110 MENTAL HEALTH PARITY

REVISION DATES: 2/16/2022, 3/24/2021
REVIEW DATE: 11/7/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR Part 457, 42 CFR Part 438, ACOM 110 Attachment A, AMPM 1020 Attachment F

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) whose contract includes this requirement and outlines the requirements to achieve and maintain compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

DEFINITIONS

Aggregate Lifetime Dollar Limit - A dollar limitation on the total amount of specified benefits that may be paid under a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP).

Annual Dollar Limit - A dollar limitation on the total amount of specified benefits that may be paid in a fiscal year 12-month period under a MCO, PIHP, or PAHP.

Benefit Package - Benefits provided to a specific population group or targeted residents (e.g., individuals determined to have a serious mental illness) regardless of the Health Care Delivery System.

Cumulative Financial Requirements - Financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and included deductibles, and out-of-pocket maximums. Cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.

Health Care Delivery System - The health care delivery system refers to the structure and organization of covered services and benefit packages available to AdSS members. Delivery systems can be fully integrated (all covered services administered by a single AdSS) or partially integrated (Members enrolled with an AdSS may receive covered services by multiple AdSS or via fee-for-service arrangements).

Medical/Surgical Benefits (M/S) - Items or services for medical conditions or surgical procedures, as defined by the State and in accordance with applicable Federal and State law, but do not include mental health or substance use disorder benefits. Any condition defined by the State as being or not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice. Medical/surgical benefits include long-term care services.

Mental Health Benefits - Items or services for mental health conditions, as defined by the State and in accordance with applicable Federal and State law. Any condition defined by the State as being or not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice. Mental health benefits include long-term care services.

Substance Use Disorder Benefits - Items or services for substance use disorders, as defined by the State and in accordance with applicable Federal and State law. Any disorder defined by the State as being or not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice. Substance use disorder benefits include long-term care services.

Treatment Limitations - Limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and non-quantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

POLICY

A. MHPAEA Final Rule

The Centers for Medicare and Medicaid Services (CMS) issued the MHPAEA final rule on March 30, 2016. The regulation, in general, prohibits the application of more restrictive limits to Mental Health/Substance Use Disorder (MH/SUD) benefits than to Medical/Surgical (M/S) benefits. MHPAEA specifically:

1. Prohibits the application of annual or lifetime dollar limits to MH/SUD benefits unless aggregated dollar limits apply to at least one third of medical benefits;

2. Prohibits the application of financial requirements (e.g., copays) and Quantitative Treatment Limitations (QTLs) (e.g., day or visit limits) on MH/SUD benefits that are more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all M/S benefits in that same classification; and

3. Prohibits the application of Non-Quantitative Treatment limits (NQTLs) (e.g., prior authorization) on MH/SUD benefits in any classification unless the NQTL, as written and in operation, is applied to the MH/SUD benefits comparably and no more stringently than to M/S benefits in the same classification.

B. Mental Health Parity Analysis Requirements

The AdSS are responsible for performing the initial and ongoing parity analyses. If some MH/SUD or M/S benefits are provided to members through another Health Care Delivery System, the AdSS are responsible for completing a parity analysis and submitting it to the Division. The Division is responsible for ensuring the AdSS are in compliance with this requirement.

1. Parity requirements apply to all MH/SUD benefits provided to members.

2. The parity analysis must be conducted and assessed at least annually and ongoing for events warranting a parity analysis as described below.

3. The parity analysis must be conducted for each benefit package regardless of Health Care Delivery System.

   a. The benefit package includes the covered services to ALTCS eligible members;

   b. A benefit package includes M/S and MH/SUD benefits, including long-term care benefits provided by the AdSS.

C. Standard Parity Requirements

1. Benefit Packages

   DDD AdSS benefit packages and Health Care Delivery Systems are defined as covered services available to children and adult members who are enrolled with the Division and ALTCS eligible, and Medicare cost sharing. Division members up to the age of 21 are designated as children for purposes of the benefit package.

   The AdSS shall adhere to all applicable established benefit packages and covered services when conducting the mental health parity analysis and assessing for ongoing compliance with parity requirements.

2. Defining MH/SUD and M/S Benefits

   MH/SUD benefits are items and services for MH/SUD conditions regardless of the type of AdSS or type of provider that delivers the item/service. The Division defines MH/SUD and M/S conditions using the ICD-10-Clincial Modification (ICD- 10). For purposes of parity, MH and SUDs are those conditions in ICD-10, chapter 5, "Mental, Behavioral and Neurodevelopmental Disorders," sub-chapters 2-7 and 10- 11.

   a. Sub-chapter 1, "Mental Disorders Due to Known Physiological Conditions," is excluded from the MH condition definition (and included in the M/S condition definition) because the physiological condition is primary for these diagnostic codes; and

   b. Similarly, sub-chapters 8 and 9 (e.g., intellectual disabilities, specific developmental disorders of speech and language, specific developmental disorders of scholastic skills and pervasive developmental disorders) are excluded from the MH condition definition (and included in the M/S condition definition) because these are neurodevelopmental conditions, which are separate and distinct from mental and behavioral conditions, as indicated by the chapter title.

   AdSS shall utilize these definitions for MH/SUD and M/S conditions when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

3. Mapping Benefits to Classifications

When conducting the parity analysis and when assessing for ongoing compliance with parity requirements, AdSS must apply the defined classifications outlined below.

In order to conduct the analysis, each service is assigned to one of four classifications: inpatient, outpatient, emergency care, and prescription drug. AdSSs shall apply the established benefit mapping when conducting the parity analysis. Refer to ACOM Chapter 100, Policy 110, Attachment A (AZ Parity Summary Benefit Package Mapping) for the benefit mapping.

Each of the above classifications are defined based on the setting in which the services are delivered. General definitions for each of the classifications include:

a. Inpatient: Includes all covered services or items provided to a member in a setting that requires an overnight stay including behavioral health placement settings;

b. Outpatient: Includes all covered services or items provided to a member in a setting that does not require an overnight stay, which does not otherwise meet the definition of inpatient, prescription drug, or emergency care services;

c. Emergency care: Includes all covered emergency services or items to treat an emergency medical condition delivered in an emergency department setting; and

d. Prescription drugs: Covered medication, drugs, and associated supplies and services that require a prescription to be dispensed, which includes drugs claimed using the NCPDP claim forms.

Parity requirements for financial requirements, quantitative treatment limits, and non-quantitative treatment limits apply by classification (e.g., as inpatient, outpatient, emergency, and pharmacy).

AdSS shall apply the defined classifications when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

4. Testing MH/SUD Financial Requirements, Quantitative Limits, Annual Dollar Limits, and Non-Quantitative Treatment Limits.

   a. When applicable, AdSS shall conduct limit testing as part of the initial arity analysis and shall re-assess compliance when changes may impact parity compliance. Testing limits includes:

      i. Identifying and evaluating financial requirements and quantitative treatment limits using a 2-part, claims-based test (if applicable). The Division determined that the 2-part, claims-based test is not necessary when performing or overseeing the initial mental health parity.

ii. Identifying and testing aggregate lifetime and annual dollar limits (if applicable) using a multi-part claims-based test. The Division did not identify any of these limits applicable to any MH/SUD services and as a result, no review or testing is necessary.

iii. Identifying NQTLs and applying the NQTL information-based test to each NQTL.

a. Financial requirements include copays, coinsurance, deductibles, out of pocket maximums (does not include aggregate lifetime or annual dollar limits),

i. The AdSS must ensure that cumulative financial requirements (deductibles) do not accumulate separately for MH/SUD benefits.

ii. Individuals eligible for AHCCCS may be charged nominal copays, unless they are receiving a covered service that is exempt from copays or the individual is in a group that cannot be charged copays. Nominal copays are also referred to as optional copays. If a member has a nominal copay, then a provider cannot deny the service if the member states that the member is unable to pay the copay. There are specific populations that are exempt from any nominal copayments,

iii. During the initial mental health parity analysis (Contract Year 2017) and presently (Fiscal Year 2019), the Division requires all outpatient office visits in all benefit packages to have a copayment, with the exception of members and services exempted from copayments. Because all outpatient office visits have a copayment, the Division concluded without testing that these are the respective predominant limits. Similarly, for prescription drugs, a copayment applies to all prescription drugs for both M/S and MH/SUD conditions. This is considered the predominant limit, and

iv. The AdSS must adhere to Division Operations Policy 431 (Copayment) regarding copayment requirements, including the populations subject to a copayment, the amount of the copayment, populations and services exempt from copayments, as well as the out-of-pocket maximum.

b. Quantitative treatment limits are numerical limits on benefits based on the frequency of treatment, number of days, days of coverage, days in a waiting period, or similar limits on treatment scope or duration. In accordance with this Policy, the AdSS shall not apply quantitative treatment limits to any MH/SUD services in any classification in any benefit package, with the exception that hour limits currently applied to respite services (600 hours/year) and visit limits (15 visits per

Contract Year) currently applied to occupational therapy services in the outpatient classification are permissible under the parity requirements.

c. NQTLs are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits.

i. Examples of NQTLs published in the Final MHPAEA Rule include:

1) Medical management standards (e.g., medical necessity criteria and processes or experimental/investigational determinations);

2) Prescription drug formulary;

3) Admission standards for provider network;

4) Standards for accessing out-of-network providers;

5) Provider reimbursement rates (including methodology);

6) Restrictions based on the location, facility type, or provider specialty;

7) Fail-first policies or step therapy protocols; and

8) Exclusions based on failure to complete a course of treatment.

ii. AHCCCS identified the following NQTLs as part of the initial MHPAEA compliance determination:

1) Utilization management NQTLs,

2) Medical necessity NQTLs,

3) Documentation requirements NQTLS, and

4) Out-of-network/geographic area coverage NQTLs.

iii. AdSSs shall not impose NQTLs for MH/SUD services in any classification unless, under the policies and procedures of the AdSS as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the NQTL to MH/SUD services 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 NQTL to M/S benefits in the classification, and

iv. Once NQTLs are identified, the AdSS shall collect and analyze information about the processes, strategies, evidentiary standards and other factors applicable to each NQTL, in writing

and in operation, relative to M/S and MH/SUD benefits in each classification.

D. Events Warranting a Parity Analysis and AdSS Specific Requirements

1. The AdSS is responsible for administering a fully integrated contract and shall perform a parity analysis when there is a change in the AdSS' operations that may impact parity compliance including but not limited to:

    a. Changes to Financial Requirements (FRs) or QTLs;

    b. Changes to Benefit Packages, utilization requirements, covered services, or service delivery structures (i.e., change in the subcontractors performing administrative functions);

    c. Substantive changes to policies or procedures of the AdSS (or subcontractors performing administrative functions on the Division's behalf) that impact benefit coverage, access to care for provider contracting.

2. If the AdSS identifies any changes or deficiencies noted in the above, the AdSS is required to attach the Mental Health Parity analysis for those FR/QTLs and NQTLs impacted by the changes. Utilizing ACOM Policy 110 Attachment C and shall include:

    a. Any actual Parity issues identified,

    b. The FR/QTLs or NQTLs associated with the Mental Health Parity concern,

    c. The applicable Benefit Package (s) and affected classification(s),

    d. The nature of the Mental Health Parity compliance issue and the actions taken to address the parity issue.

3. AdSSs that are new or newly responsible for the delivery of integrated M/S and MH/SUD services in a benefit package shall perform and document a comprehensive parity analysis prior to initiation of services. The results of the analysis must be submitted to the Division as specified in the AdSS Contract with the Division.

4. The AdSS shall also report as specified in the AdSS Contract with the Division, utilizing AMPM Policy 1020 Attachment F, a description of the self-monitoring activities for parity compliance in operation, ensuring that FR/QTLs and NQTLs are, in operation applied no more stringently to MH/SUD Benefits than for M/S Benefits

5. In the event of a contract modification, amendment, novation, or other legal act changes which limits or impacts compliance with the mental health parity requirement, the AdSS shall conduct an additional analysis for mental health parity in advance of the execution of the contract change. Further, the AdSS

shall provide documentation of how the parity requirement is met, with the submission of the contract change, and how sustained compliance will be achieved. The AdSS shall certify compliance with parity requirements prior to the effective date of the contract changes.

6. The AdSS shall report mental health parity deficiencies as specified in the AdSS' Contract with the Division and develop a corrective action plan to be in compliance within the same quarter as the submission.

7. All financial requirements, AL/ADLs, QTLs, and NQTLs must be evaluated as part of the AdSS' parity analysis.

8. The AdSS may utilize any data collection and documentation template for the parity analysis; however, the following elements must be clearly documented:

   a. Methodology, processes, strategies, evidentiary standards, and other factors applied.

   b. All financial requirements, AL/ADLs, QTLs and identified NQTLs AdSS must minimally report NQTL analysis results for prior authorization, concurrent review, medical necessity, outlier, documentation, and out of area criteria, but must also assess and document for the presence of other potential NQTLs:

      i. Monitoring mechanisms and aggregated results as applicable (e.g., denial rates);

      ii. Findings;

      iii. Components of the analysis that are determined to be non-compliant with parity along with a detailed plan to resolve identified deficiencies; and

      iv. The AdSS shall analyze and document all delegated functions that may apply to limit MH/SUD benefits in policy and in operation.

9. If there have been no changes that affect the AdSS benefit package, utilization, or Health Care Delivery Systems, the AdSS shall submit to the Division an annual attestation (ACOM Policy 110, Attachment B, Mental Health Parity Attestation Statement) certifying ongoing compliance with mental health parity requirements as specified in the AdSS Contract with the Division.

10. The AdSS shall make available upon request to members and contracting providers the criteria for medical necessity determinations with respect to MH/SUD benefits. AdSSs shall also make available to the member the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits.

11. The AdSS may be required to respond to inquiries from the Division, AHCCCS or an AHCCCS contracted consultant. Inquiries may include AdSS policies and procedures requiring review to determine compliance with mental health parity regulations.

E. Division Oversight of AdSS Mental Health Parity

1. Each AdSS is required to send their Mental Health Parity reports to the Division for review. This will occur at a minimum annually and when changes are made as addressed in this policy.

2. The AdSS shall participate in an annual Operational Review conducted by the Division to ensure AdSS compliance with Mental Health Parity analyses, methodology, processes, and other related functions including, but not limited to:

    a. The AdSS policies and procedures for monitoring compliance with Mental Health Parity.

    b. The AdSS' completed analysis demonstrating compliance with Mental Health Parity as outlined in this policy.

    c. The AdSS' process when a deficiency is identified and the plan of how the AdSS will come back into compliance.