



MENTAL HEALTH PARITY COMPLIANCE SUMMARY

MEDICAID MENTAL HEALTH PARITY OVERVIEW

BACKGROUND & PURPOSE

On March 29, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the Medicaid Mental Health Parity Rule¹ to apply certain requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to the Medicaid program. Specifically, the Parity Rule included the following requirements in the four benefit classifications (Inpatient, Outpatient, Prescription Drugs, and Emergency Care):

- Aggregate lifetime and annual dollar limits;
- Financial requirements (FR);
- Quantitative treatment limitations (QTLs);
- Non-quantitative treatment limitations (NQTLs); and
- Information requirements.

GENERAL PARITY REQUIREMENTS

Aggregate lifetime and annual dollar limits on mental health and substance use disorder benefits cannot be applied unless it applies to at least one-third of medical/surgical benefits.

Financial requirements and quantitative treatment limitations on mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in that classification.

Non-quantitative treatment limitations on mental health and substance use disorder benefits in processes, strategies, evidentiary standards, or other factors must be comparable to, and are applied no more stringently than, limitations applied to medical/surgical, in the same classification. As described in CMS' Parity Compliance Toolkit², the NQTL analysis does not focus on whether the final result is the same; instead, compliance is based upon parity in application of the underlying processes, strategies, evidentiary standards, or other factors, both in writing and in operation.

Information requirements include the availability of (1) criteria for medical necessity determinations for mental health and substance use disorder benefits upon request to Managed Care Organization (MCO) enrollees, potential enrollees, and providers and (2) the reason for any denial of reimbursement or payment for mental health and substance use disorder benefits to beneficiaries.

APPLICABILITY

Parity applies to all beneficiaries enrolled in a MCO. At such point, the beneficiary's entire benefit package is subject to parity standards regardless of the delivery system.

COMPLIANCE DATE

October 2, 2017

ONGOING COMPLIANCE

The Parity Compliance Summary will be regularly updated to reflect completion of outstanding action items and identify any future policy changes that may impact parity. The Compliance Plan and Summary are located at <http://www.dhcs.ca.gov/formsandpubs/Pages/FinalRule.aspx>.

PARITY ANALYSIS APPROACH

DHCS conducted a mandatory assessment of Medicaid benefits across the delivery systems to ensure the State's compliance with the Parity Rule. DHCS adhered to the Parity Toolkit that outlined key steps to conducting the parity analysis and examined benefits across the delivery systems for parity compliance, which included: Medi-Cal managed care plans (MCPs), county Mental Health Plans (MHPs), Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), Waivers, and Fee-for-Service (FFS).

¹ Medicaid Mental Health Parity Final Rule: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf>

² Parity Compliance Toolkit: <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>



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To gain perspectives on current practices and identify parity concerns, DHCS administered surveys to the MCPs, county MHPs, and counties providing substance use disorder services through DMC and DMC-ODS to gain perspectives on policies operationalized at the local levels. The surveys were focused in the following areas: authorizations and referral processes, pharmacy and drug formulary, provider network, credentialing and contracting, case management and care coordination, treatment restriction and/or exclusions, and financial requirements. This included collection and analysis of plan/county policies and procedures.

In addition, DHCS convened an internal workgroup comprised of program, clinical, legal, and executive staff to ensure a multidisciplinary approach to evaluating State-level policies. The workgroup reviewed State guidance within the Medicaid State Plan, waiver programs, State and Federal statutes and regulations, All Plan Letters (APL) and County Information Notices, DHCS contracts with the MCPs and MHPs, Medi-Cal Provider Manual, and the DMC and Specialty Mental Health Services (SMHS) Billing Manual for potential FRs, QTLs, and NQTLs.

PARITY ANALYSIS FINDINGS

Financial Requirements:

- ***Share of Cost – Uniform Method of Determining Ability to Pay (UMDAP) Statutes***

Counties are required to provide community mental health services (which are not Medi-Cal reimbursable) to their residents, in addition to providing SMHS through a MHP. Historically, counties have charged residents fees, based on ability to pay, for community mental health services. Current statute requires counties to charge beneficiaries for SMHS³. However, this is inconsistent with current practice; county MHPs do not charge any fees to Medi-Cal beneficiaries. Therefore, DHCS intends to amend these statutes to conform with current practice. The amendment will follow the State's legislative process and calendar.

Quantitative Treatment Limitations (QTLs):

- ***Alcohol Misuse Screening and Counseling⁴ Limits***

For purposes of parity, DHCS classified alcohol misuse screening and counseling (AMSC) as a substance use disorder benefit, thereby drawing the QTL comparison to medical/surgical preventative services. The Medi-Cal AMSC benefit currently provides for one (1) full screen and three (3) brief interventions per year for alcohol misuse. Although these limits are based on United States Preventative Services Task Force (USPSTF) recommendations, and the benefit includes a component for referral to the county alcohol and drug program for further treatment, the limits may potentially restrict appropriateness of medically necessary services in the primary care setting. DHCS will clarify in the APL and Medi-Cal Provider Manual that allow limits to be exceeded based on medical necessity.

Non-Quantitative Treatment Limitations (NQTLs):

- ***Specialty Mental Health Services Authorization Processes and Timeframes***

DHCS determined that retrospective review is the main form of authorization review used by MHPs, as prior authorization and concurrent review are less common. Existing State statutes and regulations established differing standards between MCPs and MHPs. State statutes governing MCPs are more prescriptive than Federal guidelines, while State regulations governing MHPs aligned with the Federal requirements in the Medicaid Managed Care Final Rule⁵ regulations. To meet parity, DHCS utilized the more restrictive State statutes governing the MCPs⁶ as the standardized policy across delivery systems.

³ Welfare & Institutions Code Sections 5709 and 5710

⁴ Formerly known as Screening, Brief Intervention, and Referral to Treatment (SBIRT)

⁵ Medicaid Managed Care Final Rule: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

⁶ California Health and Safety Code Section 1367.01



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DHCS will amend the MHP contract and issue further guidance regarding circumstances and timeframes in which authorizations are required for specific SMHS.

Additionally, DHCS determined that, as a result of ambiguity in State guidance, concurrent authorization reviews were not consistently conducted by MHPs. To align with MCP policy as established in State statutes, MHPs will be expected to conduct concurrent review of treatment authorizations until discharge and complete the review within five (5) business days upon receipt of request.

DHCS will ensure consistency in the required timeframes for concurrent review of inpatient hospital services by amending the contract and regulatory guidance for SMHS. As this constitutes a significant shift in local operations related to authorization of services, DHCS will work with the county MHPs to rollout the implementation of the authorization procedures.

▪ *Non-Specialty Mental Health Services Authorization Process*

Review of the MCP survey results and deliverables revealed variances within the MCPs' prior authorization processes for medical/surgical and non-specialty mental health services. Prior authorization processes appeared to vary from plan to plan; some MCPs required prior authorization to obtain an initial mental health assessment by a primary care provider or mental health provider. DHCS determined that previously issued guidance on prior authorization requirements were ambiguous. While many primary care providers (PCPs) provide the initial mental health assessments within their scope of practice, not all do. If a beneficiary's PCP does not perform a mental health assessment, and instead refers the beneficiary to another provider, it creates a barrier to access to an initial mental health assessment.

There were also variances in the composition of the authorization review team. Some MCPs utilized a different panel of experts and committee members to review authorizations for medical/surgical services as compared to mental health and substance use disorder services.

DHCS will clarify in an APL that restrictions to an initial mental health assessment is prohibited and emphasize that the authorization review process and evidentiary standards criteria must be based on clinical standards, applied consistently across medical/surgical and non-specialty mental health services, and communicated to providers.

▪ *Alcohol Misuse Screening and Counseling Provider Training*

Review of State guidance revealed that there were conflicting statements between the Medi-Cal Provider Manual and APL regarding the requirement that providers undergo alcohol misuse screening and counseling (AMSC) training as a condition of reimbursement for providing AMSC services. DHCS does not require training for any other preventative services screenings prior to medical/surgical services being provided. Therefore, DHCS will clarify in the APL that rendering licensed health care providers are recommended, but not required, to take training in order to provide and receive reimbursement for AMSC services. Further, DHCS will ensure alignment between the APL and Medi-Cal Provider Manual. These clarifications to the training requirement will help to ensure that providers can render the service if it is in their scope of practice and promote comparable access as a medical/surgical service.

▪ *Statewide Credentialing Policy*

The Medicaid Managed Care Final Rule⁷ and 21st Century Cures Act⁸ established new requirements for provider screening and enrollment. Prior to these requirements, there were no statewide credentialing standards in the SMHS delivery system; instead, MHPs were directed to develop policies and procedures for credentialing and re-credentialing of providers. In order to rectify potential inconsistencies in local policies for credentialing of providers, specialty mental health and substance use disorder programs will adopt a statewide credentialing policy, consistent with guidance issued to MCPs via

⁷ Medicaid Managed Care Final Rule, Federal Register, Vol. 81, No. 88: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

⁸ 21st Century Cures Act: <https://www.congress.gov/bill/114th-congress/house-bill/34/text>



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[APL 16-012](#). DHCS will require both MCPs and MHPs to follow those policies in accordance with 42 CFR 438.214 and 438.602(b), as well as compliance with Section 1902(kk) of the Social Security Act regarding provider terminations. DMC and DMC-ODS will also align its credentialing policies and procedures with State-established requirements according to Part II(E)(5)(a) of the DMC-ODS Intergovernmental Agreement, which is based on the Medicaid Final Rule.

▪ *Statewide Continuity of Care Policy*

DHCS continuity of care policy for MCPs includes non-participating physician providers. In order to meet parity, DHCS will adopt a continuity of care policy for specialty mental health and substance use disorder services that is consistent with the requirements in place for MCPs.

▪ *Statewide Network Adequacy Proposal*

In developing California's network adequacy standards⁹, DHCS was cognizant of utilizing comparable processes, strategies, and evidentiary standards across delivery systems in light of parity. Therefore, DHCS established the same network adequacy standards (time and distance and timely access) for both specialty and non-specialty mental health providers, as well as opioid treatment program and outpatient substance use disorder providers, thus aligning the standards with specialists providing medical/surgical benefits.

▪ *Standardized Notice of Action*

MCPs and MHPs both disseminate practice guidelines (which contain the criteria for medical necessity determinations for mental health and substance use disorder services) and are deemed to be in compliance with this requirement. However, for the second information requirement pertaining to the reason for any denial of reimbursement or payment for mental health and substance use disorder benefits, the requirements governing the MCPs are more prescriptive than Federal guidelines. In May 2017, DHCS updated its Notice of Action (NOA) templates to ensure they contain the required elements and disclosures and issued [APL 17-006](#). To promote statewide standards, DHCS will align the content of the notice among MCPs, MHPs, and DMC-ODS counties. In addition to the standardized content, the NOA will be sent within two (2) business days after an adverse action.

▪ *Transportation Policy*

MCPs currently provide non-emergency medical transportation (NEMT) to plan-covered benefits for all eligible beneficiaries and non-medical transportation (NMT) for Early and Periodic Screening Diagnostic and Treatment (EPSDT) services. For non-plan covered benefits, the MCP is required to refer and coordinate NEMT services for the beneficiary. Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016) requires DHCS to clearly define NMT in the State Plan for all Medi-Cal beneficiaries in both FFS and managed care delivery systems. NMT is subject to utilization controls and federally permissible time and distance standards, consistent with a federal requirement that state Medicaid agencies provide assurances of necessary transportation for beneficiaries to and from covered services. In the FFS delivery system, NMT is an indirect benefit that may be covered administratively through programs identified in the State Plan or through local transportation resources reimbursed through Medi-Cal's County-Based Medi-Cal Administrative Activities (CMAA) program and/or the MCPs.

As a result of AB 2394, DHCS expanded the NMT benefit in the managed care delivery systems, effective July 1, 2017, to include all enrolled beneficiaries, regardless of age, for covered plan services. Additionally, effective October 1, 2017, DHCS will require the MCPs to provide NMT benefits to its enrolled beneficiaries for non-MCP-covered services, including mental health and substance use disorder services, to comply with the Parity Rule. The changes made by DHCS will result in increasing beneficiary access to transportation for medical/surgical, mental health, and substance use disorder services. DHCS issued guidance on this via the contract, APL, and the MCP's Member Handbook template.

⁹ DHCS Network Adequacy Proposal: <http://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAFinalProposal.pdf>



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Alternative Benefit Plan and State Plan Amendment

Medicaid Alternative Benefit Packages (ABPs) were required to comport with MHPAEA for the Affordable Care Act implementation. DHCS assessed the ABP for comportment with MHPAEA and assured compliance by submission of ABP State Plan Amendment CA 13-035 on December 30, 2013. CMS approved the ABP effective January 1, 2014. Therefore, the State’s ABP is deemed to be compliant with the parity requirements for FRs, QTLs, and NQTLs with respect to beneficiaries entitled to EPSDT benefits and concludes that the State Plan is in alignment with the ABP benchmark plan.

Nonetheless, although the State Plan for Children’s Health Insurance Program (CHIP) is deemed in compliance due to the provision that the State covers EPSDT for the full EPSDT population, CMS has recently updated the CHIP State Plan template on September 20, 2017. DHCS may potentially need to submit a CHIP SPA to document consistency with parity regulations. DHCS will post the required public notification of the potential SPA changes and will work towards the amendment until December 29, 2017, if determined to be necessary.

COMPLIANCE PLAN IMPLEMENTATION STATUS

DHCS will come into compliance by incorporating the required language as instructed by CMS on the Contract Checklist¹⁰ and amend the applicable contracts to address the parity findings as described in the above section.

Table 1. Contract Amendment

CONTRACT	PROVISIONS	STATUS	ANTICIPATED SUBMISSION
MCP	<ul style="list-style-type: none"> General parity requirements 	Submitted; Pending CMS approval	10/2/2017
	<ul style="list-style-type: none"> Network adequacy standards 	In Progress	7/2018
MHP	<ul style="list-style-type: none"> General parity requirements 	In Progress	7/2018
	<ul style="list-style-type: none"> Network adequacy standards 		
SUD	<ul style="list-style-type: none"> General parity requirements 	In Progress	7/2018
	<ul style="list-style-type: none"> Network adequacy standards 		

Further, in addition to the above contract changes, DHCS will implement policy to address the parity findings through the following methods:

Table 2. Additional Implementation Methods

TYPE	PARITY FINDING	ACTION	DELIVERY SYSTEM				STATUS	ANTICIPATED COMPLETION
			MCP	MHP	SUD	Statewide		
FR	Share of Cost - Uniform Method of Determining Ability to Pay (UMDAP) Statutes	<ul style="list-style-type: none"> Amend State statutes pertaining to UMDAP 		X			In Progress	7/2018 pending legislative cycle
QTL	AMSC quantitative limits on screenings and brief interventions	<ul style="list-style-type: none"> Issue guidance via APL 	X				In Progress	10/2017
		<ul style="list-style-type: none"> Update the Medi-Cal Provider Manual 				X	In Progress	12/2017

¹⁰ CMS Contract Checklist: <https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf>



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Table 2. Additional Implementation Methods

TYPE	PARITY FINDING	ACTION	DELIVERY SYSTEM				STATUS	ANTICIPATED COMPLETION
			MCP	MHP	SUD	Statewide		
NQTL	AMSC provider training requirement	▪ Issue guidance via APL	X				In Progress	10/2017
		▪ Update the Medi-Cal Provider Manual				X	In Progress	12/2017
NQTL	Authorization processes and timeframes for specialty mental health services	▪ Issue guidance via Information Notice		X			In Progress	7/2018
NQTL	Prior authorization processes for non-specialty mental health services	▪ Issue guidance via APL	X				In Progress	10/2017
NQTL	Statewide Credentialing Policy	▪ Implement policy and issue guidance via Information Notice to conform to managed care requirements		X	X		In Progress	12/2017
NQTL	Statewide Continuity of Care Policy	▪ Implement policy and issue guidance via Information Notice to confirm to managed care requirements		X	X		In Progress	7/2018
NQTL	Statewide Network Adequacy standards	▪ Implement standards in statutes				X	Complete	1/2018 Pending Governor's signature on AB 205
		▪ Implement policy and issue guidance via APLs and Information Notice	X	X	X		In Progress	7/2018
NQTL	Standardized Notice of Action forms and disclosure Requirements	▪ Align timeframe with managed care requirements and issue guidance via Information Notice			X		In Progress	10/2017
		▪ Align NOA content and timeframe with managed care requirements and issue guidance via Information Notice		X			In Progress	12/2017
NQTL	Transportation policy for non-MCP covered services	▪ Issue guidance via APL	X				Completed	7/2017
		▪ Issue policy via MCP's Member Handbook template	X				In Progress	10/2017