Request for Comments on Templates for Documenting Compliance with Mental Health Parity and Addiction Equity Act Requirements in Medicaid and CHIP

Introduction

To improve implementation of parity in Medicaid and CHIP, CMS has developed a new set of templates and instructional guides for state agencies to document how mental health (MH) and substance use disorder (SUD) benefits provided through a state's Medicaid managed care program, Medicaid alternative benefit plans (ABPs), and/or Children's Health Insurance Program (CHIP) comply with Medicaid and CHIP Mental Health Parity and Addiction Equity Act requirements. These new tools are intended to standardize, streamline, and strengthen the process for states to demonstrate, and for CMS to determine compliance with, MH/SUD parity requirements in coverage and delivery of state Medicaid and CHIP benefits.

CMS is seeking preliminary comments on these templates and instructional guides through this informal request for comment and intends to take these comments into account before finalizing these tools. Furthermore, CMS plans to seek approval for the use of these tools from the Office of Information and Regulatory Affairs in accordance with the Paperwork Reduction Act (44 U.S.C. § 3501) before issuing these templates and instructional guides for use by managed care plans and states that will be mandatory for meeting requirements at 42 CFR §§438.3(n)(2), 438.920, 457.496, and 440.395.

Background

Most provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) [i] apply to coverage provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid ABPs and CHIP.[ii] Mental health and substance use disorder parity requirements do not apply to benefits for Medicaid beneficiaries who are not enrolled in an MCO and/or ABP, and who receive only non-ABP state plan services through a fee-for-service (FFS) delivery system, prepaid inpatient health plan (PIHP), and/or prepaid ambulatory health plan (PAHP). However, CMS encourages states to provide for parity between MH/SUD and medical or surgical (M/S) benefits for all Medicaid and CHIP beneficiaries.

CMS issued regulations in 2016 specifically focused on implementing the federal parity requirements that apply to Medicaid MCOs, CHIP, and Medicaid ABPs.[iii] These Medicaid and CHIP parity regulations were informed by the 2013 MHPAEA final regulations that apply to private health coverage. Similar to those private coverage regulations, the Medicaid and CHIP parity regulations fundamentally require that financial requirements (FRs) (e.g., coinsurance and copays) and treatment limitations (e.g., limits on the number of outpatient visits, inpatient days covered, or other similar limits on scope or duration of treatment) imposed on MH or SUD benefits may not be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical or surgical benefits in a classification

of benefits. The benefit classifications used for assessing parity compliance under the Medicaid and CHIP parity regulations are inpatient, outpatient, emergency care, and prescription drugs. Treatment limitations include both quantitative and non-quantitative treatment limitations (QTLs and NQTLs). The Medicaid and CHIP parity regulations also state that NQTLs may not be imposed on MH or SUD benefits in any benefit classification unless, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical or surgical benefits in the same classification. Common NQTLs include, but are not limited to, prior authorization requirements, concurrent review requirements, and standards for provider admission to participate in a network.

Current Processes for Ensuring Compliance with MH and SUD Parity in Medicaid and CHIP

CMS works with state agencies to ensure compliance with federal parity requirements in Medicaid managed care arrangements, Medicaid ABPs, and CHIP in accordance with Medicaid and CHIP parity regulations.[iv]

Regarding application of MH/SUD parity requirements to Medicaid managed care arrangements, in recent guidance issued June 12, 2024, CMS reiterated that states must provide documentation of compliance when benefits for MCO enrollees are split between the MCO and another managed care plan (e.g., a PIHP or PAHP) or when some benefits are provided through the MCO and some through FFS. This documentation must be posted on the state Medicaid agency's website and submitted to CMS with the MCO contract for review and approval. CMS also reinforced our expectation that states document compliance with parity requirements when a Medicaid MCO provides all benefits to enrollees, and that states submit parity compliance analyses for such MCO arrangements to CMS and post this documentation on the state Medicaid agency's website.

For Medicaid MCO delivery systems, after states submit the initial round of required documentation to CMS, ensuring ongoing compliance with parity requirements is a component of CMS' Medicaid managed care contract review process. As part of that process, states are required to update documentation when benefit or operational changes occur that may affect compliance with parity requirements; otherwise, states are permitted to attest that there are no changes that affect compliance.

Regarding separate CHIPs, states are required to submit state plan amendments (SPAs) and documentation to demonstrate compliance with MH/SUD parity requirements. When changes to CHIP coverage are made that may affect compliance with MHPAEA, states are required to submit a SPA and update this documentation. States with a Title XXI Medicaid expansion program that provide benefits through MCOs must meet the same parity requirements as other Medicaid MCOs, including the compliance documentation requirements summarized above.

States are responsible for ensuring Medicaid ABPs comply with MH/SUD parity requirements through the SPA process to implement an ABP benefit. The ABP SPA template requires states to identify any benefit limitations, and states must provide descriptions of benefits that demonstrate compliance with MH/SUD parity requirements. An additional parity analysis is required from the state if any amendment changes elements of the benefit package that are considered as part of a parity compliance determination. States providing Medicaid ABP benefits through MCOs must meet the parity requirements for Medicaid MCOs, including the compliance documentation requirements summarized above.

In the June 2024 guidance referenced above, CMS reminded states that all Medicaid managed care and separate CHIP analyses must be updated when benefits, QTLs, NQTLs, or financial requirements change; when deficiencies are corrected; or when managed care plans are added to a managed care program or there is a delivery system change for separate CHIPs. This guidance also stressed states' responsibilities to effectively monitor MH/SUD parity requirements in Medicaid managed care and ensure their policies include written procedures for regularly reviewing compliance with parity requirements. In addition, the guidance states that CMS expects states to have clear contract provisions to hold plans accountable for compliance with parity requirements, including specific potential enforcement actions by the state for continued non-compliance. Furthermore, as CMS announced in the June 2024 guidance, to facilitate state reporting of plan performance related to MH/SUD parity, CMS has recently implemented Managed Care Program Annual Report (MCPAR) fields to collect data related to parity requirements.

Draft Templates for Documenting Compliance with Medicaid and CHIP MH/SUD Parity Requirements

Last fall, CMS issued a previous informal request for comments on Medicaid.gov seeking suggestions for ways to improve implementation of MH/SUD parity requirements in Medicaid and CHIP. In the comments we received, there was broad agreement that a more standardized and simplified approach to documentation of parity compliance would be helpful. In light of the consensus in support of such action as an important way to improve compliance with parity requirements, we have developed a set of comprehensive templates and instructional guides. There was also general agreement in the comments submitted regarding the usefulness of providing additional guidance on documenting compliance for certain NQTLs.

The MH/SUD parity compliance documentation templates we are posting today for public comment include a State Summary Template for submission to CMCS to document compliance with parity requirements. In addition, there are a Managed Care Plan Template and a State FFS Benefit Template for states to use to collect information from the managed care plans providing Medicaid and CHIP benefits subject to parity requirements as well as any Medicaid or CHIP FFS benefits subject to parity. The Plan Reporting and State FFS Reporting Templates are aligned

with and designed to help states collect the information needed to complete the State Summary Template.

The templates are in Excel format and include multiple worksheets (a.k.a., tabs), including introductory information as well as worksheets for documenting parity analyses specific to program types subject to parity (i.e., Medicaid managed care, CHIP, and ABPs). Conditional formatting is incorporated in the templates to reduce duplicative entries, standardize information with drop-down options, and gray out non-relevant sections.

The fundamental unit of analysis for assessing MH/SUD parity compliance in Medicaid and CHIP is by benefit package (i.e., all benefits provided to a specific subpopulation of beneficiaries, such as, children, adults, individuals with disabilities). To ensure that all benefit packages subject to parity requirements are included in the template, there are three separate worksheets for MCO, CHIP, and ABP program types in which the state can list the benefit packages, their delivery systems for MH, SUD, and medical/surgical benefits, and the entities (MCOs, PIHPs, PAHPs, or State FFS Programs) that provide benefits for each of those categories of conditions within each benefit package.

Each of the subsequent worksheets within the templates requires states to provide information related to FRs, QTLs, and NQTLs at the benefit package level. The section for Medicaid managed care also includes a worksheet to analyze aggregate lifetime and annual dollar limits (these limits are not permitted in ABPs and will not be permitted in CHIP by the time the templates are in use).[v] Information related to FRs, QTLs, and NQTLs will also be included by benefit classification (i.e., inpatient, outpatient, emergency care, and prescription drugs) within which the comparison between MH/SUD and medical/surgical benefits is made for determining parity compliance. This information will be included in the templates for each of the program types (i.e., Medicaid managed care, CHIP, and ABP).

The NQTL worksheets for each program type are designed to provide structure for the following types of NQTLs for documentation and analysis: prior authorization, concurrent review, step therapy/fail first, standards for provider network admission, and standards for access to out-of-network providers. These NQTLs were selected based on public comments received in response to the request for comment last fall. Additional optional tables are included for states to add other NQTLs, as the requirement to document compliance with MH/SUD parity requirements is not limited to those NQTLs listed.

CMCS developed the new templates and instructional guides to clarify for states and plans what information to submit to demonstrate compliance with MH/SUD parity requirements in a standardized format. Submission of information through these tools will streamline the review process to minimize submission of duplicative information and support coordination of review across CMCS divisions. Thus, these tools are intended to reduce time spent by states and plans

collecting information to document compliance and improve efficiency and effectiveness of review and analysis of the information submitted to ensure compliance with parity requirements by CMCS. Furthermore, when benefit packages are identical, including identical application of NQTLs, these tools would allow states to avoid entering duplicative information and instead consolidate relevant documentation into a single parity analysis for multiple programs.

Request for Comments

CMS is seeking comments on these draft templates and instructional guides posted at the links below for states to document compliance with MH/SUD parity requirements in Medicaid managed care, Medicaid ABPs, and CHIP. These tools have been designed to address concerns regarding lack of compliance with parity requirements in some Medicaid and CHIP coverage arrangements and complaints regarding a lack of clarity on how to demonstrate compliance. We are seeking feedback through this round of public comments on how these tools may improve our processes for ensuring compliance with parity requirements in Medicaid and CHIP.

Parity State Summary Template: https://www.medicaid.gov/medicaid/downloads/parity-state-summary-temp.xlsx

Instructional Guide for Parity State Summary Template:
https://www.medicaid.gov/medicaid/downloads/parity-state-summary-temp-instr-guide.pdf

Parity Plan Reporting Template: https://www.medicaid.gov/medicaid/downloads/parity-plan-report-temp.xlsx

Parity State FFS Reporting Program Template:
https://www.medicaid.gov/medicaid/downloads/parity-state-ffs-report-prog-temp.xlsx

Instructional Guide for Parity Plan and State FFS Program Reporting:
https://www.medicaid.gov/medicaid/downloads/parity-plan-state-ffs-prog-report-instr-guide.pdf

Some specific questions are listed below. However, we are interested in any other feedback regarding the utility of these tools for ensuring compliance with parity in Medicaid and CHIP and how they may be improved.

Please submit comments to the following email address by October 29, 2024, to receive full consideration: MedicaidandCHIP-Parity@cms.hhs.gov.

Specific Questions for Comment

1. Do the templates adequately incorporate all the MH/SUD parity requirements that apply to Medicaid managed care, Medicaid ABP, and CHIP?

2. Do the templates and instructional guides help to clarify and standardize the information that states are required to submit to CMS to demonstrate compliance with MH/SUD parity requirements in Medicaid managed care, Medicaid ABPs, and CHIP?

3. Are the requests for information in the templates clear and easy to follow? Are there additional explanations or examples CMS should consider adding to the instructional guide(s)?

4. Are the NQTLs highlighted in the templates (i.e., prior authorization, concurrent review, step therapy/fail first, standards for provider network admission, and standards for access to out-of-network providers) the most common and critical NQTLs? Are there others we should consider including or some on this list that are not as critical?

5. Would combining the FR and QTL worksheets into a single worksheet help streamline the parity analysis/documentation, since these limits are subject to the same two-part test?

6. Are there any potential risks (e.g., missing important information regarding benefit limitations or NQTLs) that should be considered?

7. Has experience shown that managed care plans apply NQTLs identically across Medicaid managed care, CHIP, and/or ABPs when the benefit packages across the programs are identical? For example, some states have the same managed care benefit package for Medicaid and CHIP children. If the benefit packages are the same, are some or all of the NQTLs typically the same or different in Medicaid and CHIP?

8. In what way could data entry be further streamlined for managed care plans and/or State FFS programs that deliver benefits that are subject to MH/SUD parity requirements across multiple program types?

9. As we consider how best to structure and format these templates and the number of worksheets that may be needed, it would be helpful to have information in response to the following questions:

    a. What is the maximum number of benefit packages that could be expected to be subject to parity requirements in a state?

    b. What is a maximum number of entities (i.e., managed care plans and State FFS programs) that could be expected to deliver benefits for a given benefit package in a state?

c. What is the average number of entities that deliver benefits for a given benefit package?

10. Existing Medicaid MCO, ABP, and separate CHIP programs are already required to have completed an initial parity analysis. Upon which triggering event(s) requiring parity analysis updates (e.g., new managed care plan joins the program, benefit or limit changes are implemented that affect parity compliance, parity deficiencies are corrected) would it be easier, or more challenging, to begin using a standardized template; and how much time should CMS allow for this template conversion?

11. Once these templates are finalized in accordance with the Paperwork Reduction Act, CMS intends to require states to use them to document their compliance with the parity requirements.

    a. What is a reasonable transition period that CMS should consider allowing before requiring the use of these templates?

    b. Should CMS's transition timeline vary based on the type of program? For example, if CMS is using these templates to document compliance with the parity requirements for Medicaid managed care, ABPs, and/or separate Children's Health Insurance Program (CHIP plans, should the transition timeline vary by these program types?

    c. Can states provide any initial estimates for the anticipated staff time to complete these templates?

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[i] MHPAEA was enacted on Oct. 3, 2008, as Title V, subtitle B (sections 511- 512) of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Pub. L. 110-343). https://www.govinfo.gov/content/pkg/PLAW-110publ343/pdf/PLAW-110publ343.pdf

[ii] Details on the statutory provisions applying parity requirements to Medicaid and CHIP are included in the legislative history section of the Medicaid and CHIP parity final rules - Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; 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; Final Rule. 81 Fed. Reg. 18390 (March 30, 2016) (codified at 42 CFR Parts 438, 440, 456, and 457). https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of

[iii] *Ibid.*

[iv] *Ibid.*

[v] Annual, lifetime or other aggregate dollar limitations on any medical or dental services that were previously covered under the CHIP state plan must be eliminated effective June 3, 2025 as specified in 457.480 of this final rule: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health.