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Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP

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On September 26, 1996, Congress enacted the Mental Health Parity Act of 1996 (MHPA), which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. The Balanced Budget Act of 1997 (BBA) generally applied certain aspects of MHPA to Medicaid Managed Care Organizations and CHIP benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. The changes made by MHPAEA consist of new standards, including parity for coverage of substance use disorder benefits, as well as amendments to the existing mental health parity provisions enacted in MHPA.

MHPAEA originally applied to group health plans and group health insurance coverage and was amended by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the “Affordable Care Act”),”), to also apply to individual health insurance coverage. Additionally, the Affordable Care Act requires non-grandfathered individual and small group plans (including those in the state and federal Marketplace) to provide coverage of mental health and substance use disorder services as one of ten essential health benefit categories and those benefits must meet parity requirements and are required benefits in Medicaid alternative benefit packages. In addition, the Children’s Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111-3) (CHIPRA) requires that CHIP plans that provide both medical and surgical benefits and MH/SUD benefits comply with the parity provisions of MHPAEA, in the same manner as a group health plan.

In this final rule, CMS applies certain provisions of the MHPAEA to requirements for Medicaid managed care organizations, Medicaid alternative benefit plans, and the Children’s Health Insurance Program (CHIP). The rule is designed to align as much as possible with the approach taken in the final MHPAEA regulation to create consistency between the commercial and Medicaid markets. This helps to prevent inequity between beneficiaries who have mental health or substance use disorder conditions in the commercial market (including the state and federal Marketplace) and Medicaid and CHIP, and helps to promote greater consistency for these beneficiaries.

The final rule requires that all beneficiaries who receive services through managed care organizations, alternative benefit plans, or CHIP be provided access to mental health and substance use disorder benefits that comply with parity standards, regardless of whether these services are provided through the managed care organization or another service delivery

system. States are required to include contract provisions requiring compliance with parity standards in all applicable contracts for these Medicaid managed care arrangements that provide services to enrollees in managed care organizations, including prepaid inpatient health plans or prepaid ambulatory health plans.

In contrast to the proposed rule, this final rule also extends parity protections to apply to long term care services for mental health and substance use disorders in the same manner that they are applied to other services.

Key Provisions for Medicaid Managed Care Organizations

Under the final rule, states that have contracts with managed care organizations are required to meet the parity requirements regarding financial and treatment limitations consistent with the regulation applicable to private insurers. States will include the cost of providing additional services or removing treatment limitations in their capitation rate methodology for affected managed care plans. By allowing changes to the managed care rate setting process, the rule also provides each state with flexibility to enable Medicaid managed care organizations to fully comply with the rule by including additional costs necessary to include extra services or remove treatment limits without changing the state's non-alternative benefit plans and state plan. In addition, the final rule requires managed care entities to make available upon request to beneficiaries and contracting providers the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits. The rule also directs managed care plans to make available to the enrollee the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits.

Key Provisions for Medicaid Alternative Benefit Plans

Under the final rule, states with Medicaid alternative benefit plans are required to provide mental health and substance use disorders benefits in compliance with parity standards, regardless of the delivery system. In addition, the final rule requires the managed care plan (or in some instances the state) to make available upon request to beneficiaries and contracting providers the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits. The rule directs the managed care plan or the state to make available to the enrollee the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits.

Key Provisions for CHIP Program

Under the final rule, separate CHIP programs, regardless of delivery system (including fee-for-service and managed care), are subject to parity standards. CHIP state plans that provide full coverage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services will be deemed in compliance with the parity requirements. In CHIP plans that do not provide the full EPSDT coverage, the final rule applies parity standards in the same manner as the law applies those standards to health insurance issuers and group health plans. In addition, the final rule requires the state or the managed care entity to make available upon request to beneficiaries and contracting providers the criteria for medical necessity determinations with respect to

mental health and substance use disorder benefits. The rule directs the state or managed care entity to make available to the enrollee the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits.

This final rule is on display at https://www.federalregister.gov/public-inspection and will be posted on https://www.federalregister.gov/.