy revisions, or enhanced oversight mechanisms.

SCDHHS is also developing additional monitoring processes that are designed to promote greater insight into various aspects of parity requirements. This includes using CMS' new set of templates and instructional guides to document how mental health and substance use disorder benefits provided through Healthy Connections comply with Medicaid Mental Healthy Parity and Addiction Equity Act requirements. Additionally, SCDHHS has contracted with a third-party vendor to conduct secret shopper reviews of all Healthy Connections MCOs beginning in calendar year 2025. These reviews will examine the accuracy of MCO provider directories and analyze whether patients can readily schedule appointments within the specified timeframes with in-network providers. The wait time standards established in the final rule include service categories such as mental health and substance use disorder, which will provide SCDHHS with additional insights into gaps in provider accessibility that may signal parity-related challenges.

External Quality Review

SCDHHS leverages the EQRO to conduct mental health parity assessments for each contracted MCO. This assessment is conducted via a two-step process. Step one involves assessing the QTLs, which are limits on the scope or duration of, and step two assesses NQTLs, including medical management standards, provider network admission standards and reimbursement rates, policies, and other limits on the scope or duration of benefits. The EQRO works with plans to collect information, including Program Descriptions, various utilization and network access reports, Member and Provider Handbooks, and benefit maps. In addition, the EQRO provides MCOs with templates that allow the plan to enter information based on copays, session limits, day limits, and other QTL information to determine compliance with the parity regulations. EQR findings are summarized in the subsections that follow.

QTL Assessment

The EQR assessment found that although some MCOs did apply copays within certain benefit classifications they were generally applied consistently across medical/surgical and behavioral health services. As a result, the EQR found that each plan complied with parity regulations. SCDHHS notes that as of July 1, 2024, all services are now covered without cost-sharing.

NQTL Assessment

In general, the EQR assessment found that each of the plans reviewed has the tools, plans, and interventions to support the goal of Parity, and that their mental health services comply with Parity requirements of comparability and stringency. Notably, the reports did highlight a few areas that SCDHHS should monitor closely to ensure that NQTLs applied to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification. These include:

- **Quality of Care Concerns**: One plan had a significantly higher rate of quality of care-related complaints for MH/SUD than for M/S, which the plan noted was due to issues related to care coordination. Although the plan implemented interventions to address the discrepancy,

SCDHHS should provide active oversight over member complaints, including the identification of trends by complaint category and service type.

- **Appeals and Denials**: One plan had a significantly higher rate of inpatient MH/SUD per service request than for M/S. SCDHHS should closely monitor denial rates and appeals rates to identify potentially problematic trends. Additionally, SCDHHS should review appeal data to identify root causes. For instance, appeals could demonstrate administrative necessity (i.e., procedural errors, incorrect application of regulations, or other issues related to the administrative process) as opposed to medical necessity. Administrative necessity would indicate a discrepancy in comparability while medical necessity would indicate a discrepancy in stringency.
- **Provider Network**: Though provider networks were generally robust, newer health plans were still building networks and thus were working to ameliorate gaps in their MH/SUD network. SCDHHS should continue to monitor all MCO's network submissions for adequacy and take appropriate action, as outlined in the MCO Policy and Procedure Manual, for discrepancies. This includes instituting a Corrective Action Plan, assessing liquidated damages, or amending Service Areas.

In its review HMA noted that it was difficult to identify any potential parity risks or opportunities across the MCOs because of the EQR report format. Although several of the NQTL assessment categories were the same (e.g., Utilization Management Review Criteria, Appeals and Denials, etc.) the data that was presented in the categories differed substantially. For instance, when reviewing potential challenges in the Provider network, some reviews included ECHO survey results on member's self-reported ability to find a good behavioral health provider, while others did not. Additionally, HMA noted that stringency cannot necessarily be determined by looking at denial, appeal, and appeal overturn rates generally. Instead, stringency assessments should be conducted for each identified NQTL to determine whether the same processes, strategies, evidentiary standards, or other factors were applied, to MH/SUD and M/S benefits.

Where possible, HMA recommended finding opportunities to standardize the data requested and/or the metrics used to indicate potential discrepancies in comparability and stringency. This will allow for a clearer identification of trends that exist across MCOs that may indicate the need for a policy or programmatic action.

Financial Requirement Review

Prior to the recent policy decision to eliminate copays, SCDHHS collected information to determine compliance with the "Two-Part Test" for FRs and QTLs as part of the Annual Rate Survey that is conducted by Milliman. This survey is sent to each MCO to develop capitation rates for the coming fiscal year. SCDHHS engages in a cost analysis that consists of looking at each type of FR and QTL on MH/SUD benefits in each classification and applying a data-driven mathematical formula (the two-part test) to determine whether the type of FR or QTL applies to substantially all the M/S benefits in the same classification. If it does, then the level of the FR or QTL is evaluated to determine whether it is equivalent to or less restrictive than the predominant level of that type of FR or QTL for M/S benefits in that classification. If FRs or QTLs apply to MH/SUD benefits in a classification and a cost analysis is needed, an analysis is performed for each FR or QTL based on the projected costs for all M/S benefits in the classification for the benefit package.

The study found significant variation across the MCOs in their application of copays as seen in Figure 6 below. Although the copayment amounts aligned with the published Copayment Schedule, the selective application of copayments to some behavioral health services likely did not align with parity requirements. Additionally, although most MCOs passed the Two-Part Test in the application of FRs, one MCO's applied copays to less than one-half of the payments for M/S in the inpatient benefit classification, and thus failed the Predominant (i.e., one-half) Test.

SCDHHS now prohibits MCOs for charging copays and has determined that Medicaid MCOs meet parity regulations regarding financial requirements. The EQR now monitors compliance annually via templates that allow each MCO to enter information based on copays, session limits, day limits, etc. to determine ongoing compliance.

	Absolute Total Care	Molina	Healthy Blue	Humana	Select
Inpatient hospital	$25.00	N/A	N/A	N/A	$25.00
Outpatient hospital	$3.40	N/A	N/A	N/A	$3.40
Retail pharmacy	$3.40	N/A	N/A	N/A	$3.40
Physician Office Visit	N/A	N/A	N/A	N/A	$3.30
FQHC	N/A	N/A	$3.30	N/A	$3.30
RHC	N/A	N/A	N/A	N/A	$3.30
BH MD assessment	N/A	N/A	$3.30	N/A	N/A
Prescription Drugs	N/A	N/A	$3.40	$3.40	N/A

Figure 6: Itemized copayments for Mental Health/Substance Use Disorder services by MCO

SUMMARY OF FINDINGS

This report demonstrates SCDHHS's commitment to achieving and maintaining compliance with the MHPAEA and ensuring equitable access to care for Medicaid enrollees. While the findings indicate substantial compliance with parity requirements, areas for improvement have been identified,

particularly in the application of non-quantitative treatment limitations and the alignment of managed care practices. SCDHHS will implement targeted enhancements, including improved oversight, standardized processes, and strengthened collaboration with stakeholders, to address these gaps. These efforts will ensure that South Carolina's Medicaid program continues to deliver high-quality, parity-compliant services to all beneficiaries.

Key next steps and recommendations arising from the findings in this report include:

- **Enhanced Oversight**: Strengthen monitoring of MCO practices through data-driven reviews and expanded quality improvement initiatives.
- **Align Documentation Requirements**: Ensure that prior authorization and other NQTL processes for MH/SUD services are applied with the same level of rigor as M/S services.
- **Standardize Data Collection**: Collaborate with the EQRO to harmonize data collection and reporting formats, enabling clearer identification of parity trends across MCOs, particularly for NQTLs.
- **Cross-Functional Coordination**: Continue to promote collaboration among different internal stakeholders, including engagement with the newly formed Quality Improvement Committee to systematically address parity compliance and promote consistency across service categories.

Financial Requirements

As of July 2024, The SCDHHS required all services to be covered without cost-sharing, and as a result, there are no longer any financial requirements on any MH/SUD service. In parallel, SCDHHS implemented a single, state-directed pharmacy benefit PDL for providers and eliminated all cost-sharing, including copays, for prescription drugs. As a result, the state has determined that the Healthy Connections program complies with parity requirements for these types of financial requirements.

Aggregate Lifetime and Annual Dollar Limits

Neither SCDHHS nor its MCOs apply aggregate lifetime or annual dollar limits on MH/SUD services. Given that MH/SUD benefits are not subject to aggregate lifetime or annual dollar limits, it was determined the program complies with parity requirements for these types of treatment limitations.

Quantitative Treatment Limitations

SCDHHS nor its plans impose quantitative benefit limits on MH/SUD services in the inpatient, outpatient, emergency, or prescription drug classification. Although certain benefit limitations are in place, state policy does not allow for these to be treated as “hard limits” on MH/SUD services. As a result, all MCOs should have a process in place to review and approve additional units of service when medically necessary, per state policy.

Non-Quantitative Treatment Limitations

The study tentatively found that its application of NQTLs complies with parity requirements; however, as noted in the narrative and summarized above, has identified recommendations and next steps to ensure compliance. These next steps include working with internal staff (e.g., business intelligence team) and external stakeholders (e.g., QIO) to enhance data-driven efforts to ensure NQTLs are being applied comparably and with equivalent stringency.

APPENDIX 1: BENEFIT MAPPING RESULTS

	Inpatient	Outpatient	Emergency Care	Pharmacy
M/S	Inpatient hospital	Outpatient hospital	Emergency transportation/ambulance	Brand medications
	Physical therapy	Rural health clinic services and other ambulatory services furnished by a rural health clinic	Emergency department services	Generic medications
	Occupational therapy	Federally qualified health center services furnished by an FQHC	Perinatal emergency room visit	Pharmacy supplies and supplements
	Inpatient rehabilitation	Ambulatory care		
	Intermediate care facility for individuals with intellectual disabilities	Radiology and nuclear medicine		
	Hospice	EPSDT services (ages 21 and under)		
	Emergency hospital services	Family planning		
	Physical therapy	Tobacco cessation		
	Hospital inpatient maternity	Physician services		
	Organ and tissue transplantation	Dermatology services		
	Anesthesia services	Oncology and hematology services		
	Hospital inpatient dialysis	Medical and surgical services furnished by a dentist		

	Inpatient	Outpatient	Emergency Care	Pharmacy
	Pediatric inpatient rehabilitation	Podiatrist services		
	Nursing facility resident care	Ophthalmology and optometry services		
	Skilled/intermediate nursing services	Anesthesia		
	Subacute care	Chiropractic services		
		Home health care		
		Physical therapy		
		Occupational therapy		
		Speech pathology		
		Audiology services		
		Private duty nursing		
		Clinic services		
		Preventive dental services		
		Orthotics and prosthetics		
		Diagnostic services		
		Screening services		
		Preventive services		
		Rehabilitation services		
		Nurse midwife		

	Inpatient	Outpatient	Emergency Care	Pharmacy
		Hospice		
		Case management services		
		Tuberculosis directly observed therapy		
		Pregnancy-related postpartum services		
		Services for conditions that may complicate pregnancy		
		Ambulatory prenatal care		
		Respiratory care services		
		Pediatric and nurse practitioner services		
		Non-emergency medical transportation		
		Personal care services		
		Targeted case management		
		Durable medical equipment		
		Renal dialysis clinic services		
		Ambulatory surgery center services		
		Professional dietician services		

	Inpatient	Outpatient	Emergency Care	Pharmacy
		Developmental evaluation services		
		Injectable and self-administered injectable drugs		
		Outpatient hospital dialysis		
		Outpatient pediatric AIDS clinic services		
		Diabetes management		
		Sickle cell disease management		
		Preventive and rehabilitative services for primary care enhancement		
		Home visiting		
		Medicaid Adolescent Pregnancy Prevention Services		
		School based services		
		PACE services		
		Primary care services		
		Office/outpatient exams		
		Evaluation and management		
		Cancer screening		

	Inpatient	Outpatient	Emergency Care	Pharmacy
		Telehealth		
		Pharmacist services		
		Pain management		
		Pathology and laboratory services		
		PACE services		
MH/SUD	Inpatient hospital	Targeted case management	Emergency transportation/ ambulance	Brand medications
	Inpatient psychiatric services	Medication assisted therapy	Emergency department services	Generic Medications
	Psychiatric residential treatment facility services	Behavioral health screening	Perinatal emergency room visit	Pharmacy supplies and supplements
	Clinically managed residential detoxification	Diagnostic assessment	Crisis intervention service	
	Medical monitored residential detoxification	Individual psychotherapy		
	Long-term residential treatment	Group psychotherapy		
	Short-term residential treatment	Family psychotherapy		
	Hospital-based crisis stabilization	Multiple Family Group Psychotherapy		
	Psychiatric physician inpatient	Crisis intervention service		
	Residential substance abuse treatment	Peer support therapy		

	Inpatient	Outpatient	Emergency Care	Pharmacy
		Applied behavioral analysis assessment services		
		Applied behavioral analysis treatment services		
		Adaptive behavior treatment		
		Group adaptive behavior treatment		
		Psychiatric diagnostic evaluation		
		Developmental evaluation center services		
		Psychological testing and evaluation		
		Alcohol and drug abuse rehabilitation services		
		Alcohol and drug assessment		
		Structured screening and brief intervention		
		Service plan development		
		Individual alcohol and drug/substance abuse counseling		
		Group Alcohol and Drug Substance Abuse Counseling		

	Inpatient	Outpatient	Emergency Care	Pharmacy
		Medication management		
		Medication administration		
		Psychosocial rehabilitation individual		
		Psychosocial rehabilitation group		
		Family support		
		Intensive outpatient		
		Day treatment/partial hospitalization		
		Opioid treatment program services		
		Mental health comprehensive assessment		
		Assertive community treatment		
		Assertive community treatment		
		Multisystemic therapy		
		Intensive in-home services		
		Community integration services		
		Behavioral modification		

	Inpatient	Outpatient	Emergency Care	Pharmacy
		Therapeutic childcare individual		
		Therapeutic childcare group		
		Therapeutic foster care		
		Injectable medication administration		
		Nursing		
		Medical evaluation and management		
		Nutrition counseling		
		Telehealth		
		Environmental intervention for medical management		
		Neuropharmagen-genomic testing		
		Skills training and development services for children		
		Evaluation and management of medical services		
		Psychiatric Collaborative Care Model services		