New Hampshire Department of Health and Human Services

Mental Health Parity and Addiction Equity Act
NH DHHS Compliance Plan

Updated August 2017

2008: The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or Parity Act)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or Parity Act) requires health insurance carriers to achieve coverage parity between Mental Health/Substance Use Disorders (MH/SUD) and Medical/Surgical (M/S) benefits, especially in regard to financial requirements and treatment limitations.

March 2016: CMS Finalizes the MH and SUD Parity Rule for Medicaid and CHIP Programs

The Centers for Medicare and Medicaid Services (CMS) finalized a rule to strengthen access to mental health and substance use disorder services for people with Medicaid or Children's Health Insurance Program (CHIP) coverage, aligning with protections already required of private health plans.

Final Rule

- The final rule addresses the application to Medicaid and the Children's Health Insurance Program (CHIP) of certain mental health parity requirements added to the Public Health Service Act (PHS Act) by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. 110-343), enacted on October 3, 2008).
- Specifically, the final rule addresses the application of MHPAEA parity requirements to:
  - (1) Medicaid managed care organizations (MCOs) as described in section 1903(m) of the Social Security Act (the Act);
  - (2) Medicaid benchmark and benchmark-equivalent plans (referred to in this rule as Medicaid Alternative Benefit Plans (ABPs)) as described in section 1937 of the Act; and
  - (3) Children's Health Insurance Program (CHIP) under title XXI of the Act.

Parity Analysis

The final Medicaid/CHIP parity rule requires analysis of the following:

- Aggregate lifetime and annual dollar limits [AL's/ADL's]
- Financial requirements [FR's] and treatment limitations, including:
  - FR's such as copayments, coinsurance, deductibles and out of pocket maximum
  - Quantitative treatment limitations [QTL's], which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits
- Non-Quantitative treatment limitations such as medical management standards, provider network admission standards and reimbursement rates, fail-first policies, prior authorizations, drug formularies, and other limits on the scope or duration of benefits
- Availability of Information:
  - Criteria for Medical Necessity Determinations
  - Reason for Denial of Reimbursement or Payment for MH/SUD benefits

Parity Requirements

The general parity requirement for Aggregate Lifetime/Annual Dollar Limits is that an AL/ADL cannot be applied to MH/SUD benefits unless it applies to at least one-third of medical surgical [M/S] benefits.

The parity requirement for Financial Requirements and Quantitative Treatment Limitations is as follows:

> An FR or QTL that applies to MH/SUD benefits within a classification may not be more restrictive than the predominant FR or QTL that applies to substantially all M/S benefits in that classification.

Parity Requirements

The requirement for Non-Quantitative Treatment Limitations [NQTLs] is as follows:

> A NQTL may not apply to MH/SUD benefits in a classification unless, under the policies and procedures of the state or MCO, 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 applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification

Parity

Parity does not mandate coverage of MH/SUD benefits. However, if coverage is provided for MH or SUD benefits in any classification, coverage for MH or SUD benefits must be provided in every classification in which M/S benefits are provided.

The four classifications are:

- Inpatient
- Outpatient
- Prescription Drugs
- Emergency Care

Key Steps in Parity Analysis

- Identify relevant Medicaid benefit packages [such as Managed Care Organization [MCO], Children's Health Insurance Program [CHIP] & Alternative Benefit Plan [ABP].
- Determine who is responsible for conducting the Parity Analysis: [MCO]
- Determine which covered benefits are MH/SUD benefits and which are M/S benefits
- Define the 4 benefit classifications
- Identify a recognized standard for categorizing diagnoses or conditions as either medical/surgical or BH/SUD [ICD-10]
- Identify and test each AL/ADL applied to MH/SUD benefits for compliance
- Identify and test each FR and QTL applied to MH/SUD benefits in a classification for compliance with applicable parity requirements
- Identify and test each NQTL applied to MH/SUD benefits in a classification for compliance with applicable parity requirements

Key Steps in Parity Analysis

- Assess compliance regarding Availability of Information
- Develop a Monitoring Compliance Process
- Develop a Stakeholder Input Process
- MCO submits attestation and report to DHHS regarding Parity compliance
- DHHS submits Parity Analysis to CMS

Timeline

- DHHS finalized its framework for the MCO Parity Analysis in June 2017
- MCO's are currently working on completion of the analysis: July 3-September 15, 2017
- DHHS submits results of Parity Analysis as well as its plan for on-going Compliance Monitoring to CMS on/before October 2, 2017

Medicaid managed care beneficiary protections

Members have the right to file an appeal or grievance if dissatisfied with the health plan in any way.

Description		Examples
First Level Appeal to the Plan	Standard Appeal	• Plan decision to: ○ **Deny** or **limit** a requested health care service or request for prior authorization, in whole or in part ○ **Reduce**, **suspend**, or **end** a health care service ○ **Deny** payment for a service in whole or in part • When a member is unable to access health care services in a timely manner
	Expedited Appeal	
Second Level Appeal to NH DHHS	State Fair Hearing	
Grievance to the Plan	Grievance	• Dissatisfaction with the quality of care or services you receive • Dissatisfaction with the way you were treated by the plan or its network providers • If you believe your rights were not respected by the plan or its network providers

Medicaid managed care appeal and grievance timeframes

Description		Member Filing Period	Decision or Response Deadline
First Level Appeal to the Plan	Standard Appeal	Within **60 calendar days** of the plan's written adverse notice; oral appeal must be followed by written, signed appeal*	Plan decision within **30 calendar days** after the plan's receipt of the appeal request*
	Expedited Appeal	Within **60 calendar days** of the plan's written adverse notice; oral appeal must be followed by written, signed appeal*	Plan decision within **72 hours** after the plan receives the appeal request, or as expeditiously as the member's health requires**/***
Second Level Appeal to NH DHHS	State Fair Hearing	Within **120 calendar days** of the plan's first level denial notice; requires written, signed appeal*	NH DHHS decision within **_ days** after _
Grievance to the Plan	Grievance	At any time orally or in writing	Plan response no later than **45 calendar days** after the plan's receipt of the grievance

* In order to keep service(s) in place pending the outcome of the appeal, a member must specifically request continuation of benefits from the plan AND file an appeal within **10 calendar days** from the date of the plan's written adverse notice.
For appeals relative to the plan's decision to deny, reduce, limit, suspend or end services, members may request continuation of benefits AND must file an appeal within **10 calendar days** of receipt of the plan's written adverse notice.
** Plan may take up to additional **14 calendar days** if the member requests extension or plan needs additional information and feels the extension is in member's best interest.
*** Plan must reasonably attempt oral notice within **2 calendar days** if plan needs to extend decision up to an additional **14 calendar days.**

Resources:

- Website with information about Medicaid Parity Requirements and Parity Analysis: https://www.dhhs.nh.gov/ombp/medicaid/parity.htm
- Dedicated Email address for Medicaid Parity questions or suggestions: nhparity@dhhs.nh.gov
- New Hampshire Insurance Department: Accessing Behavioral

  Health Services Through Private Insurance: The Path to Parity: https://www.nh.gov/insurance/consumers/documents/parity_ppt.pdf
- New Futures: Resource Guide For Addiction and Mental Health Care Consumers: September 2016: http://www.new-futures.org/sites/default/files/pages/attachments/Resource%20Guide%20for%20Addiction%20and%20Mental%20Health%20Care%20Consumers.pdf