DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Supra	7-10-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000006	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Mr. Keck, Kost, Depts, CMS file	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

RE: Calendar Year (CY) 2013 Oct - Dec Phased-down State Contribution Final Per-Capita Rates

June 28, 2013

Dear State Medicaid Director:

As you know, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that the Centers for Medicare & Medicaid Services (CMS) notify each State of its per capita drug payment expenditure amount. Payments for the phased-down State contribution are made on a monthly basis. These payments are defined by the MMA to be the product of the annual per capita full dual-eligible drug payment amount and the monthly State enrollment of full dual eligibles.

This letter is to notify you of the phased-down State contribution full dual-eligible per capita Medicaid drug payment amount for October - December 2013, as required by the MMA.

Oct-Dec 2013 phased-down State contribution per capita rates are shown in Attachment 1. The per capita drug expenditure amount for Oct-Dec 2013 is based on the value for Jan-Sep 2013, adjusted for the change in FMAP, if any, between FY 2013 and FY 2014.

Questions regarding these calculations may be directed to Carolyn Lawson, Division of Information Analysis and Technical Assistance, Data & Systems Group, at 410-786-0704 or via email at Carolyn.Lawson@cms.hhs.gov.

Sincerely,

/s/

Elaine Olin
Director, Data & Systems Group

ATTACHMENT 1: Phased-down State Contribution Rates Oct - Dec 2013

STATE	STATE NAME	OCT-DEC 2013
AK	Alaska	153.42
AL	Alabama	67.46
AR	Arkansas	57.95
AZ	Arizona	51.63
CA	California	103.70
CO	Colorado	133.62
CT	Connecticut	164.38
DC	District of Columbia	58.96
DE	Delaware	117.76
FL	Florida	118.20
GA	Georgia	80.99
HI	Hawaii	92.06
IA	Iowa	119.31
ID	Idaho	83.88
IL	Illinois	134.32
IN	Indiana	91.63
KS	Kansas	120.73
KY	Kentucky	80.26
LA	Louisiana	99.67
MA	Massachusetts	110.07
MD	Maryland	140.42
ME	Maine	90.05
MI	Michigan	67.06
MN	Minnesota	135.53
MO	Missouri	125.92
MS	Mississippi	55.63
MT	Montana	90.63
NC	North Carolina	94.31
ND	North Dakota	117.77
NE	Nebraska	127.13
NH	New Hampshire	156.10
NJ	New Jersey	167.95
NM	New Mexico	56.11
NV	Nevada	93.86
NY	New York	123.84
OH	Ohio	123.53
OK	Oklahoma	73.36
OR	Oregon	101.10
PA	Pennsylvania	134.66
RI	Rhode Island	133.25
SC	South Carolina	55.79
SD	South Dakota	127.23
TN	Tennessee	106.56
TX	Texas	86.61
UT	Utah	92.81
VA	Virginia	141.42
VT	Vermont	115.13
WA	Washington	133.88
WI	Wisconsin	113.76
WV	West Virginia	71.97
WY	Wyoming	147.81

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SHO # 13-001
ACA #24

January 16, 2013

RE: Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans

Dear State Health Official:
Dear State Medicaid Director:

This letter provides guidance on the applicability of the requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, Pub.L. 110-343)[1, 2] to Medicaid non-managed care benchmark and benchmark-equivalent plans (referred to in this letter as Medicaid Alternative Benefit plans) as described in section 1937 of the Social Security Act (the Act), the Children's Health Insurance Programs (CHIP) under title XXI of the Act, and Medicaid managed care programs as described in section 1932 of the Act. The Centers for Medicare & Medicaid Services (CMS) previously issued a State Health Official (SHO) letter on November 4, 2009, concerning section 502 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, Pub.L. 111-3)[3]. This letter issues new guidance on the application of MHPAEA in Medicaid and expands upon the guidance for CHIP.

Legislative History and Background

Starting in 1996, Congress enacted several laws designed to improve access to mental health and substance use disorder services under health insurance or benefit plans that provide medical/surgical benefits.

The Mental Health Parity Act of 1996 (MHPA, Pub.L. 104-204) addressed aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits offered by group health plans (or health insurance coverage offered in connection with such plans). The Balanced Budget Act of 1997 (BBA, Pub.L. 105-33) added sections 1932(b)(8) and 2103(f)(2) of the Act to apply certain aspects of MHPA to Medicaid managed care organizations (MCOs) and CHIP benefits.

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[1] https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/MHPAEA.pdf.
[2] See 29 CFR 2590.712((c)(4). See also FAQs about Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation, available at http://www.dol.gov/ebsa/pdf/faq-aca7.pdf.
[3] http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf

MHPAEA extended the MHPA requirements to substance use disorder benefits in addition to mental health benefits. MHPAEA also added new requirements regarding financial requirements and treatment limitations in addition to the limitations on aggregate annual and lifetime dollar limits.

In 2009, section 502 of CHIPRA amended section 2103(c) of the Act by adding paragraph (6), which incorporates, by reference, provisions added to section 2705 of the Public Health Service Act (PHSA) by MHPAEA.[4] Consequently, the mental health and substance use disorder parity requirements of MHPAEA apply to coverage under a CHIP state plan in the same manner MHPAEA applies to group health plans.

The Affordable Care Act (Pub.L. 111-148) expanded the application of MHPAEA to benefits in Medicaid non-managed care benchmark and benchmark-equivalent state plan benefits pursuant to section 1937 of the Act (referred to in this letter as Medicaid Alternative Benefit plans) (see section 2001(c)(3) of the Affordable Care Act, adding section 1937(b)(6)). The application of MHPAEA to Medicaid non-managed care Alternative Benefit plan benefits was effective on March 23, 2010. Also effective as of that date, Medicaid Alternative Benefit plans that are benchmark-equivalent plans must include mental health and substance abuse services as a basic service (see section 2001(c) of the Affordable Care Act).

MHPAEA's requirements include:

- Financial requirements that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements that are applied to substantially all medical/surgical benefits. The statute defines "predominant" as the most common or frequent of such type of limitation or requirements.
- There are no separate cost sharing requirements that apply only to mental health or substance use disorder benefits.
- Treatment limitations that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- The criteria for medical necessity determinations with respect to mental health or substance use disorder benefits are made available to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits is made available within a reasonable timeframe to participants and beneficiaries upon request.
- If a plan or coverage provides out-of-network coverage for medical/surgical benefits, it provides out-of-network coverage for mental health or substance use disorder benefits.

On February 2, 2010, the Departments of Health and Human Services, Labor, and the Treasury (the Departments) published an Interim Final Rule (IFR) under MHPAEA. The IFR is

[4] The mental health parity provisions are currently found in PHSA section 2726, after Title XXVII of the PHSA was reorganized and amended by the Affordable Care Act.

applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010. In the IFR, the Departments interpreted the statutory requirement precluding more restrictive treatment limitations for mental health or substance use disorder benefits to apply to both quantitative and non-quantitative treatment limitations. Examples of quantitative treatment limits include a limit on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Examples of non-quantitative treatment limits that were identified in the IFR include preauthorization requirements and medical management standards.

Application of Mental Health/Substance Use Disorder Parity Requirements to Medicaid Alternative Benefit Plans

All Medicaid Alternative Benefit plans (including benchmark equivalent and Secretary–approved benchmark plans) are required to meet the provisions within MHPAEA, regardless of whether services are delivered in managed care or non-managed care arrangements. This includes Alternative Benefit plans for individuals in the new low-income Medicaid expansion group, effective January 1, 2014. Specifically:

- Section 1932(b)(8) of the Act applies parity requirements to MCOs (see below for more details regarding requirements for Medicaid MCOs).
- Section 1937(b)(6) of the Act, as added by the Affordable Care Act, directs that approved section 1937 Medicaid non-managed care Alternative Benefit plans that provide both medical/surgical benefits and mental health or substance use disorder benefits comply with MHPAEA[5].

In order to comply with the MHPAEA provisions regarding financial requirements, states with Medicaid Alternative Benefit plans should review Attachment 4.18 of their Medicaid state plans to ensure that financial requirements (such as deductibles, co-payments, co-insurance, and out-of-pocket expense limits) applicable to mental health or substance use disorder benefits provided through such plans are no more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits in the Medicaid Alternative Benefit plan.

Likewise, to comply with the MHPAEA requirements on treatment limitations, states with approved Medicaid Alternative Benefit plans should review these plans to determine whether any types of treatment limitations imposed in these benefit plans on coverage of mental health or substance use disorder benefits are more restrictive than those imposed on medical/surgical benefits. This should include a review of both quantitative and non-quantitative treatment limitations.

Finally, states must assure that Medicaid Alternative Benefit plans apply the MHPAEA requirements regarding the availability of out-of-network coverage and the availability of information regarding criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits.

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[5] See State Health Official letter describing Alternative Benefit plans under section 1937 as modified by the Affordable Care Act, http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf.

States with Alternative Benefit plans for children should already meet the requirements for MHPAEA for children. States that enroll children in a Medicaid Alternative Benefit plan are directed by section 1937(a)(1)(A)(ii) of the Act to assure that eligible children under age 21 receive the full Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit offered through a Medicaid Alternative Benefit plan or through a combination of the Medicaid Alternative Benefit plan and wrap-around services. Section 1937(b)(6)(B) of the Act provides that states extending Medicaid coverage for individuals under age 21 through Medicaid non-managed care Alternative Benefit plans that include the EPSDT benefit shall be deemed to satisfy the mental health and substance use disorder parity requirements with respect to the individual. CMS will also deem Medicaid Alternative Benefit managed care plans to be compliant with MHPAEA, to the extent they provide coverage for children, regardless of whether the MCO provides full EPSDT services or the state assures EPSDT through a wrap-around arrangement.

States with Medicaid Alternative Benefit plans that are not in compliance with the parity requirements described above should take steps to come into compliance with the those requirements.

Application of Mental Health/Substance Use Disorder Parity Requirements to CHIP

For CHIP programs, section 2103(c)(6) of the Act (amended by section 502 of CHIPRA) applies the MHPAEA provisions of the PHSA to the CHIP state plan. Thus, for CHIP programs, mental health and substance use disorder parity requirements apply to all delivery systems, including fee-for-service and managed care. To the extent that the state CHIP plan provides full coverage of the EPSDT benefit as defined in section 1905(r) of the Act, the MHPAEA requirements shall be deemed to be met under section 2103(c)(6)(B) of the Act. Otherwise, MHPAEA applies to the CHIP state plan in the same manner as the law applies to health insurance issuers and group health plans.

States not providing full EPSDT benefits under their CHIP state plan need to review CHIP state plans, contracts, and demonstrations/waiver projects in order to come into compliance with MHPAEA. States may want to consider (and potentially modify) the services offered in section 6 of the CHIP state plan. That section describes the coverage offered with respect to the amount, duration, and scope of services covered, as well as any exclusions or limitations. For example, treatment limitations on mental health services in sections 6.2.10 and 6.2.11 or substance use disorder benefits in sections 6.2.18 and 6.2.19 must be no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits such as those in sections 6.2.1 and 6.2.2. Medical management techniques used within CHIP, such as pre-authorization requirements or a step therapy approach described in section 3.2 of the state plan, applied to mental health or substance use disorder services must be comparable to and applied no more stringently than medical management techniques that are applied to medical/surgical benefits.

Similarly, states need to review the financial requirements in section 8.2 of the CHIP state plan where states identify any deductibles, coinsurance, co-pays, or other out-of-pocket cost-sharing charges and the services to which those charges apply. Finally, states need to assure that the MHPAEA requirements regarding the availability of out-of-network coverage and the

availability of information regarding criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits apply under the CHIP state plan.

States with CHIP plans that are not in compliance with the parity requirements described above should take steps to come into compliance with those requirements.

Application of Mental Health/Substance Use Disorder Parity Requirements to Managed Care Organizations

The CMS noted in its November 2009 SHO letter that mental health and substance use disorder parity requirements apply to MCOs (defined in section 1903(m) of the Act) that contract with the state to provide both medical/ surgical and mental health or substance use disorder benefits. In light of Medicaid regulations that direct states to reimburse MCOs based only on state plan services, CMS will not find MCOs out of compliance with MHPAEA to the extent that the benefits offered by the MCO reflect the financial limitations, quantitative treatment limitations, nonquantitative treatment limitations, and disclosure requirements set forth in the Medicaid state plan and as specified in CMS approved contracts. However, this does not preclude state use of current Medicaid flexibilities to amend their Medicaid state plans or demonstrations/waiver projects to address financial limitations, quantitative treatment limitations, nonquantitative treatment limitations, and disclosure requirements in ways that promote parity.

Any additional or alternative treatment limitations put in place by the MCO, however, must comply with mental health and substance use disorder parity requirements. For example, MCOs must meet the following requirements:

- Medical management techniques used by the MCO, such as pre-authorization requirements, which are applied to mental health or substance use disorder benefits must be comparable to and applied no more stringently than the medical management techniques that are applied to medical/surgical benefits.
- Any benefits offered by an MCO beyond those specified in the Medicaid state plan also must be compliant with MHPAEA.
- In accordance with MHPAEA and federal Medicaid managed care regulations at 42 CFR 438 Subpart F, the criteria for medical necessity determinations made under the plan for mental health or substance use disorder benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contracting provider upon request. The reasons for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits must be provided to plan participants and beneficiaries upon request within a reasonable time.
- When out-of-network coverage is available for medical/surgical benefits, it also must be available for mental health or substance use disorder benefits. States are responsible for assessing their contracts with all MCOs that offer medical and surgical benefits and mental health or substance use disorder benefits, to ensure that plans comply with the provisions of MHPAEA as set forth above.

In addition to MCOs, which are statutorily-defined, CMS has, by regulation, recognized entities known as Prepaid Inpatient Hospital Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). These entities provide a more limited set of state plan services (in some instances through a carve-out arrangement). CMS urges states with these arrangements to apply the principles of parity across the whole Medicaid managed care delivery system when mental health and substance use disorders services are offered through a carve-out arrangement. CMS intends to issue additional guidance that will address this issue and will continue to consider additional regulatory changes that may be necessary to properly implement MHPAEA.

MCOs that are not in compliance with the parity requirements described above should take steps to come into compliance with those requirements. States should assess their contracts with all MCOs which offer medical and surgical benefits and mental health or substance use disorder benefits to assure that plans comply with the provisions of MHPAEA. CMS will offer technical assistance to states regarding strategies for PIHPs and PAHPs to implement MHPAEA.

If you have any questions about the guidance provided in this letter, please contact Ms. Barbara Coulter Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-0325.

Sincerely,

Cindy Mann
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health Operations

Matt Salo
Executive Director
National Association of Medicaid Directors

Alan R. Weil, J.D., M.P.P.
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