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CLIENT ALERT

Mental Health Parity Requirements and Medicaid Plans: CMS Seeks Comment on Proposed Rule

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May 2015

On April 10, 2015, the Centers for Medicare & Medicaid Services ("CMS") published in the *Federal Register* a proposed rule ("Proposed Rule")[1] implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("MHPAEA"),[2] addressing the application of certain mental health parity provisions to Medicaid managed care organizations ("MCOs"), Medicaid benchmark or benchmark-equivalent plans (known as "Alternative Benefit Plans" or "ABPs"), and the Children's Health Insurance Program ("CHIP"). Comments on the Proposed Rule are due to CMS by 5 p.m. on June 9, 2015. Managed care entities, behavioral health plans, providers, and other stakeholders should closely review the Proposed Rule to assess its potential impact on their operations.

The Proposed Rule follows on from CMS's 2013 final rule implementing MHPAEA as it applies to employment-related group health plans and health insurance coverage offered in connection with a group health plan ("2013 Final Rule").[3] However, the 2013 Final Rule did not apply to MCOs, ABPs, or CHIP and, while the Proposed Rule mirrors the 2013 Final Rule in a number of ways, there are key differences of which stakeholders should be aware because the compliance requirements may be different across segments of the market. We encourage all stakeholders to review the Proposed Rule carefully and to comment, especially in those places where CMS is specifically seeking comments.

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[1] Centers for Medicare & Medicaid Services, "Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans," 80 Fed. Reg. 19,418 (Apr. 10, 2015) *available at:* https://www.federalregister.gov/articles/2015/04/10/2015-08135/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of.

[2] The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), enacted on October 3, 2008 as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Pub. L. 110–343).

[3] 78 Fed. Reg. 68,240 (Nov. 13, 2013).

Legislative Background

Congress enacted the Mental Health Parity Act ("MHPA") in 1996 to require parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits offered by certain health plans.[4] In 1997, through the Balanced Budget Act, Congress amended the Social Security Act to apply certain aspects of MHPA, including the parity requirement in aggregate lifetime and annual dollar limits, to MCOs and CHIP benefits.[5] MHPAEA further amended the then existing mental health parity provisions and added new parity requirements, including those for substance use disorder benefits.

Congress has amended the mental health parity laws twice more since enactment of MHPAEA. In 2009, under the Children's Health Insurance Program Reauthorization Act,[6] CHIP state plans that provide both medical and surgical benefits and mental health or substance use disorder ("MH/SUD") benefits were required to comply with prohibitions on health factor-based discrimination in eligibility and enrollment. In 2010, under the Affordable Care Act ("ACA"),[7] Congress again amended the parity provisions and added other requirements affecting coverage of MH/SUD services and treatments. Specifically, the ACA included mental health benefits as one of the categories of services to be covered through ABPs and directed that such plans include medical/surgical benefits and MH/SUD benefits and ensure that the financial requirements and treatment limitations applicable to these benefits comply with the mental health parity provisions.

MHPAEA's statutory provisions were self-implementing and generally became effective for plan years beginning after October 3, 2009. In 2010, the Departments of Health and Humans Services, Labor, and the Treasury (collectively, "Departments") published an interim final rule[8] further implementing MHPAEA and applicable to plan years beginning on or after July 1, 2010. In 2013, the Departments published the 2013 Final Rule, which was applicable to employment-related group health plans and health insurance coverage offered in connection with a group health plan for plan years beginning on or after July 1, 2014.[9] The 2013 Final Rule, however, did not apply to MCOs, ABPs, or CHIP.

Overview of Proposed Rule

This Client Alert addresses the following aspects of the Proposed Rule:

[4] Mental Health Parity Act of 1996 (Pub. L. 104-204, enacted Sept. 26, 1996). These provisions are codified at section 2726 of the Public Health Service Act.
[5] The Balanced Budget Act of 1997 (Pub. L. 105-33, enacted on Aug. 5, 1997).
[6] Pub. L. 111-3, enacted on February 4, 2009.
[7] The Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted March 30, 2010).
[8] 75 Fed. Reg. 5,410 (Feb. 2, 2010).
[9] 78 Fed. Reg. 68,240 (Nov. 13, 2013).

A. Overview of Medicaid and CHIP Coverage of Mental Health and Substance Use Disorder Services

B. Definitions

C. General Parity Requirement for Financial Requirements and Treatment Limitations

D. Parity with Regard to Cumulative Financial Requirements and Cumulative Quantitative Treatment Limitations

E. Nonquantitative Treatment Limitations

F. Disclosure of Underlying Processes and Standards

G. Increased Cost Exemption

H. Enforcement, Managed Care Rate Setting, and Contract Review and Approval

I. Application of Other Requirements

In the discussion below, we highlight areas where the Proposed Rule differs from the 2013 Final Rule, applicable to employment-related coverage, as well as areas on which CMS has specifically requested input. The Proposed Rule would provide states with up to 18 months from the date of publication of the final rule to comply with the provisions therein.

A. Overview of Medicaid and CHIP Coverage of Mental Health and Substance Use Disorder Services

State Medicaid Programs have flexibility in defining how they cover and deliver MH/SUD services, which are largely optional benefits under the traditional Medicaid benefits package. Some states provide such services through MCOs or through entities offering more limited benefit packages, such as prepaid inpatient health plans ("PIHPs") or prepaid ambulatory health plans ("PAHPs"), or through a combination of mechanisms. CMS's proposals in the Proposed Rule seek to ensure that beneficiaries enrolled in MCOs have access to a set of benefits that meets parity requirements, regardless of the mechanism or multiple mechanisms through which MH/SUD services are provided. Similarly, CMS defines how ABPs and CHIP state plans are expected to provide both medical/surgical benefits and MH/SUD benefits in a manner that ensures that financial requirements and treatment limitations for such benefits comply with parity requirements to the same extent as such requirements apply to a group health plan.[10]

[10] Regardless of whether services are delivered in managed care or non-managed care arrangements, all Medicaid ABPs (including benchmark equivalent and benchmark plans approved by the Secretary of

If a state uses private health plans or MCOs to provide *any* of its state plan benefits under an MCO contract, then MHPAEA's parity protections apply to the MH/SUD services, regardless of whether the MCO provides medical/surgical or MH/SUD services. Where the MH/SUD services provided to MCO enrollees are delivered through multiple managed care (or non-managed care) delivery vehicles, CMS proposes to apply the parity provisions across the managed care delivery systems in the Medicaid program and CHIP to the entire package of services MCO enrollees receive, whether from the MCO, PIHP, PAHP, or through traditional fee-for-service ("FFS").

CMS expects states to work with their MCOs (or PIHPs and PAHPs) to determine the best method for achieving compliance with these proposed parity requirements for benefits provided to the MCO enrollees. In states where the MCO has responsibility for offering all medical/surgical and MH/SUD benefits, CMS proposes that the MCO be responsible for conducting the parity analysis and informing the state of additional changes that would be required to bring the MCO contract into compliance with parity requirements. In states where some or all MH/SUD benefits are provided through MCOs, PIHPs, PAHPs, or FFS, the state itself would maintain responsibility for completing the parity analysis across these delivery systems and determining if the existing benefits and any financial or treatment limitations are consistent with these regulatory requirements. Based on its analysis, the state would have to make any changes needed to ensure compliance with parity requirements for its Medicaid MCO enrollees and make the analysis public within 18 months of the effective date of the final rule.

CMS proposes revisions to the regulatory provisions addressing state development of actuarially sound rates for MCOs, PIHPs, and PAHPs that provide MH/SUD services to take into account costs for services beyond those in the state plan that would be required to ensure that the MCO, PIHP, or PAHP comply with the parity requirements. However, CMS requests comments on whether this approach runs the risk that states may read this proposed change in a broader manner than intended in order to support inclusion of non-state plan services in rate setting for the MCO, PIHP, or PAHP benefit package that are not strictly required to comply with the proposed parity requirements, and, if this is in fact a risk, CMS asks how this risk might be mitigated.

CMS considered requiring that all MH/SUD state plan services be provided under MCO contracts to ensure that MCO enrollees receive the full protections afforded by MHPAEA but undertook the approach included in the Proposed Rule[11] to maximize state flexibility. However, CMS is requesting comment on whether this would be a better approach to ensuring parity protections for MCO enrollees.

Health and Human Services) and CHIP state plans are required to meet the financial requirements and treatment limitations component of the mental health parity provisions.

[11] For states that offer MH/SUD services to MCO enrollees through FFS, a state would have the option of either (1) making changes to the non-ABP state plan to provide MH/SUD services through the FFS system in a manner that is on parity with the MCO-provided medical/surgical services consistent with the Proposed Rule, or (2) including relevant MH/SUD services in the MCO contract (or PIHP or PAHP contract, as applicable), in which case the managed care entity would have to comply with the Proposed Rule.

B. Definitions

The Proposed Rule includes most of the terms included in the 2013 Final Rule, with certain modifications or additions to reflect terminology specific to Medicaid. Among the terms that have been modified or added are the following:

- **"Medical/surgical benefits."** This term refers to

  > benefits for items or services for medical conditions or surgical procedures, as defined by the state and in accordance with applicable federal and state law, but do not include mental health or substance use disorder benefits. Any condition defined by the state as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or state guidelines). Medical/surgical benefits do not include long-term care services.

- **"Mental health benefits."** This term refers to

  > benefits for items or services for mental health conditions, as defined by the state under the terms of the ABP and in accordance with applicable federal and state law. Any condition defined by the state as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or state guidelines. Mental health benefits do not include long-term care services.

- **"Substance use disorder benefits."** This term refers to

  > benefits for items or services for substance use disorders, as defined by the state under the terms of the ABP and in accordance with applicable federal and state law. Any disorder defined by the state as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines). Substance use disorder benefits do not include long-term care services.

These definitions differ from the ones used in the 2013 Final Rule as, under Medicaid, the state defines the covered benefits to be provided by the MCOs, PIHPs, PAHPs,

ABPs, or CHIP. CMS is requesting comment on its proposal to exclude long-term care services from the definition of "medical/surgical services."

C. General Parity Requirement for Financial Requirements and Treatment Limitations

CMS proposes that MHPAEA's Medicaid parity requirements, like those applied to employment-related coverage, would prohibit an MCO, PIHP, or PAHP (when providing services to an MCO enrollee), ABP (when used in a non-managed care arrangement),[12] or CHIP state plan from imposing a financial requirement or treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant[13] financial requirement or quantitative treatment limitation that applies to substantially all[14] medical/surgical benefits in the same classification. Using these standards, the state or MCO would determine what level of a financial requirement or quantitative treatment limitation, if any, is the most restrictive level that could be imposed on MH/SUD benefits within a classification.

CMS proposes that the portion of medical/surgical benefits in a classification subject to a financial requirement or quantitative treatment limitation be based on the dollar amount of all payments for medical/surgical benefits in the classification expected to be paid during a specific contract or state plan year (depending upon the mechanism through which such services are delivered). When MCOs, PIHPs, and PAHPs are responsible for the MH/SUD benefit, they would need to work together with the state to collectively determine the total amount projected to be expended (including FFS) in order to calculate the two-thirds threshold. CMS is requesting comment on this proposed approach to determining the threshold when multiple managed care delivery systems are involved.

1. Classification of Benefits

The Proposed Rule provides that parity requirements must be applied on a classification-by-classification basis, proposing **four** benefit classifications, in contrast to the six applicable under the 2013 Final Rule: (1) Inpatient, (2) Outpatient, (3) Emergency care, and (4) Prescription drugs. CMS states that the level of distinction

[12] ABPs offered by MCOs, PIHPs, or PAHPs already are required to comply with parity provisions related to financial requirements and treatment limitations. For ABP benefits offered only through FFS delivery systems, financial requirements and treatment limitations are the only parity provisions that apply. Aggregate lifetime or annual dollar limits on benefits are excluded from the term "financial requirement." Thus, these are not included in the "financial requirements and treatment limitations" parity requirements applicable to Medicaid ABPs furnished through FFS delivery systems. In addition, parity provisions related to access to out-of-network providers are not applicable to Medicaid ABPs furnished through FFS delivery systems because they are not "financial or treatment limitations."

[13] For these purposes, "predominant" means that *more than one-half* of medical/surgical benefits in the classification are subject to the financial requirement or quantitative treatment limitation.

[14] For these purposes, "substantially all" means at least *two-thirds* of the medical/surgical benefits in a classification as measured by the total dollar amount of payments for medical/surgical benefits in the classification expected to be paid within a measurement year (i.e., the MCO, PIHP, or PAHP contract year or for the year starting on the effective date of the approved ABP or CHIP state plan).

used in the 2013 Final Rule was not necessary as there is no need in the Medicaid context to distinguish between in-network and out-of-network services—all services are effectively in-network. The four proposed classifications would be the only ones used to apply parity requirements to Medicaid and CHIP. All Medicaid benefits should fall into one of these four categories, with the exception of long-term care services.

Consistent with the 2013 Final Rule, CMS proposes to allow the MCO, PIHP, PAHP, ABP, or CHIP state plan to divide prescription drug classifications into tiers without violating the parity requirements. Such tiers must be based on reasonable factors and established without regard to whether the drug is generally prescribed for medical/surgical or MH/SUD benefits. The Proposed Rule would further allow the responsible entities to use a sub-classification for office visits, apart from other outpatient items and services. Proposed parity requirements would prohibit the MCO, PIHP, PAHP, ABP, or CHIP state plan from imposing any financial requirement or quantitative treatment limitation on MH/SUD benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification. Unlike the 2013 Final Rule, the Proposed Rule would not allow sub-classifications based on network tiering.

2. Measuring Plan Benefits

As mentioned above, the proposed regulatory standard would prohibit an MCO, PIHP, or PAHP (when providing services to an MCO enrollee), ABP (when used in a non-managed care arrangement), or CHIP state plan (or managed care entity contracting with a CHIP state plan) from imposing a financial requirement or treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification.

The first step in the MH/SUD parity compliance analysis for assessing a financial requirement or quantitative treatment limitation would be to determine whether the financial requirement or quantitative treatment limitation applies to "substantially all"—i.e., at least two-thirds—of the medical/surgical benefits in that classification, based on the dollar amount of all payments for medical/surgical benefits in the classification expected to be paid during a particular year.[15] If the financial requirement or quantitative treatment limitation does apply to substantially all medical/surgical benefits in a classification, the next step would be to determine the predominant level of that type of financial requirement or quantitative treatment limitation, with "predominant" meaning that more than one-half of medical/surgical benefits in the classification is subject to the financial requirement or quantitative treatment limitation. The Proposed Rule uses the term "type" to refer to financial requirements and treatment limitations of the same nature. Types of financial requirements include copayments, coinsurance, and out-of-

[15] For purposes of this calculation, the MCOs, PIHPs, and PAHPs (when such organizations are responsible for MH/SUD benefits) would collectively (with the assistance of the state) determine the total amount projected to be expended (including FFS) to determine the two-thirds threshold.

pocket maximums. Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits. The term "level" is used to refer to the magnitude of a type of financial requirement or treatment limitation.

Consistent with parity requirements, the predominant type and level of financial requirement or treatment limitation applicable to a classification of medical/surgical benefits may be applied to MH/SUD benefits in that same classification.

D. Parity with Regard to Cumulative Financial Requirements and Cumulative Quantitative Treatment Limitations

Similar to the provisions in the 2013 Final Rule, CMS proposes in the Proposed Rule that the affected entities not be permitted to apply separate cumulative financial requirements[16] (separate for mental health, substance use, or medical/surgical). In contrast to the 2013 Final Rule, however, CMS proposes to permit quantitative treatment limitations to accumulate separately[17] for medical/surgical and MH/SUD services as long as they comply with the general parity requirement. This divergence is based, in part, on the operational challenges that joint accumulation would pose for states using multiple benefit delivery mechanisms.

E. Nonquantitative Treatment Limitations

Nonquantitative treatment limitations ("NQTLs") are limitations that are not expressed numerically and cannot be translated into quantitative limitations (such as prior authorization or geographic limitations), including medical management standards, prescription drug formulary design, standards for provider admission to participate in a network, and conditioning benefits on completion of a course of treatment. The Parity Rule would follow the approach taken in the 2013 Final Rule and prohibit the imposition of any NQTL to MH/SUD benefits in any classification unless, under the written and employed policies and procedures of the MCS, PIHP, or PAHP any factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and applied no more stringently than, the factors used in applying the limitation for medical surgical/benefits in the classification. The term "factors" refers to the processes, strategies, evidentiary standards, or other considerations used in determining limitations on coverage of services. The phrase "applied no more stringently" requires that any processes, strategies, evidentiary standards, or other factors that are comparable on their face be applied in the same manner to medical/surgical benefits and MH/SUD benefits.

CMS proposes to add providing access to out-of-network providers to the illustrative list of NQTLs. Accordingly, MCOs, PIHPs, PAHPs, and ABPs provided through managed care that provide access to out-of-network providers for MH/SUD benefits in any classification would have to use the same processes, strategies, evidentiary standards, or other factors as are used in providing access to out-of-network providers for

[16] Examples of cumulative financial requirements include deductibles and out-of-pocket maximums.
[17] Examples of cumulative quantitative treatment limitations include annual or lifetime day or visit limits.

medical/surgical benefits within the same classification. This requirement would not apply in the context of ABPs or CHIP state plans that use a FFS delivery system or other non-managed care arrangement because beneficiaries may choose from any qualified provider that has signed a Medicaid or CHIP provider agreement and are not limited to a network.

For states that are using a non-managed care delivery system for their ABPs or CHIP state plan, a state (through its ABP or CHIP state plan) may only impose an NQTL on a MH/SUD benefit in any classification if the state has written and operable processes, strategies, evidentiary standards, or other factors used in applying—to MH/SUD benefits in that classification— the NQTL that are comparable to or less restrictive and applied no more stringently than any processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical services in that classification.

Based on parity considerations, CMS proposes to delete an NQTL that is prescribed in current Medicaid regulations as a means of utilization management of inpatient services in mental hospitals. Current regulations require the state to evaluate each beneficiary needing inpatient admission into a mental hospital. There is no comparable requirement of inpatient hospital admissions for medical/surgical services. CMS notes in the Proposed Rule that states may continue to evaluate inpatient admissions to mental hospitals but would need to ensure that such efforts meet the parity requirements in the Proposed Rule.

F. Disclosure of Underlying Processes and Standards

Similar to the provisions in the 2013 Final Rule, CMS proposes to apply the "criteria for medical necessity determination" and "reason for denial" disclosure requirements imposed on health insurance issuers in a similar manner to MCOs, and to PIHPs or PAHPs that provide coverage to MCO enrollees.

MCOs, PIHPs, and PAHPs subject to MHPAEA's Medicaid parity requirements must make their medical necessity criteria for MH/SUD benefits available to any enrollee, potential enrollee, or contracting provider upon request. However, MCOs, PIHPs, and PAHPs found to be in compliance with existing regulations at 42 C.F.R. § 438.236(c)—which require dissemination of practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees—will be deemed to meet this proposed requirement. Further, MCOs, PIHPs, and PAHPs are required to make available the reason for any denial of reimbursement or payment for services for MH/SUD benefits to the enrollee. Existing regulations at 42 C.F.R. § 438.210(c) already require each contract with an MCO, PIHP, or PAHP to provide for the MCO, PIHP, or PAHP to notify the requesting provider and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

Although the statute that applies MHPAEA to ABPs does not include specific provisions regarding the availability of plan information (i.e., criteria for medical necessity

determinations and reasons for denial), CMS nevertheless proposes to extend this requirement to all ABPs, as well as to those ABPs with services delivered through MCOs, PIHPs, and PAHPs. Accordingly, states delivering ABP services through a non-MCO must make available to beneficiaries and contracting providers upon request the criteria for medical necessity determinations for MH/SUD benefits, as well as make available to beneficiaries the reason for any denial of reimbursement or payment for services for MH/SUD benefits.

CMS also clarifies in the Proposed Rule that the provisions under 29 C.F.R. § 2560.503-1 that discuss requirements related to notices for group health plans subject to the Employee Retirement Income Security Act ("ERISA") do not apply to Medicaid or CHIP.[18] CMS is not proposing to make these ERISA provisions applicable as a condition for deemed compliance for Medicaid or CHIP because similar requirements are already applicable to these programs.[19]

G. Increased Cost Exemption

The 2013 Final Rule contains an increased cost exemption for plans and health insurance issuers that make changes to comply with the law and incur an increased cost of (1) at least 2 percent in the first year that MHPAEA applies to the plan or coverage, or (2) at least 1 percent in any subsequent plan or policy year. Plans or issuer-offered coverage that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan or policy year, and the exemption lasts for one plan or policy year.

However, CMS is not including an increased cost exemption for MCOs, PIHPs, or PAHPs under the Proposed Rule. CMS does not believe that these Medicaid managed care entities will incur any net increase in costs because CMS also is proposing that the actuarially sound payment methodology will take costs of compliance with parity requirements into account. As discussed above, CMS is proposing to allow states to include the cost of providing services beyond what is specified in the state plan (which may include adding services or removing or aligning treatment limitations in managed care benefits) into the actuarially sound rate methodology so long as those services, beyond what is specified in the state plan, are necessary to comply with mental health parity requirements. These changes to the managed care rate setting process would authorize states, in instances where they choose not to change their state plan, to include the cost of services beyond what is specified in the state plan into the capitation

[18] 29 C.F.R. § 2560.503-1 establishes rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided by the plan or issuer, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to a claimant's claim for benefits.

[19] States, MCOs, PIHPs, and PAHPs are required to give a "reason" for any adverse benefit determinations under requirements for notices in 42 C.F.R. § 431.210 and § 438.404. Further, CHIP enrollees have an opportunity for an external review of denials, a reduction, or a suspension of health services under 42 C.F.R. § 457.1130.

rate development to the extent that the services are required to be provided by the MCO, PIHP, or PAHP and outlined under contract to comply with the Medicaid parity requirements. Therefore, the Medicaid program, rather than the managed care entity, will bear the costs of these changes.

Further, CMS is not proposing to permit states delivering services through an ABP or CHIP state plan to apply for a cost exemption due to the mandatory delivery of essential health benefits ("EHBs") and the requirement that ABPs be compliant with MHPAEA.

H. Enforcement, Managed Care Rate Setting, and Contract Review and Approval

As Medicaid and CHIP programs are jointly administered by the states and the federal government, with states responsible for administering the state plan in compliance with federal law, CMS proposes to require states to provide an assurance of compliance with parity requirements when submitting ABP or CHIP state plans. States would further be required to include terms requiring compliance with parity requirements in all applicable MCO, PIHP, and PAHP contracts. CMS expects, but does not require, that states will include in such contracts a methodology for the MCO, PIHP, or PAHP to demonstrate compliance with parity requirements, including assurances that all MCOs, PIHPs, or PAHPs in a state's Medicaid delivery system will collaborate to ensure that any MCO enrollee in the state is provided access to benefits consistent with parity requirements.

Where the MCO itself does not demonstrate that access to MH/SUD services complies with parity requirements (for example, because there may be services provided outside of the MCO contract that are needed to demonstrate compliance), the state must provide supplemental materials to the MCO contract or a contract amendment to demonstrate that the parity requirements are met. To the extent that a state fails to document that the MCO contract complies with parity requirements, CMS notes that it may defer federal financial participation on expenditures for the MCO contract.

I. Application of Other Requirements

1. Essential Health Benefits

States are not required to provide any specific MH/SUD benefits; however, in providing coverage through an ABP, the state must cover the EHBs, which are comprised of 10 statutory benefit categories, including MH/SUD services and behavioral health treatment. As states determine their ABP service package, they must use all of the EHB services from the base-benchmark plan selected by the states to define EHBs consistently with the applicable requirements in 45 C.F.R. Part 156. States have some flexibility to provide medical assistance by designing different benefit packages, including other services beyond the EHBs for different groups of eligible individuals, as long as each benefit package contains all of the EHBs and meets certain other requirements, including parity provisions.

2. *Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") Benefits*

The EPSDT benefit is a required benefit under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population and, if elected for that population, the EPSDT benefit must be made available to all Medicaid-eligible individuals under age 21. Under the EPSDT benefit, states must provide for screening, vision, hearing, and dental services at intervals that meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. States must also provide for medically necessary screening, vision, hearing, and dental services, regardless of whether such services coincide with established periodicity schedules for these services. Additionally, other necessary health care, diagnostic services, and treatment, as well as other measures to correct or ameliorate defects, physical and mental illnesses, and conditions identified by the screening services must be provided to EPSDT beneficiaries whether or not such services are otherwise covered under the Medicaid state plan.

A CHIP state plan is deemed to satisfy the parity requirements related to financial requirements and treatment limitations if the plan provides coverage of EPSDT benefits.[20] However, states that apply NQTLs to EPSDT services must ensure that these limitations are applied in a manner that is consistent with the parity provisions.

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This Client Alert was authored by **Lynn Shapiro Snyder**, **Helaine I. Fingold,** *and* **Lesley R. Yeung**. *If you would like to discuss submitting comments to the Proposed Rule or have additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

[20] Annual or lifetime limits are not permissible in EPSDT benefits and, therefore, would not impact a CHIP state plan's compliance with parity requirements.

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