Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA) Report for the Centers for Medicare & Medicaid Services

Submitted by

Maryland Department of Health

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Executive Summary

This report presents the Maryland Department of Health's (MDH's) preliminary analysis of state's Medicaid and Children's Health Insurance Program's (CHIP) compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA) and the Affordable Care Act. MHPAEA requires parity in the treatment limitations and financial requirements for mental health and substance use disorder (MH/SUD) benefits, as compared to medical/surgical (M/S) benefits, provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and Children's Health Insurance Programs (CHIP).

States were required to analyze parity compliance based on the following variables:

- **Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)**—Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis are not applied to MH/SUD benefits unless a limit is applied to at least one-third of M/S benefits.
- **Financial Requirements (FRs)**—Payment by beneficiaries for services received including copayments, coinsurance, and deductibles applied to a classification of MH/SUD benefits may be no more restrictive than the financial requirements applied to M/S benefits in the same classification.
- **Quantitative Treatment Limitations (QTLs)**—Limits on the scope or duration of a benefit that are expressed numerically such as day or visit limits applied to a classification of MH/SUD benefits may not be more restrictive than the QTLs applied to M/S benefits in the same classification.
- **Non-Quantitative Treatment Limitations (NQTLs)**—Limits on the scope or duration of benefits that cannot be expressed numerically, such as prior authorization, network admission standards, or data collection requirement, which otherwise limit the scope or duration of benefits applied to MH/SUD benefits such that they are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply NQTLs to M/S benefits.

Following its initial assessment, MDH determined that AL/ADLs, FRs, and QTLs are not applicable to the State's parity analysis. Therefore, MDH made the decision to focus its analysis on NQTLs. MDH conducted the parity analysis of NQTLs by surveying benefit information from the State's nine MCOs, the behavioral health administrative services organization (ASO), and CHIP. MDH identified one NQTL of particular concern—Data Collection Requirements. To remedy this potential issue, MDH will commence a stakeholder process in September 2018 to determine the best pathway to ensure the continued completeness and utility of the data collection system while minimizing the risk of violating MHPAEA. MDH will use these forums to solicit input from the provider community and the broader public. MDH intends to align any changes to the data collection process with the planned re-procurement of the ASO contract in 2019. MDH will submit a comprehensive final parity analysis in October 2018.

I. Introduction

On March 30, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule addressing the requirements for Medicaid and Children's Health Insurance Programs (CHIPs) compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA) and the Affordable Care Act (https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf).

MHPAEA requires parity in the treatment limitations and financial requirements for mental health and substance use disorder (MH/SUD) benefits, as compared to medical/surgical (M/S) benefits, provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and Children's Health Insurance Programs (CHIPs). States must provide each MCO enrollee with benefits that are in compliance with parity, regardless of whether MH/SUD services are provided by the MCO or are carved out of the MCO benefit package. Parity requirements do not apply to MH or SUD benefits for beneficiaries who receive only Medicaid non-ABP fee-for-service (FFS) state plan services. This report is meant to meet the analysis and reporting requirements of MHPAEA.

States were asked to look at their benefit and utilization management practices and policies to ensure compliance with the following general requirements:

- **Aggregate lifetime and annual dollar limits (AL/ADLs)**—Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis are not applied to MH/SUD benefits unless a limit is applied to at least one-third of M/S benefits.
- **Financial Requirements (FRs)**—Payment by beneficiaries for services received including copayments, coinsurance, and deductibles applied to a classification of MH/SUD benefits may be no more restrictive than the financial requirements applied to M/S benefits in the same classification.
- **Quantitative Treatment Limitations (QTLs)**—Limits on the scope or duration of a benefit that are expressed numerically such as day or visit limits applied to a classification of MH/SUD benefits may not be more restrictive than the QTLs applied to M/S benefits in the same classification.
- **Non-Quantitative Treatment Limitations (NQTLs)**—Limits on the scope or duration of benefits that cannot be expressed numerically, such as prior authorization, network admission standards, or data collection requirement, which otherwise limit the scope or duration of benefits are applied to MH/SUD benefits such that they are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply NQTLs to M/S benefits.

The rule required Maryland Department of Health (MDH) to submit documentation of compliance with the parity requirements to CMS no later than October 2, 2017. Maryland has been in constant contact with CMS as it has developed its parity analysis and has sought and received technical assistance from CMS contractors on several occasions. This report presents MDH's preliminary parity analysis, which identified one NQTL of particular concern—Data Collection Requirements. MDH will commence a stakeholder process in September 2018 to determine the best pathway to ensure the continued completeness and utility of the data

collection system while minimizing risk of violating MHPAEA. MDH will submit a comprehensive final parity analysis in October 2018.

The parity analysis is a joint effort between the Maryland Department of Health's Health Care Financing, which administers the Maryland Medicaid Program, and the Behavioral Health Administration.

II. Methodology

Compliance Process

MDH adopted an approach to parity analysis consistent with CMS guidance as outlined in the CMS parity toolkit, "*Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*" and included the following steps:[1]

1. Identifying all benefit packages to which parity applies.
2. For each benefit package, determining whether the State or an MCO is responsible for the parity analysis.
3. Determining which covered benefits are MH/SUD benefits and which are M/S benefits.
4. Defining the four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care) and determining into which benefit classification MH/SUD and M/S benefits fall.
5. Determining whether AL/ADL apply to MH/SUD benefits, and if they do, whether assessing for compliance with applicable parity requirements.
6. Determining whether any FRs or QTLs apply to MH/SUD benefits and testing the applicable FRs or QTLs for compliance with parity.
7. Identifying and analyzing NQTLs that apply to MH/SUD benefits, and testing the applicable NQTLs for compliance with parity.

III. Medicaid/CHIP Delivery System and Benefits Package

Medicaid/CHIP Delivery System

MDH is responsible for all Medicaid funded services in the state. The vast majority of participants receive services through the HealthChoice Program. HealthChoice—Maryland's statewide mandatory Medicaid managed care program—was implemented in 1997 under authority of Section 1115 of the Social Security Act. As of July 2018, 1,379,101 Marylanders are enrolled in Medicaid. Approximately 86 percent of the State's Medicaid population is enrolled in the HealthChoice Program. Participants in the HealthChoice Program include children enrolled in the Maryland Children's Health Program (MCHP), Maryland's Children's Health Insurance Program (CHIP). Maryland elected to expand services to adults under the age 65 up to 138% of

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

the federal poverty level under the Affordable Care Act in 2014. These individuals are also covered under HealthChoice. HealthChoice participants choose one of the nine (9) participating managed care organizations (MCOs).

Maryland currently operates a bifurcated care delivery system for M/S and MH/SUD benefits. MCOs are responsible for delivering all Medicaid covered services *except* for inpatient, emergency, and specialty outpatient MH/SUD services,[2] which are delivered on a fee-for-services basis through an Administrative Services Organization (ASO) model. Beacon Health Options currently operates the ASO. MH/SUD prescription services are managed by MDH on a fee-for-service (FFS) basis. Long-term services and supports, including services for individuals with intellectual and developmental disabilities, HIV/AIDS medications, and dental services are also carved out from the MCO contracts. As such, MDH has the responsibility of performing the parity analysis for benefits and to identify and address any areas on non-compliance across all delivery systems.

The groups of Medicaid-eligible individuals who enroll in HealthChoice MCOs include the following:

- Families with low income that have children;
- Families that receive Temporary Assistance for Needy Families (TANF);
- Children younger than 19 years who are eligible for MCHP;
- Children in foster care and individuals up to age 26 who were previously enrolled in foster care;
- Adults under age 65 with income up to 138 percent of the federal poverty level (FPL);
- Women with income up to 264 percent of the FPL who are pregnant or less than 60 days postpartum; and
- Individuals receiving Supplemental Security Income (SSI) who are under 65 and not eligible for Medicare.

Not all Maryland Medicaid beneficiaries are enrolled in HealthChoice MCOs. These participants receive care on a FFS basis. Groups that are not eligible for MCO enrollment include the following:

- Medicare beneficiaries;
- Individuals aged 65 years and older;[3]
- Individuals in a "spend-down" eligibility group who are only eligible for Medicaid for a limited period of time;
- Individuals who require more than 90 days of long-term care services and are subsequently disenrolled from HealthChoice;
- Individuals who are continuously enrolled in an institution for mental disease for more than 30 days;
- Individuals who reside in an intermediate care facility for intellectual disabilities; and
- Individuals enrolled in the Model Waiver or the Employed Individuals with Disabilities program. Additional populations covered under the HealthChoice waiver—but not

[2] Note, MH/SUD services delivered by the participant's primary care provider are the responsibility of the MCO.
[3] Individuals aged 65 and older can be enrolled in a HealthChoice MCO if covered as a parent or caretaker.

enrolled in HealthChoice MCOs—include individuals in the Family Planning and REM programs.

Benefits Package

For purposes of the parity analysis and administration of MH/SUD services, MDH defines behavioral health conditions as those conditions listed in ICD-10CM, Chapter 5, "Mental, Behavioral Health, and Neurodevelopmental Disorders." The conditions listed in Chapter 5: subchapter 1, "Mental disorders due to known physiological conditions" (F01 to F09), subchapter 8, "Intellectual disabilities" (F70 to F79), and subchapter 9, "Pervasive and specific developmental disorders" (F80 to F89) are excluded. Details regarding specialty behavioral health services administered by the ASO can be found in COMAR 10.09.70.02.[4]

M/S conditions definitions are consistent with the M/S conditions listed in ICD-10-CM, Chapters 1-4, Chapters 5-subchapter 1, 8, and 9, and Chapters 6-20.

MCO Administered Benefits[5]

MCOs must cover MH/SUD services delivered by the participant's primary care provider. The MCO benefit package also includes, but is not limited to, the following M/S services:

- Inpatient and outpatient hospital care;
- Physician care;
- Federally qualified health center (FQHC) or other clinic services;
- Laboratory and X-ray services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children;
- Prescription drugs, with the exception of mental health and HIV/AIDS drugs;
- Durable medical equipment and disposable medical supplies;
- Home health care;
- Vision services;
- Dialysis;
- The first 90 days of long-term care services; and
- Somatic services related to gender identity disorder, including gender reassignment surgery.

M/S FFS Administered Benefits

The following services are carved out of the MCO benefit package and instead are covered by the Medicaid FFS system:

- Dental care for children, pregnant women, and adults in the REM program;

[4] http://www.dsd.state.md.us/comar/comarhtml/10/10.09.70.02.htm.

[5] For individuals who are not eligible for HealthChoice, these services are provided on a FFS basis by MDH.

- Health-related services and targeted case management services provided to children when the services are specified in the child's Individualized Education Plan or Individualized Family Service Plan;
- Therapy services (occupational, physical, speech, and audiology) for children;
- Personal assistance services offered under the Community First Choice program;
- Viral load testing services, genotypic, phenotypic, or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS;
- HIV/AIDS drugs; and
- Services covered under 1915(c) home and community-based services waivers.

MH/SUD Benefits Administered on a FFS Basis by the ASO

MH/SUD benefits are administered by the ASO are as follows:

MH Services:

- Inpatient care in psychiatric units of acute general hospitals for all ages;
- Inpatient psychiatric services for individuals under 21 years old in free-standing Institutions for Mental Diseases (IMDs);
- Mental health assessment;
- Individual therapy;
- Group therapy;
- Mental health targeted case management;
- Family psychotherapy and psychoeducation;
- Psychiatric rehabilitation;
- Psychological testing;
- Assertive community treatment;
- Mobile treatment;
- Intensive outpatient program services;
- Partial hospitalization; and
- Laboratory services.

SUD Services:

- Inpatient detoxification in acute general hospitals for individuals of all ages;
- Inpatient detoxification and SUD treatment services for individuals under 21 years old in free-standing IMDs, which in Maryland are licensed as Intermediate Care Facilities for Addictions;
- Inpatient detoxification and SUD treatment services for individuals from 21 to 64 years of age who are enrolled in a Medicaid MCO and reside in a non-public IMD for ASAM Residential levels 3.1, 3.3, 3.5, 3.7, and 3.7WM (licensed at 3.7D in Maryland);[6]

[6] Effective July 1, 2017, MDH provides reimbursement for up to two non-consecutive 30-day stays annually for ASAM levels 3.1, 3.3, 3.5, 3.7, and 3.7WM. MDH intends to phase in coverage of ASAM level 3.1 beginning on January 1, 2019 and extend coverage of benefits for dual-eligibles at these levels of care no later than January 1, 2020.

- Alcohol and/or drug assessment;
- Individual therapy;
- Group therapy;
- Intensive outpatient program services;
- Partial hospitalization;
- Ambulatory detoxification;
- Opioid maintenance therapy for individuals 18 years of age and over; and
- Laboratory services.

IV. Benefits Classification

For purposes of the parity analysis, MDH adopted the following definitions for each benefits classification:

- **Inpatient:** Any non-emergency service that involves the individual staying overnight at a facility. This includes inpatient MH and SUD treatment and crisis stabilization services occurring in a facility. All covered services or items provided to a beneficiary when a physician has written an order for admission to a facility.

- **Outpatient:**
  - **Outpatient—Office Visits:** Office visits (primary care or specialist) that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care.
  - **Outpatient—All Other Items & Services:** All services other than office visits that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care.

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

- **Emergency:** All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting.

V. Preliminary Parity Analysis

This report presents MDH's preliminary parity analysis, which identified one NQTL of particular concern—Data Collection Requirements. MDH will commence a stakeholder process in September 2018 to develop recommendations to ensure the continued completeness and utility of the data collection system while minimizing risk of violating MHPAEA. MDH will submit a comprehensive final parity analysis in October 2018.

Following its initial assessment, MDH determined that FR, AL/ADLs, and QTLs are not applicable to the State's parity analysis. Therefore, MDH made the decision to focus its analysis on NQTLs. MDH does not have AL/ADLs in place for its MH/SUD benefits. Additionally, FRs

are limited to copays for medications: $1 for generic/preferred drugs and $3 for brand-name/non-preferred drugs. Copays are applied consistently to medications across the MH/SUD and M/S benefit packages. The only meaningful QTL in place on the MH/SUD benefit package is for inpatient residential treatment services for adults ages 21 to 64. Services at ASAM levels 3.1, 3.3, 3.5, 3.7, and 3.7D are limited to up to two 30-day stays annually pursuant to the requirements in MDH's § 1115 waiver approved by CMS. CMS has advised MDH that this service limit does not fall under the parity rules as it is an expansion service that would not be covered but for the § 1115 waiver authority. MDH further notes that while the setting of provider rates falls outside the scope of the MPHAEA parity requirements, it is conducting an independent cost-driven, rate-setting study to set community provider rates for community-based behavioral health services that includes a rate analysis and an impact study that considers the actual cost of providing community-based behavioral health services as required by S.B. 967—*the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017* (Ch. 572 of the Maryland Acts of 2017).

Under MPHAEA, a state or MCO may not impose an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the benefit as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/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 with respect to M/S benefits in the classification. MHPAEA regulations generally define an NQTL as any limit on benefits that cannot be expressed numerically, but which otherwise limits the scope or duration of benefits for treatment under a plan or coverage.

MDH conducted the parity analysis of NQTLs by surveying benefit information from the State's nine MCOs, the behavioral health ASO, and CHIP. MDH sought information on the NQTLs in place through the ASO and MCOs in the following categories: (1) inpatient services, (2) outpatient services (office visits and all other services), (3) prescription drugs, and (4) emergency care.

MDH's preliminary analysis identified one NQTL of particular concern—Data Collection Requirements. When an individual presents for MH/SUD services delivered by the ASO, the provider must submit certain data. Types of data collected include Social Determinants of Health (SDOH), such as living situation, criminal justice involvement, and employment. The purpose tracking of SDOH at inception of care is to establish a baseline and then track changes at regular intervals thereafter. Collection of this data allows tracking of progress over time and helps determine whether the treatment is having the desired positive effect. Data is also used to meet data reporting requirements of the State's Substance Abuse and Mental Health Services Administration (SAMHSA) grants and other federal data reporting requirements.

The Data Collection NQTL applies to some, but not all of all of the MH/SUD services administered by the ASO. Specifically, there is no data collection requirement for MH/SUD assessment, emergency room, and laboratory services; Opioid Treatment Program Guest Dosing; SUD residential administrative days; capitation services; and inpatient professional services. However, there is a data collection requirement for the remainder of the MH/SUD services as a condition of the authorization of services and payment to the provider. The data collection requirement is also required at six month intervals as a condition of continued treatment for these services. A comparable process does not exist for the delivery of M/S benefits.

Given these considerations, the MDH analysis determined that CMS would be likely to determine the MH/SUD Data Collection Requirement may be a limit on the scope and duration of Medicaid benefits and that the requirement may not comparable and may be more stringent than the Data Collection Requirements for M/S benefits.

To remedy this potential issue, MDH will commence a stakeholder process in September 2018 to determine the best pathway to ensure the continued completeness and utility of the data collection system while minimizing risk of violating MHPAEA. MDH will use these forums to solicit input from the provider community and the broader public. Collecting this data through another process continues to be a high priority for MDH. MDH intends to align any changes to the data collection process with the planned re-procurement of the ASO contract in 2019.

VI. Additional Considerations

MDH is currently finalizing the remainder of its comprehensive parity analysis. MDH anticipates submitting its comprehensive analysis to CMS in October 2018. This interim analysis is intended to permit work to begin rectifying issues with the NQTL identified as not being in compliance with MPHAEA. The comprehensive analysis will include formal demonstration of compliance for the NQTLs listed in the table below:

Table 1: Remaining NQTLs to be evaluated in October 2018 submission.

NQTL*	Benefit Category				
	Inpatient	**Outpatient—Office Visits**	**Outpatient—All Other Items & Services**	**Prescription Drugs**	**Emergency Care**
Medical Necessity	N/A	X	X	X	N/A
Prior Authorization	X	X	X	N/A	N/A
Concurrent Review	X	X	X	N/A	N/A
Retrospective Review	X	N/A	N/A	N/A	N/A
Outlier Management	X	X	X	X	N/A
Medical Appropriateness	X	X	X	N/A	N/A
Practice Guidelines/ Selection Criteria	X	X	X	N/A	N/A

**Cells with a designation of N/A indicate that preliminary analysis demonstrates that these standards are not in place on the MH/SUD side; therefore, additional analysis is not required.*

VII. Next Steps

MDH will proceed with the planning process for stakeholder engagement with the goal of commencing formal public meetings in September. MDH is also in the process of finalizing its analysis with respect to other NQTLs. MDH will submit its final comprehensive analysis to CMS and post it the MDH website for the public in October 2018.