



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

September 2, 2010

Dear Director:

The Centers for Medicare and Medicaid Services (CMS) has determined that the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which is effective for plan years beginning after October 3, 2009, applies to Medicaid managed care plans. The State Insurance Department issued guidance to commercial MCOs via Circular Letter No. 20 in September 2009 and it is expected that additional guidance will be forthcoming.

An interim final rule implementing MHPAEA was published in the Federal Register on February 2, 2010 and was effective April 5, 2010. While it is anticipated that federal regulations specifically addressing government programs will be issued at a later date, the Department requests that Medicaid managed care plans review their policies and operations to ensure that they are in compliance with MHPAEA and the current interim final regulations for group health plans. This letter addresses those requirements in the regulation that are most relevant to the Medicaid managed care program, the quantitative and non-quantitative treatment limitation requirements in the law.

MHPAEA generally requires that if a health plan provides both medical/surgical benefits and mental health or substance use disorder (behavioral health) benefits, financial requirements or treatment limitations may not be applied to behavioral health benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the classification. Treatment limitations are grouped into quantitative and non-quantitative limitations.

Quantitative and non-quantitative treatment limitation requirements must be assessed within six benefit classifications: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency care; and, prescription drugs. Parity must be ensured between behavioral health and medical health benefits within each of the six classifications for both quantitative and non-quantitative treatment limitations. **Quantitative treatment limitations** include limits on benefits based on the frequency of treatment, number of visits, days of coverage, or other limits on the scope or duration of services. **Non-quantitative treatment limitations** include, but are not limited to:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is

experimental or investigative (medical management standards are implemented through processes such as preauthorization, concurrent review, retrospective review, case management and utilization review);

- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and,
- Exclusions based on failure to complete a course of treatment.

Non-quantitative treatment limitations are prohibited to the extent that any of the plan's processes, strategies, evidentiary standards or other factors are not comparable to or are applied more stringently to behavioral health benefits as compared with medical/surgical benefits. These requirements apply both to written factors and to plan operations. Variations in the application of limitations are permitted only to the extent that recognized clinically appropriate standards of care allow a difference.

Some examples of non-quantitative treatment limitations are included in the regulation. ***Prohibited treatment limitations*** include requiring concurrent review for inpatient in-network behavioral health benefits while applying retrospective reviews for inpatient in-network medical/surgical benefits. This is unacceptable because the concurrent review process is not comparable to the retrospective review process. While different review processes may be permissible in certain individual cases based on recognized clinically appropriate standards of care, it is not permissible for distinguishing between all medical/surgical benefits and all behavioral health benefits. An ***acceptable treatment limitation*** would be the practice of basing medical necessity determinations on evidentiary standards developed from recommendations made by panels of experts with appropriate training and experience in each field of medicine. Although the evidentiary standards are applied in a manner that may differ based on clinically appropriate standards of care for a condition, this practice complies with MHPAEA because the non-quantitative treatment limitation – medical appropriateness – is the same for both behavioral health and medical/surgical benefits and the processes for developing the evidentiary standards and the application of these standards to behavioral health benefits are comparable to and are applied no more stringently than for medical/surgical benefits.

The MHPAEA also includes certain disclosure requirements. While Medicaid managed care plans are currently required to provide the criteria for medical necessity determinations for behavioral health services to any current or potential enrollee upon written request, the new regulations also require such disclosure to any contracting provider and do not require a written request. In addition, the regulations require plans to disclose, upon request by an

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enrollee, the reason for a claim denial within a reasonable time and in a reasonable manner, and that compliance with 29 CFR 2560.503-1 satisfies this requirement. As Medicaid managed care plans are required by CMS to comply with 42 CFR 438.210 and 438.400, we believe this disclosure provision is satisfied by existing notice requirements as described in Appendix F of the Medicaid managed care model contract. The full text of the regulation can be found at: <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf>

The Department is requesting Medicaid managed care plans to review any relevant policies and operations, including but not limited to utilization review policies, step therapy or similar policies, quantitative benefit limitations and disclosure policies, to ensure parity between medical and behavioral health policies and operations consistent with the MHPAEA and the interim regulations. Plans that delegate operational responsibilities to Behavioral Health Organization (BHO) must also ensure that BHO policies and operations are in compliance with the MHPAEA and interim regulations as applicable.

Feel free to contact me or Vida Wehren should you have additional questions.

Sincerely,



Vallencia Lloyd
Director, Division of Managed Care

CC: Ms. Frescatore
Mr. Fiore
Ms. Piel
Mr. Macielak
Mr. Iselin