Mental Health and Substance Use Disorder Parity Assessment and Corrective Action Plan

April 2018

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The Michigan Department of Health and Human Services (MDHHS), Medical Services Administration (MSA), has conducted an assessment of compliance with federal parity regulations, specifically 42 CFR Part 438, Subpart K and 42 CFR Part 440. The following report describes the process employed by MDHHS, the specific steps taken, the initial findings and the proposed pans to address any areas of non-compliance.

Executive Summary

Michigan has a mature managed care system for Medicaid that has, for the past twenty years, carved-out the management of specialty behavioral health services to public Prepaid Inpatient Health Plans (PIHP). This includes specialty services for persons with serious mental illness, children with serious emotional disturbance, individuals with intellectual/developmental disabilities, and services for persons with substance use disorders. The public PIHPs are a part of Michigan's public behavioral health system, which also includes county based community mental health service programs and an array of public and private provider organizations. There is also a mental health benefit for those with mild to moderate needs in the comprehensive care program, as well as in the adult Medicaid expansion APB program, managed by the Medicaid Health Plans (MHPs).

In addressing the parity of the management of the mental health/substance use disorder benefit, the MSA within the MDHHS conducted an assessment of limitations, per the CMS Parity Toolkit. As a result of the specialty behavioral health carve-out, and the varying geographic regions, this evaluation involved 66 different MHP – PIHP combinations. Consequently, a statewide approach was used, i.e., restrictions applied to a mental health/substance use disorder benefit were compared to the least restrictive similar limitation in the same classification for the medical/surgical benefit, regardless of which MHP utilized the limits. This approach promotes statewide consistency for access to the specialty behavioral health services.

The results of this assessment have been reviewed, shared with the MHPs and PIHPs and appropriate corrective actions have been planned. The results indicated:

- The only financial requirements applied to any Mental Health/Substance Use Disorder (MH/SUD) benefit are prescription co-pays. Co-pays are not applied to substantially all of the medical and surgical (M/S) benefit in the prescription drug classification, and will therefore be discontinued in the MH/SUD benefit.
- No annual dollar limits or aggregate lifetime limits are applied to any classification of the MH/SUD benefit.
- No quantitative treatment limitations have been identified in any classification of the MH/SUD benefit.
- The following non-quantitative treatment limitations were assessed: Medical necessity determinations/service authorizations, Continuing authorizations, Step Therapy or Fail First practices, Out-of-Network Provider Access, Provider Credentialing and Licensing Requirements, Refusal to Pay if Treatment not Completed, and Other Limitations to Treatment. It was determined that the medical necessity determination/authorization processes used in the Inpatient and Outpatient classifications of the MH/SUD benefit were not comparable to those used in the same classifications of the M/S benefit. This involves practices of the PIHPs. A plan to address this has been developed and is being implemented.

Work Group

An internal work group was established to lead the assessment of compliance with the regulations. This work group included members with appropriate expertise from various administrations within the MDHHS.

Additional Information and Stakeholder Input

In developing a plan to assess parity compliance, and implementing that assessment, the Work Group utilized a variety of information sources. These included the CMS Parity Compliance Toolkit, the CMS developed Frequently Asked Questions, as well as participation in state assistance calls. The Work Group also utilized information from multiple other states.

Throughout the Parity assessment process, the internal workgroup gave regular presentations, providing updates to and seeking input from, various stakeholder groups. Parity compliance is a regular, monthly agenda item with the MHPs and PIHPs. The primary MH/SUD service delivery system is the Community Mental Health Services Programs (CMHSPs) located throughout the state, including every County. Parity updates and discussions were provided to CMHSP Directors' meetings, as well as the stateside CMHSP conferences. Conferences included the general statewide conference for Board members, staff, and other stakeholders, as well as a specialty conference bringing finance, quality improvement, information management, provider network management and compliance staff together. Additionally, Parity updates have been provided to the Medical Care Advisory Committee and other various advocacy meetings.

Assessment Process, Results, and Actions

Application of Rule

Rules found in 42 CFR Part 438, Subpart K, apply most of the provisions of the Mental Health Parity and Addictions Equity Act of 2008 to Medicaid. Specifically, the rules pertain to those Medicaid beneficiaries enrolled in managed care, and applies to all benefits provided to the beneficiary, whether through the managed care arrangement or through fee for service. The rules also apply to coverage provided by Medicaid alterative benefit plans (ABPs) and Children's Health Insurance Programs (CHIPs).

The Healthy Michigan Plan, the State's Medicaid adult expansion program, utilizes an Alternative Benefit Plan (ABP) to delineate the healthcare services available to eligible beneficiaries. As part of the ABP review and approval process, the State received confirmation from the Center for Medicare & Medicaid Services (CMS) that the program benefits complied with the parity requirements. Since the Healthy Michigan Plan ABP aligns with the state plan benefits offered through the state's managed care organizations, all provisions were essentially reassessed as part of this compliance assessment.

In January of 2016, Michigan converted its CHIP funded MIChild program to a Medicaid expansion program. As part of this process, the state used its State Plan as the vehicle for development and management of its CHIP program coverage which includes benefits under

EPSDT benefits. As such, the benefits are included in this assessment of Medicaid services and would be deemed compliant under 1905 (r) of the Social Security Act.

The state's other CHIP funded program, Maternity Outpatient Medical Services (MOMS), provides health coverage which is limited to pregnancy-related services for pregnant women who are eligible for Emergency Services Only (ESO) Medicaid. Since this program does not provide mental health or substance use disorder benefits, the mental health parity requirements do not apply according to regulations.

In Michigan, this results in the parity assessment applying to enrollees in traditional Medicaid comprehensive healthcare coverage programs enrolled through Medicaid Health Plans (MCOs) and enrollees in the Medicaid expansion program, Healthy Michigan Program, managed by these same Medicaid Health Plans.

The specialty behavioral health benefits, including benefits for adults with a serious mental illness (SMI), children with a serious emotional disturbance (SED), persons with intellectual/developmental disabilities (I/DD) and persons with a substance use disorder (SUD) are "carved out" of the comprehensive health care program and managed via public Prepaid Inpatient Health Plans (PIHPs). This is for both the Medicaid beneficiaries and the ABP (Healthy Michigan) beneficiaries.

Responsibility for Parity Assessment

Because of the "carve out" of mental health/substance use disorder benefit, except for outpatient services for those with a mild mental health need, the responsibility for assessing and ensuring compliance with parity regulations rests with the state Medicaid agency. Currently, there are 11 MHPs managing the physical health benefit, including a mental health benefit for those with mild to moderate mental health needs. There are 10 PIHPs managing the mental health and substance use disorder benefit.

Due to varying geographic regions, there are 66 possible MHP-PIHP combinations. As such, the decision was made to assess parity from a statewide perspective. To achieve this, all limitations applied to any classification in mental health/substance use disorder (MH/SUD) benefits will be compared to the least restrictive similar limitation applied by any of the 11 MHPs in the same classification for M/S benefits. This approach not only results in a more understandable assessment, but more importantly, it ensures statewide consistency in the application of any limitations to the MH/SUD benefit.

Michigan's Medicaid program includes a number of benefit plans under a variety of financing authorities. The list of benefit plans is as follows:

- Habilitation Supports Waiver Program
- Healthy Michigan Plan – Managed Care
- Medicaid Managed Care
- MiChild Program (CHIP)
- Home and Community Based Waiver Services – Managed Care
- Prepaid Inpatient Health Plan
- PIHP Healthy Michigan Plan
- Children's SED Waiver Program

Within the managed care structures, including contracts with MCOs and PIHPs, the administration of the Medicaid benefit, as relates to the parity of limitations, is consistent across these various benefit plans. To streamline the analysis of financial limitations, quantitative limitations and non-quantitative limitations, MDHHS rolled up the benefit packages into a single analysis.

Defining Medical/Surgical (M/S) vs. Mental Health/Substance Used Disorder (MH/SUD) Benefits

The CMS Parity Compliance Toolkit provides direction for determining which Medicaid benefits are mental health/substance use disorder (MH/SUD) benefits and which are medical/surgical (M/S) benefits. Essentially, items and services provided to treat a mental health or substance used disorder condition are MH/SUD benefits. Items and services provided to treat a medical condition that is not mental health or substance use disorder are M/S benefits. The rules, and the Toolkit, also specify that the determination of what is a mental health or substance use disorder condition be based on a nationally recognized standard.

The Work Group determined that the International Classification of Diseases (ICD 10) would be the nationally recognized standard for determining MH/SUD and M/S benefits.

Mapping Benefits to Classification

The parity regulations require that all benefits be mapped to one of four classifications: inpatient, outpatient, prescription drugs and emergency care. Again, the CMS Parity Compliance Toolkit provides guidance on this task. Mapping to classifications must be based on generally accepted consensus, and shall not be arbitrary. The regulations also allow for a "sub-classification" with the Outpatient classification for Office Visits. Michigan decided not to use this sub-classification. Therefore, the mapping of benefits to classifications is based on these definitions:

> Inpatient Services – all services provided in a 24 hour setting, requiring a physician order for admission. Includes all covered accommodations, services and items, including medications that the facility provides.
>
> Prescription Drugs – all covered medications, drugs and supplies requiring a prescription and dispensed at an outpatient pharmacy.
>
> Emergency Care – all services provided in, or relating to, an emergency department for an emergency situation.
>
> Outpatient Services – all covered services that do not meet the definition of Inpatient, Prescription Drugs and Emergency Care. This includes services provided in offices, group homes, outpatient hospitals, agencies, at home or in the community.

Attachment 1 provides the classification definitions and mapping.

Developing Survey Instruments
As noted previously, due to the behavioral health carve-out, and the multiple MHP-PIHP combinations for coverage, the State bears the responsibility for conducting the parity assessment. In order to collect the necessary information, the Work Group sought examples of surveys that would facilitate reporting potential limitations to both MH/SUD benefits and M/S benefits. After reviewing the limited examples available, the Work Group used these examples as a starting point for its work.

The Work Group was able to develop two survey instruments to align with Michigan's managed care structure. It was decided that Michigan would utilize separate survey instruments for the PIHPs and MHPs, while ensuring that this approach recognized the limited MH/SUD benefit managed by the MHPs.

Once modified, the survey instruments were shared with the MHPs and PIHPs. Meetings were held with each group to solicit input, answer questions, and plan for completion of the surveys. The feedback received from each group was incorporated, as appropriate, into the survey instrument.

Each MHP completed a survey instrument and provided supporting documentation. Each PIHP completed a survey, and included CMHSPs within their region, in their answers. Responses varied significantly is detail and size. The information provided, as well as follow-up information requested, allowed for an assessment of compliance with the parity regulation.

Internal Analysis
In addition to collecting information from PIHPs and MHPs regarding potential limitations on benefits, the Work Group also examined state policy and practice, contractual requirements, and the Medicaid Provider Manual to identify any potential limitations that may be inadvertently imposed. The following potential limitations were identified and reviewed by the Work Group:

- Michigan Mental Health Code requirement for assessment for psychiatric inpatient admission,
- Medicaid Provider Manual references to amount of service for SED and Child Waiver,
- Autism Benefit requirements for determining eligibility, and
- Medical Necessity determination and Service Authorization for Autism Benefit.

Michigan Mental Health Code requirement for assessment for psychiatric inpatient admission.
Section 330.1410 of P.A. 258 of 1974, as amended, commonly referred to as the Michigan Mental Health Code, requires that individuals seeking admission to a psychiatric inpatient unit under contract with a CMHSP may only be admitted upon authorization by a CMHSP. The intent of this requirement is not to limit access to the inpatient benefit, but to ensure individuals are served in the least restrictive, appropriate setting. Upon review, it was determined that the inpatient screening process required under the statute is, indeed, a diagnostic process to determine current functional impairment. For purposes of this parity analysis, the authorization process, which is a non-quantitative treatment limitation, begins after the diagnostic process has been completed.

Medicaid Provider Manual references to amount of service for SED and Child Waiver

Michigan operates two Waivers specifically for children: the Children's Serious Emotional Disturbance Home and Community Based Waiver (SED Waiver) and the Children's Waiver Community Living Support Services Waiver (Child Waiver). Both of these waivers are currently operated in a fee for service structure, managed by the State. However, the waiver services are available to individuals enrolled in managed care, and therefore are a part of the parity assessment.

The SED Waiver covers a variety of services which are managed through the Community Mental Health Services Program (CMHSP). Once an individual is determined to be eligible for the Waiver and is enrolled, the management of the services, including any limitations, is consistent with the specialty behavioral health services managed by the PIHP/CMHSP system. The only potential limitations are NQTLs relating to prior and continued authorization. This is included in the findings and corrective actions noted below.

The Child Waiver is structured differently. Specific service levels are detailed in the Michigan Medicaid Provider Manual. These service levels and amounts are recommendations and do not constitute a set, hard limit. As such, they are an NQTL and subject to tests of comparability and stringency. Unlike other services provided through the CMHSP system, authorization for Child Waiver services is provided by the Michigan Department of Health and Human Services (MDHHS). Criteria, as specified in the Michigan Medicaid Provider Manual provide various ranges of services specific to levels of need, based upon needs and functioning of the beneficiary and the beneficiary's family and caregivers.

The criteria for authorization of Child Waiver services, developed with clinical input by the MDHHS with CMS support, and applied by the MDHHS, while not a national standard, do provide a level of objectivity comparable to the standards utilized in similar limitations to Medical/Surgical benefits in the Outpatient Classification. Processes give beneficiaries and providers the right to appeal denials and to seek retrospective authorization, and therefore are no more stringently applied than similar limitations. As such, the limitations applied to the Child Waiver service are determined to be compliant with the parity regulations.

Autism Benefit requirements for determining eligibility

The Autism Benefit was initially provided under a 1915i State Plan Amendment approved by CMS. The benefit has since been expanded and is a part of the state plan, no longer utilizing the 1915i SPA. As part of the State Plan, this is deemed compliant under the EPSDT provisions.

Medical Necessity Determination and Service Authorization for Autism Benefit

While Autism services, as part of the EPSDT, are compliant, the current language in Michigan's Medicaid Provider Manual is confusing.

The Medicaid Provider Manual, as currently written, does not provide a clear distinction between the diagnostic process and the medical necessity/authorization process. This will be corrected to avoid confusion.

Evaluation and Identification of Limits

As previously explained, information regarding various limitations was gathered from each MHP and PIHP in the state. These surveys sought information regarding potential limitations as defined in the regulations. Additionally, plan Member Handbooks were reviewed as necessary to provide clarity and confirmation.

The federal parity regulations, at 42 CFR Part 438.900 provide a description of the various limits subject to the parity analysis. These are the limits and definitions used by the State of Michigan in conducting this parity assessment.

Financial Requirements

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums.

Aggregate Lifetime and Annual Dollar Limits

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a MCO, PIHP, or PAHP. Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12 month period under a MCO, PIHP, or PAHP.

Treatment Limitations – Quantitative and Non-quantitative

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a 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.

Section 438.910(d)(2) provides an illustrative list of non-quantitative treatment limitations, including: medical management standards (medical necessity criteria), formulary designs for prescription drugs, multiple network tiers, provider network admission standards, methods for determining usual, customary and reasonable charges, fail first policies or step therapies protocols, exclusions based on failure to complete a course of treatment, restrictions based on geographic location, facility type, provider specialty or other criteria that limit the scope or duration of benefits, and standard for providing access to out-of-network providers.

Findings

Financial Requirements

The only Financial Requirements applied to any MH/SUD benefit is a tiered copay for certain prescription drugs. This copay is attached to certain M/S drugs as well. However, because it is not uniformly applied to the M/S benefit by all Medicaid Health Plans, an analysis was required.

The analysis included all outpatient pharmacy claims for six months (4/1/17 – 9/30/17). The initial data review separated out the ABP from the rest of Medicaid. It was found that copay requirements were applied to only 26% and 32% of the total dollars in the pharmacy classification of the M/S benefits, respectively. As such, no further analysis was completed. It was determined that the copay is NOT applied to substantially all of the prescription drugs classification of the M/S benefit and therefore, cannot be applied to the prescription drug classification in the MH/SUD benefit.

Aggregate Lifetime and Annual Dollar Limits
There are no aggregate lifetime or annual dollar limits applied to any classification of the MH/SUD benefit. Therefore there is no parity analysis required.

Quantitative Treatment Limitations
There are no hard number limits set on any MH/SUD benefit. While certain programs include specific numbers or amounts of service, additional sessions or services may be requested when medically necessary. This equates to a non-quantitative treatment limitation, and is addressed in that section. As there are not QTLs, no parity analysis is required.

Non-quantitative Treatment Limitations
MDHHS collected information from Medicaid Health Plans (MHPs) and Prepaid Inpatient Health Plans (PIHPs) regarding many potential NQTLs, including:

- Medical necessity determinations/service authorizations
- Continuing authorizations
- Step Therapy or Fail First practices
- Out-of-Network Provider Access
- Provider Credentialing and Licensing Requirements
- Refusal to Pay if Treatment not Completed
- Other Limitations to Treatment

Information collected from the MHPs and PIHPs revealed the following:

- Medical necessity determinations/service authorizations, both initial and ongoing, are applied to the Inpatient and Outpatient classifications for both M/S and MH/SUD benefits. It was also determined that the evidentiary standards applied in both classifications for MH/SUD are not consistently comparable to those applied in both classifications of the M/S benefit. The current structure was determined to not be in compliance with the parity regulations.

  Authorization processes for the specialty Autism Benefit differ from other processes found in the MH/SUD benefit. The State has identified practice guidelines, published by the Behavioral Analyst Certification Board, as the standard for these services. This evidentiary standard is comparable to those found in the M/S Outpatient Classification. These are compliant with the parity requirements.

- Step Therapy or Fail First practices are not applied in the any classification of the MH/SUD benefit. Therefore, no parity issues exist.

- Out-of-Network providers are available in all classifications for both M/S and MH/SUD benefits. Processes for obtaining approval of out-of-network providers are comparable and no more stringently applied in the MH/SUD benefit. There is no parity issue.
- Provider Credentialing and Licensing requirements are followed for both M/S and MH/SUD benefits. In all cases, licensing requirements are consistent with state mandated licensing requirements. Credentialing processes are consistent with either NCQA requirements (MHPs) or state contractual requirements (PIHPs). No parity issues are identified.
- Refusal to Pay if Treatment not Completed. This practice is not applied in any classification of MH/SUD benefit. No parity issue exists.
- Other Limitations to Treatments. Each MHP and PIHP was asked to identify any other limitations that are in place. No additional limitations were identified. Additionally, the PIHPs were asked about prescribing practices and requirements for anti-psychotic medications. Only medically necessary and appropriate laboratory tests are required. No parity issues were identified

Corrective Actions

Pharmacy Co-Pays
The Michigan Department of Community Health will end copays for all MH/SUD prescription drugs. This process for this change includes policy promulgation and various system changes to remove copay requirements. It is expected that all changes will be completed by October 1, 2018.

NQTLs: Prior and continuing authorization process for MH/SUD in both Inpatient and Outpatient Classifications
The changes necessary to comply with the parity regulation apply to the medical necessity determination and service authorization processes (initial and ongoing) employed by much of the PIHP/CMHSP system. This is true for both the inpatient and outpatient classifications. It was found that in many PIHPs, or in CMHSPs where this function is delegated, the evidentiary standard for such determinations is based on either the Michigan Medicaid Provider Manual or local clinical practice. This evidentiary standard is not comparable to the nationally recognized standards (Interqual or MCG) used in the M/S benefit.

In response to this finding, a workgroup consisting of representatives from each of the 10 PIHPs has been convened. This group has developed a plan, for all ten PIHPs in Michigan, to achieve compliance. This plan includes the following steps:

- Acute Care Services
  - The PIHPs will issue an RFP for the selection and purchase of a nationally recognized standardized tool for acute care medical necessity determinations, including prior and continuing stay authorizations.
  - Upon selection of a tool and execution of appropriate contracts, training and implementation will begin. Full use of the tool will be in place by September, 2018.
- Non-Acute Care, Community Based Waiver Services

    - If the tool selected for Acute Care Services includes necessary standards for Waiver services, then that will be implemented along with the Acute Care solution.
    - For services not addressed through the previous step:
        - Adults with SMI – The PIHPs will utilize the Level of Care Utilization System (LOCUS) to support medical necessity and service authorization processes. This tool is currently in use, but not for the authorization process. This will be done system wide by October 2018.
        - Children with SED – The PIHPs will utilize the Devereux Early Childhood Assessment (DECA), the Preschool and Early Childhood Functional Assessment Scale (PECFAS), and the Child and Adolescent Functional Assessment Scale (CAFAS) to support medical necessity and service authorization processes. These scales are currently in use, but not consistently used for authorization. This will be done system wide by October 2018.
- Services to Persons with I/DD
    - PIHPs currently use the Supports Intensity Scale, a nationally standardized instrument, to document needed levels of supports and services for individuals with I/DD.
    - Standardized authorization guidelines, utilizing the Supports Intensity Scale to inform level of care authorizations, will used by the PIHPs.
    - This will be done system wide by October 2018.

As noted previously, the Michigan Medicaid Provider Manual includes specific requirements for determining eligibility for the Autism Benefit provided. Eligible diagnostic determination is not an NQTL. However, the Medicaid Provider Manual, in detailing the requirements, intersperses reference to medical necessity determination. The specific requirements listed apply only to the diagnostic and eligibility determination, and not the determination of medical necessity for the services to be authorized. In order to avoid confusion, this language in the Medicaid Provider Manual will be amended. This process includes:

1. Determination of appropriate language.
2. Policy Promulgation
3. Publication of Medicaid Manual Changes

Information Requirements and Parity Compliance Monitoring

Each Medicaid Health Plan and each Prepaid Inpatient Health Plan is contractually required to comply with all applicable federal regulations, including the information requirements in the parity regulations (42 CFR Part 438), specifically 438.915 Availability of Information. The Michigan Department of Health and Human Services (MDHHS) will monitor that each plan maintains compliance with these provisions.

The MDHHS will work with the PIHP/CMSHP system to ensure that the necessary changes to achieve full compliance are successfully implemented. Additionally, the Behavioral Health and Developmental Disabilities Administration, within the MDHHS will incorporate appropriate parity compliance testing in its regular contractual monitoring of the PIHPs and CMHSPs. The Medical Services Administration within the MDHHS will similarly test ongoing compliance by the MHPS as appropriate.

ATTACHMENT 1: Classification Mapping

Mapping of MH/SUD and MED/SURG Benefits

	MH/SUD	MED/SURG
Inpatient	All benefits and services provided while admitted to: • Inpatient Psych Facility • Medications given during admission	All benefits and services provided while admitted to: • Hospital • Inpatient Rehabilitation • Medical Detox • Nursing Home • Inpatient Hospice • Medications given during admission
Outpatient	All benefits and services provided that are not in other classifications. Examples: • Therapy • Medication give during Office Visit • Residential • Intensive Outpatient • Sub-Acute Detox • ACT • CLS • Personal Care • Psycho-social Rehab • Crisis Residential	All benefits and services provided that are not in other classifications. Examples: • Therapy • Medication given during Office Visit • Residential • Outpatient Surgeries • Physical Therapy • Occupational Therapy • Outpatient Hospice
Prescription Drugs	All prescription drugs and supplies requiring a prescription dispensed at a free standing pharmacy	All prescription drugs and supplies requiring a prescription dispensed at a free standing pharmacy
Emergency Care	All services and benefits provided in, and related to, an Emergency Department, including • Physician • Medications • Assessments • Emergency transportation	All services and benefits provided in, and related to, an Emergency Department, including • Physician • Medications • Assessments • Emergency transportation