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**Frequently Asked Questions:  
Mental Health and Substance Use Disorder Parity Final  
Rule for Medicaid and CHIP**

March 29, 2016

**Q1. How does the final rule impact Medicaid and the Children’s Health Insurance Program?**

**A1.** Under this final rule, CMS applies certain mental health and substance use disorder parity provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) to the coverage provided to the enrollees of Medicaid managed care organizations (MCOs), Medicaid alternative benefit plans (ABPs), and Children’s Health Insurance Program (CHIP) to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits in these programs.

**Q2. Why are the regulations needed?**

**A2.** CMS believes a regulation specific to MHPAEA’s application to Medicaid and CHIP is important because the final rules applying MHPAEA to the commercial market do not currently apply to Medicaid and CHIP. The statutory provisions applying specific MHPAEA provisions to Medicaid managed care organizations, Medicaid alternative benefit plans, and CHIP are stated generally and do not include significant detailed provisions. In the absence of a Medicaid or CHIP-specific regulation, states and plans may not have the necessary guidance to implement the parity requirements for these programs in a uniform manner. CMS believes that adopting these regulations for Medicaid and CHIP will implement existing statutory provisions but also better align regulation of Medicaid and CHIP with commercial product regulation.

**Q3. How does the final rule impact Medicaid and CHIP beneficiaries?**

**A3.** Medicaid beneficiaries enrolled in Medicaid managed care organizations or receiving benefits through Medicaid alternative benefit plans will benefit from the final rule. This includes beneficiaries who receive medical and surgical benefits through a managed care organization, but whose mental health and substance use disorder benefit are provided through fee-for-service. Similarly all CHIP beneficiaries, regardless of delivery system, will benefit from the protections in the final rule. Coverage for Medicaid benefits for beneficiaries that are not enrolled in an MCO and receive non-ABP state plan benefits offered under a fee-for-service basis is not subject to these parity standards.

**Q4. How does the final rule apply to long term care services for mental health and substance use disorders?**

**A4.** Although the proposed rule did not apply to long term care services, the final rule applies parity protections to long term care services for mental health and substance use disorders

in the same manner that these protections apply to other services for these conditions. This approach will improve the quality of care for beneficiaries with mental health and substance abuse disorders by requiring that states and plans apply MHPAEA-compliant treatment limitations consistently across all mental health and substance use disorder services rather than only a subset of services. This approach will also improve simplicity and transparency for beneficiaries and ease of administration of the regulation. Because few states that offer long term care services for mental health and substance use disorders apply quantitative treatment limits to these services, we believe that the financial impact of this policy will be minimal in most states.

**Q5. Does the final rule allow for cost exemption for Medicaid managed care organizations?**

**A5.** In contrast to the MHPAEA regulations for the commercial market, the final rule does not include an increased cost exemption for Medicaid managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans. Instead, this rule allows states to include the cost of providing services beyond what is specified in the state plan into the actuarially sound rate methodology, so long as services beyond what is specified in the state plan are necessary to comply with mental health and substance use disorder parity requirements. This may include adding services or removing or aligning treatment limitations in managed care benefits. Given that the actuarially sound payment methodology will take into account the costs of compliance with parity requirements, Medicaid rather than the plan will bear the costs of these changes. Therefore, CMS does not believe that Medicaid managed care entities will incur any net increase in costs as a result of this final rule. This is different from the circumstances of the commercial market and removes the rationale for an increased cost exemption for Medicaid managed care organizations, prepaid inpatient health plans and prepaid ambulatory health plans.

**Q6. What options do states have if their plans do not meet the requirements under the final rule?**

**A6.** States have two options if they find that the benefit package provided to enrollees of Medicaid managed care organizations does not meet the requirements of these final rules:

- Change their state plan so that the service package in the state plan complies with these final rules; or
- Add benefits, or remove or align any relevant treatment limitations or treatment limitations in the benefit package provided to enrollees of the Medicaid managed care organizations without making any change to the service in the non-ABP state plan as a whole.

If a state chooses the second option, in order to ensure that the Medicaid managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans receive appropriate funding for the delivery of those services, the payment provisions at 42 CFR §438.6 have been revised to allow the state to include those additional services when developing actuarially sound rates.

**Q7. What is a state's responsibility under the final rule?**

- A7.** This final regulation requires the state to determine whether the overall delivery system complies with the provisions of this final rule, including when some MH/SUD services are not included in the MCO benefit package. In states where the Medicaid managed care organization has sole responsibility for offering medical/surgical and mental health/substance use disorder services, the Medicaid managed care organization is responsible for undertaking the parity analysis and informing the state what changes are needed to the Medicaid managed care organization contract to comply with the provisions of this final rule.

In states where some or all mental health and substance use disorder services for enrollees of Medicaid managed care organizations are provided through some combination of Medicaid managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans, the state has the responsibility for undertaking the parity analysis across these delivery systems and determining if the benefits and any financial requirements or treatment limitations are consistent with this final rule. In addition, states must make available documentation of compliance with these final regulations to the general public within 18 months of the publication date of this rule.

For CHIPs, the state is responsible for ensuring parity regardless of the delivery system, and is responsible for making the corresponding changes in the state plan.

**Q8. How will CMS ensure compliance with this rule?**

- A8.** States have the responsibility of administering the state plan in compliance with federal law, so states are required to provide an assurance of compliance with parity requirements when submitting ABP or CHIP state plans. This rule requires the state Medicaid agency to include contract provisions requiring compliance with parity requirements in all applicable contracts with managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans. These provisions must ensure that all of the Medicaid managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans included in the delivery system work together to ensure any MCO enrollee in a state is provided access to a set of benefits that meets the requirements of this rule regardless of the mental health and substance use disorder benefits being provided by the Medicaid managed care organization.

**Q9. How long do states have to comply with the final rule?**

- A9.** Under the final rule, states have up to 18 months after the date of the publication of the final rule to comply with the finalized provisions. This timeframe allows states sufficient time to take any actions needed to comply with the final rule, which may include budget requests to add new services or additional service units, contract changes to their Medicaid managed care organizations, prepaid inpatient health plans and prepaid ambulatory health plans contracts, and obtaining approval from CMS to make changes to their non-ABP state plan for services delivered through fee-for-service (if they so choose).

**Q10. Where can I find additional information on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act?**

- A10.** Additional information can be found at:

<http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=27169>  
<http://www.dol.gov/ebsa/faqs/faq-aca17.html>  
<http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html>  
<http://www.dol.gov/ebsa/faqs/faq-mhpaeaimplementation.html>

**Q11. Where can I find additional information on the final rule?**

**A11.** Additional information can be found on Medicaid.gov at:

<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html>