MHPAEA REPORT FOR PUBLIC COMMENT

I. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) issued a final rule that applies requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid managed care organizations (MCOs), the Children's Health Insurance Program (CHIP), and Medicaid alternative benefit plans (ABPs). Delaware and its contracted Medicaid/CHIP MCOs must be in compliance with the final Medicaid/CHIP parity rule on or before October 2, 2017. This includes providing documentation of parity compliance to the general public and posting this information to the State's Medicaid website by October 2, 2017. Though not required by the rule, the Division of Medicaid and Medical Assistance (DMMA) is providing this draft documentation of compliance for public notice and comment.

In addition to providing documentation of parity compliance to the general public, the State will need to submit documentation of parity compliance to CMS. Therefore, the State has prepared this report based on CMS guidance for the documentation to be submitted to CMS so that the final report can be used to provide documentation of parity compliance to both the general public and CMS.

This draft report reflects over nine months of work by the State and its MCOs to conduct a review of the State's Medicaid/CHIP delivery system to assess compliance with the final Medicaid/CHIP parity rule. This process started in the fall of 2016 with the establishment of a cross-agency workgroup tasked with conducting the parity analysis. The workgroup included representatives from state agencies involved in the administration of the State's Medicaid/CHIP program, including:

- The Division of Medicaid and Medical Assistance (DMMA)
- The Division of Substance Abuse and Mental Health (DSAMH)
- The Department of Services for Children, Youth and Their Families (DSCYF)
- The Division of Developmental Disabilities Services (DDDS)

II. METHODOLOGY

The approach and results of each component of the analysis are discussed in detail in later sections of this report. Delaware's approach to conducting the parity analysis followed CMS guidance as outlined in the CMS parity toolkit, *"Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs"*[1] and included the following steps:

1. Identifying all benefit packages to which parity applies.
2. Determining whether the State or MCO is responsible for the parity analysis (by benefit package).

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[1] Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs, https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf

3. Determining which covered benefits are mental health or substance use disorder (MH/SUD) benefits and which are medical/surgical (M/S) benefits.
4. Defining the four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care) and mapping MH/SUD and M/S benefits to these classifications.
5. Determining whether any aggregate lifetime or annual dollar limits (AL/ADLs) apply to MH/SUD benefits.
6. Determining whether any financial requirements (FRs) or quantitative treatment limitations (QTLs) apply to MH/SUD benefits and testing the applicable financial requirement (prescription drug copayment) for compliance with parity.
7. Identifying and analyzing non-quantitative treatment limitations (NQTLs) that apply to MH/SUD benefits.

III. MEDICAID/CHIP DELIVERY SYSTEM AND BENEFIT PACKAGES

Medicaid/CHIP Delivery System

Over 90% of Medicaid/CHIP beneficiaries in Delaware are enrolled in MCOs. This includes 100% of beneficiaries in Delaware's alternative benefit plan (ABP) and 100% of beneficiaries in Delaware's separate CHIP (S-CHIP) program.[2] Delaware's Medicaid/CHIP managed care program, comprised of the Diamond State Health Plan (DSHP) and DSHP Plus, is authorized under the authority of a Section 1115 demonstration. DSHP was implemented in 1996 and requires most Medicaid/CHIP beneficiaries to receive acute physical and behavioral health care services through an MCO. In 2012, Delaware implemented the DSHP Plus program, which expanded the populations required to enroll in managed care to include dual eligibles and individuals receiving nursing facility or home and community-based services (HCBS) as an alternative to nursing facility services. It also expanded the MCO benefit package to include long-term nursing facility services and HCBS for Medicaid clients who meet the applicable level of care.

DMMA currently contracts with two MCOs, Highmark Health Options (HHO) and United Healthcare Community Health Plan (UHCP) to serve DSHP and DSHP Plus beneficiaries. Certain services, including some MH/SUD benefits, are provided fee-for-service (FFS).

Delaware has a complex MH/SUD delivery system, with MH/SUD services being covered by MCOs and/or FFS (managed by two different agencies) for different populations. MCOs are responsible for providing 30 units of MH/SUD outpatient services to members under 18; all MH/SUD benefits for members 18 and older who are not enrolled in PROMISE; and inpatient, crisis, and pharmacy services (other than medication assisted treatment for SUD) to members who are enrolled in PROMISE.[3] The MH/SUD benefits for

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[2] Delaware's CHIP program, called the Delaware Healthy Children Program (DHCP), is a combination of Medicaid expansion and a separate program. All S-CHIP beneficiaries are enrolled in MCOs as a condition of eligibility. MCOs are responsible for covering EPSDT for S-CHIP enrollees. However, the State does not currently cover non-emergency medical transportation (NEMT) for S-CHIP beneficiaries.

[3] Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) is a program authorized under the State's Section 1115 demonstration that is administered by DSAMH and provides home and community based services (HCBS) in the most integrated setting to adults 18 and older meeting targeted behavioral health diagnostic and functional limitations.

children under age 18 that are carved out of the MCOs are managed by DSCYF, and the MH/SUD benefits for adults 18 and older enrolled in PROMISE are managed by DSAMH. While there is some overlap in covered services and provider network, DSAMH and DSCYF manage separate delivery systems. In addition, while the MCOs provide many of the MH/SUD state plan benefits provided by DSCYF and DSAMH and there is some overlap in provider networks among DSCYF, DSAMH, and the MCOs, each MCO manages its own delivery system.

Benefit Packages

Delaware identified 12 benefit packages subject to the requirements in the final Medicaid/CHIP parity rule. For each benefit package, Delaware covers MH and SUD benefits in each classification in which there is an M/S benefit (all four benefit classifications).

For the purposes of the NQTL analysis, Delaware structured the benefit packages into three groups based on how MH/SUD benefits are delivered (see Table 1 below). As noted above, the MCO is responsible for providing MH/SUD benefits to adults who are not in PROMISE, and DSAMH is responsible for providing the majority of MH/SUD benefits to adults in PROMISE. The MCO is responsible for providing 30 units of outpatient MH/SUD benefits to children, and DSCYF is responsible for providing services to children who need services beyond the 30 units of outpatient or require more intensive services than those provided by the MCO. Note that as part of the NQTL request for information (see Section VIII) both the State agencies and MCOs were asked to identify any differences in the application of an NQTL within a benefit package group.

TABLE 1 – BENEFIT PACKAGE GROUPS

Adults not in PROMISE	Adults in PROMISE	Children
• DSHP adults who are not ABP nor PROMISE • DSHP adults who are ABP but not PROMISE • DSHP Plus adults who are not LTSS and not PROMISE • DSHP Plus LTSS adults who are not PROMISE	• DSHP adults who are not ABP but are PROMISE • DSHP adults who are also ABP and PROMISE • DSHP Plus adults who are not LTSS but are PROMISE • DSHP Plus LTSS adults who are PROMISE	• Medicaid children under age 18 • Medicaid children age 18 – 21 • Children in separate CHIP (under Age 18) • Children in separate CHIP(18+)

IV. DEFINITION OF MH/SUD AND M/S BENEFITS

For the purposes of the parity analysis, Delaware adopted the most recent version of the International Classification of Diseases (ICD), the ICD-10-CM, as its standard for defining MH/SUD and M/S benefits. ICD-10-CM is the current version of the ICD, which is identified in the final Medicaid/CHIP parity rule as an example of a “generally recognized independent standard of current medical practice” for defining M/S, MH, and SUD conditions.

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Delaware defined MH/SUD conditions as those conditions listed in ICD-10-CM, Chapter 5 “Mental, Behavioral, and Neurodevelopmental Disorders” with the exception of:

- The conditions listed in subchapter 1, “Mental disorders due to known physiological conditions” (F01 to F09);
- The conditions listed in subchapter 8, “Intellectual disabilities” (F70 to F79); and
- The conditions listed in subchapter 9, “Pervasive and specific developmental disorders” (F80 to F98).

Delaware defined M/S conditions as those conditions listed in ICD-10-CM Chapters 1-4, subchapters 1, 8 and 9 of Chapter 5, and Chapters 6-20.

Delaware excluded subchapter 1 from the definition of MH/SUD because these mental disorders are due to known physiological conditions (e.g., dementias, delirium, psychosis and mood disorders due to known physiological conditions) and all except one require that the physiological condition be coded first, indicating that the physiological (rather than the MH) condition is the focus of services. Delaware excluded subchapters 8 and 9 from the definition of MH/SUD because these chapters identify neurodevelopmental disorders as opposed to mental or behavioral disorders.

Excluding subchapters 8 (intellectual disabilities) and 9 (developmental disorders) from the definition of MH/SUD is consistent with the State’s current structure and practice. Services for these conditions are managed by DDDS, not by DSAMH or DSCYF. In addition, not including these disorders as MH/SUD disorders is consistent with CMS’ definition of “mental disease,” in the State Medicaid Manual (SMM) Section 4390.D, which provides as follows: “…the term ‘mental disease’ includes diseases listed as mental disorders in the [ICD-9-CM], with the exception of mental retardation, senility, and organic brain syndrome.”[4] Also, not including F70 to F79 (intellectual disabilities) and F80 to F98 (pervasive and specific developmental disorders) is consistent with the definition of “Persons with related conditions” in 42 CFR 435.1010: “Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: (a) It is attributable to (1) Cerebral palsy or epilepsy; or (2) Any other condition, other than mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons…” (sections (b) through (d) omitted; emphasis supplied).[5]

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[4] State Medicaid Manual – Part 4 Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R74SMM.pdf
[5] 42 CFR § 435.1010 - DEFINITIONS RELATING TO INSTITUTIONAL STATUS, https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol4/xml/CFR-2015-title42-vol4-sec435-1010.xml

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V. BENEFIT CLASSIFICATIONS

Delaware developed the following definitions for each of the four benefit classifications identified in the Medicaid/CHIP parity rule.

Inpatient: All covered services or items (including medications) provided to a member while in a setting (other than a home and community-based setting as defined in 42 CFR Part 441) that requires an overnight stay.

Outpatient: All covered services or items (including medications) provided to a member that do not otherwise meet the definition of inpatient, emergency care, or prescription drugs.

Emergency Care: All covered services or items (including medications) delivered in an emergency department (ED) setting or free standing emergency room.

Prescription Drugs: Covered medications, drugs and associated supplies and services that require a prescription to be dispensed. These products are claimed using the National Council for Prescription Drug Programs (NCPDP) format.

As noted above, Delaware's state plan covers MH and SUD benefits in each classification in which there is an M/S benefit.

VI. AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS (AL/ADLS)

No aggregate lifetime or annual dollar limits apply to Medicaid/CHIP MH/SUD benefits in any benefit package. Note that the 2017 MCO contract prohibits the MCOs from applying aggregate lifetime and annual dollar limits to MH/SUD benefits (see MCO contract section 3.4.12.2).

VII. FINANCIAL REQUIREMENTS (FRS) AND QUANTITATIVE TREATMENT LIMITATIONS (QTLS)

Financial Requirements

Only one financial requirement (FR), a tiered copayment for prescription drugs, applies to Medicaid/CHIP benefits. Delaware's tiered copayment for prescription drugs is based on the Medicaid cost/payment for the prescription. This tiered copayment applies to all prescription drugs and to both Medicaid FFS beneficiaries and MCO enrollees who are not exempt from the copayment. See below for the copayment schedule. The copayment amount is based on the Medicaid payment for the drug and not whether the drug is used for the treatment of a MH/SUD or M/S condition, and the same level of copayment is applied across each tier without regard to whether the drug is for the treatment of a MH/SUD or M/S condition.

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There is an out-of-pocket monthly maximum of $15. This out-of-pocket maximum applies to all prescription drugs; the out-of-pocket maximum does not apply separately to M/S and MH/SUD drugs.

Medicaid Payment for the Drug	**Copayment**
$10.00 or less	$.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

The 2017 MCO contract requires that any cost sharing comply with parity (see Section 3.4.9.1.2), prohibits the MCO from applying cumulative financial requirements separately for MH/SUD benefits (see Section 3.4.12.5), and prohibits the MCO from applying any FRs to MH/SUD benefits that do not comply with parity requirements (see Section 3.4.12.3 of the MCO contract).

Quantitative Treatment Limitations

Delaware does not apply any quantitative treatment limitations to MH/SUD benefits that cannot be exceeded based on medical necessity. Thus, these limitations were analyzed as NQTLs (see Section VIII). In addition, the 2017 MCO prohibits the MCO from applying any QTLs to MH/SUD benefits that do not comply with parity requirements (see Section 3.4.12.3 of the MCO contract).

VIII. NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTLS)

Identifying NQTLs and Information Collection

Based on the illustrative list of NQTLs in the final Medicaid/parity rule, the parity toolkit, information provided through the Substance Abuse and Mental Health Services Administration (SAMHSA) Medicaid/CHIP parity policy academy,[6] written guidance from the Department of Labor regarding the commercial parity rule (including FAQs, MHPAEA enforcement updates, and a document identifying potential "red flag" NQTLs), information from the State's consultant, and discussion during the workgroup meetings, Delaware identified a list of potential NQTLs, including NQTLs related to medical management, benefits coverage, and provider admission, and a couple of NQTLs specific to prescription drugs. DSAMH and DSCYF reviewed the list to determine which NQTLs applied to MH/SUD benefits managed by their agency. The State developed a request for information (RFI) for each agency to complete with information needed to conduct the NQTL analysis, including information on the processes, strategies, and evidentiary standards in both writing and operations for each of the NQTLs the agency applies to MH/SUD benefits managed by the state agency, by classification and benefit package. This RFI included prompts to help identify the type of information relevant to the parity analysis. Separate prompts were provided for processes, strategies, and evidentiary standards for each part of the NQTL analysis (comparability and stringency) and to collect information on how the factors apply both in writing and in operation. The information provided by each state agency was reviewed by the workgroup, which conducted follow up as necessary.

[6] Delaware applied for and was accepted as a participant in SAMHSA's Medicaid/CHIP parity policy academy (MPPA), which was designed to provide technical assistance to states to ensure compliance with parity requirements.

In addition to collecting information on NQTLs that apply to MH/SUD benefits managed by the State (referenced as the FFS MH/SUD NQTLs), the State developed a request for information (RFI) to collect information from each MCO on how the MCO applies the FFS NQTLs to MH/SUD and M/S benefits managed by the MCO as well as any additional NQTLs applied by the MCOs to MH/SUD benefits (including information on how the MCO applies those NQTLs to M/S benefits). The RFI included the list of NQTLs identified by the State as described above but also asked the MCOs to identify any other NQTLs that they apply to MH/SUD benefits. The MCOs completed a summary grid that identified which FFS MH/SUD NQTLs and other NQTLs they apply to MH/SUD benefits, by benefit package and classification, and provided information, by benefit package and classification, on the MH/SUD and M/S benefits to which the NQTL applies and the processes, strategies, and evidentiary standards for each of the NQTLs. As in the State RFI, the MCO RFI included prompts to help the MCOs provide the information needed for the parity analysis. The information provided by each MCO was reviewed by the workgroup, and the State conducted follow up as needed.

Conducting the NQTL Analysis
The State used the information from the RFIs to compare the processes, strategies, evidentiary standards and other factors for each MH/SUD NQTL as it applies to MH/SUD benefits and M/S benefits, in writing and in operation, in a classification, for each benefit package. The processes, strategies, evidentiary standards and other factors were reviewed for comparability and stringency in writing and in operation.

The NQTL analysis consisted of the following steps:

- Consolidation of the NQTL information collected from the state agencies and the MCOs into a side-by-side structure with information on MH/SUD on one side and M/S on the other side for each NQTL, by benefit package and classification. The information included the MH/SUD and M/S benefits to which the NQTL applies and a summary of the NQTL's processes, strategies, and evidentiary standards.
- Review of the side-by-side information to develop a preliminary determination for each NQTL, by benefit package and classification.
- Review and revision of the side-by-side summary information and preliminary determinations.
- MCO review of the side-by-side summary information and preliminary determinations.
- Workgroup review of the side-by-side summary information and preliminary determinations and final determination of compliance.

List of MH/SUD NQTLs
Table 2 and 3 lists the NQTLs that apply to MH/SUD benefits and the State has determined comply with parity. The table also identifies the applicable benefit package groups and classification. In the tables below, a "ü" indicates the NQTL applies to a certain benefit package(s) and classification(s). Grayed out sections in the tables below indicate the NQTL does not apply to a certain benefit package or classification.

TABLE 2 – NQTLS – MCO A

NQTL Name	Adults not in PROMISE				Adults in PROMISE				Children			
	IP	OP	EC	PD	IP	OP	EC	PD	IP	OP	EC	PD
Development/Modification/Addition of Medical Necessity/ Medical Appropriateness/Level of Care Guidelines*	ü	ü			ü	ü			ü	ü		
Prior Authorization*	ü	ü		ü	ü	ü		ü	ü	ü		ü
Concurrent Review*	ü	ü			ü	ü			ü	ü		
Retrospective Review	ü	ü			ü	ü			ü	ü		
Requiring Use of Preferred Drugs before Approving Non-preferred Agents (Step Therapy)				ü				ü				ü
Experimental/Investigational Determinations	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü
Provider Reimbursement (in-network)*	ü	ü		ü	ü	ü		ü	ü	ü		ü
Usual, Customary and Reasonable (UCR) Determinations (out-of-network provider reimbursement)	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Provider Credentialing Requirements*	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Geographic Restrictions	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Standards for Out-of-Network Coverage	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Drugs not Covered Pursuant to Section 1927(d)(2)				ü				ü				ü
Early Refills				ü				ü				ü
Copay Tiers				ü				ü				ü
Pharmacy Lock-In				ü				ü				ü

* Applies to FFS MH/SUD
IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drugs

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TABLE 3 – NQTLS – MCO B

NQTL Name	Adults not in PROMISE				Adults in PROMISE				Children			
	IP	OP	EC	PD	IP	OP	EC	PD	IP	OP	EC	PD
Development/Modification/Addition of Medical Necessity/ Medical Appropriateness/Level of Care Guidelines*	ü	ü			ü	ü			ü	ü		
Prior Authorization*	ü	ü		ü	ü	ü		ü	ü	ü		ü
Concurrent Review*	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Retrospective Review	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Requiring Use of Preferred Drugs before Approving Non-preferred Agents (Step Therapy)				ü				ü				ü
Experimental/Investigational Determinations	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü
Provider Reimbursement (in-network)*	ü	ü		ü	ü	ü		ü	ü	ü		ü
Usual, Customary and Reasonable (UCR) Determinations (out-of-network provider reimbursement)	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Provider Credentialing Requirements*	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Geographic Restrictions	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Standards for Out-of-Network Coverage	ü	ü	ü		ü	ü	ü		ü	ü	ü	
Drugs not Covered Pursuant to Section 1927(d)(2)				ü				ü				ü
Early Refills				ü				ü				ü
Copay Tiers				ü				ü				ü
Pharmacy Lock-In				ü				ü				ü

* Applies to FFS MH/SUD
IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drugs

The 2017 MCO contract prohibits the MCO from applying NQTLs to MH/SUD benefits unless the NQTL meets the applicable requirements of the Medicaid/CHIP parity rule (see Section 3.4.12.6).

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