STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: August 29, 2017

TO: Ms. Nicole Cunningham, DMMA
Planning & Policy Development Unit

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 21 DE Reg. 158 [DMMA Notice: MHPAEA (Mental Health Parity and Addiction Equity Act) Compliance (8/1/17)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMAs) notice on its plan/approach to determining compliance of the Delaware Medicaid and CHIP programs with federal parity law, i.e., the Mental Health Parity and Addiction Equity Act (MHPAEA). The Notice was published as 21 DE Reg. 158 in the August 1, 2017 issue of the Register of Regulations.

The Division of Medicaid & Medical Assistance (DMMA) is soliciting comments on its plan/approach to determining compliance of the Delaware Medicaid and CHIP programs with federal parity law, i.e., the Mental Health Parity and Addiction Equity Act (MHPAEA). CMS issued final regulations in 2016 [81 Fed Reg. 18390 (March 30, 2016)] and Delaware is required to comply with the regulations no later than October 2, 2017. See 21 DE Reg. 158, 159 (8/1/17). A CMS summary of the MHPAEA is attached. DMMA clarified in an August 3 email to the DLP that it is soliciting comments on the process used to determine whether Delaware is compliant with the federal regulation, not whether Delaware is actually compliant.

Relevant documents are available through the DMMA website: http://dhss.delaware.gov/dhss/dmma/info_stats.html. The 9-page Report offers background on the methodology used to develop Delaware's assessment of compliance with the MHPAEA.

The SCPD has the following observations.

First, the Report is the product of a 9-month review which was ostensibly limited to State agencies and MCOs with zero private provider and consumer input:

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)

Report, p. 1.

Although the CMS regulation does not require involvement of other stakeholders, it does "encourage" states to do so as preferred practice:

> Although we are not requiring states to work with stakeholders and other public interests to determine the best way to comply with these rules, we believe that states will need to discuss options with stakeholders in their current delivery systems to be able to ascertain the best delivery system for any additional benefits that may be required. We also encourage states to have discussions with stakeholders other than their providers and plans to ensure they achieve compliance in the best way for their beneficiaries.

81 Fed Reg. at 18415.

The validity and reliability of the approach adopted in the Report may be viewed as suspect without the benefit of consumer input.

Second, the definitions of mental health and substance abuse disorders subject to application of the parity law merits review. DHSS generally adopts conditions listed in ICD-10-CM, Chapter 5 "Mental, Behavioral, and Neurodevelopmental Disorders" with several exceptions. At p. 4. For example, DHSS is excluding dementia as well as psychosis and mood disorders attributable to physiological conditions:

> 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.

Report, at p. 4.

This approach is troubling. Excluding mental health disorders because of a correlation with physiological etiology is the polar opposite of the approach adopted in Delaware's State parity law. The Delaware parity law requires a biological basis for a mental health condition as a prerequisite of application of the parity law:

> "Serious mental illness" means any of the following biologically based mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo affective disorder, and delusional disorder.

See H.B. No. 41 enacted May 30, 2017.

The focus of the federal parity law was not on the catalysts and causes of a mental illness. Rather, the intent of the federal law is best promoted through adoption of a liberal approach to definitions of mental health and substance abuse disorders.

Third, DHSS is excluding not only mental disorders due to physiological conditions but neurological conditions as well:

> Delaware excluded subchapters 8 and 9 from the definition of MH/SUD because these chapters identify neurodevelopmental disorders are opposed to mental or behavioral disorders.

Report, at p. 4. If the DHSS approach results in exclusion of brain injuries, it is an unfortunate result which will have a disproportionate effect on veterans who suffered service-connected brain trauma.

Fourth, the DHSS description of its ICD-10 coding approach implies that secondary codes may be ignored or overlooked when assessing application of parity law. See above reference, "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." There may be occasions when a treatment modality addresses both mental and physical impairments. For example, prescribing a medication to alleviate headache or pain for a patient with depression could be justified under both mental and physical bases. Alternatively, someone with autism (ostensibly unqualified for protection under the intellectual or pervasive developmental disorder exclusion) may have a secondary mental health diagnosis (e.g. intermittent explosive disorder; depression). A treatment may be prescribed to address a mental health condition which should trigger application of the parity law. Cf. inclusion of "behavioral health treatment", "pharmacy care", and "psychiatric care" in the definition of "treatment of autism spectrum disorders" in the autism parity law [Title 18 Del.C. §§3366(e) and 3370A(e)].

Fifth, the Report ignores overlapping State laws which promote parity. See 18 Del.C. §§3366 and 3570A and 18 Del.C. §§3343 and 3578. The latter statutes specifically incorporate some standards from the federal parity law [18 Del.C. §§3343(b)(1)a.2 and 3578(b)(1)a.2]. If there are State law provisions which reinforce or overlap with the federal parity law, they should preferably be included in the Report.

Sixth, the DHSS approach to "quantitative treatment limitations" should be reconsidered. The description is as follows:

> 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 (non-quantitative treatment limitations) (see Section VIII).

Report, at p. 6.

The problem with this approach is that it ignores presumptive limits. For example, if an MCO employed presumptive limits for 90% of mental health drugs and only 10% of physical health drugs, the parity standards are not met. Alternatively, if an MCO adopted a formulary which discouraged a significantly higher percentage of mental health drugs, parity standards would not be met. Requiring prescribers to overcome additional "hurdles" to prescribe a quantity of mental health drugs versus physical health drugs is discriminatory. Simply allowing an appeal based on medical necessity does not remove the discrimination inherent in the adoption of differential "presumptive" or formulary limits.

The SCPD has serious reservations concerning the Report.

Thank you for your consideration and please contact SCPD if you have any questions regarding our observations and reservations on the Report in the proposed regulation.

cc: The Honorable Kara Walker, DHSS
Mr. Steve Groff, DMMA
Ms. Susan Cycyk, DPBHS
Ms. Jill Rogers, DDDS
Dr. Clarence Watson, DSAMH
Ms. Teresa Avery, Autism Delaware
Mr. Joshua Thomas, NAMI-DE
Ms. Emily Vera, Mental Health Association of DE
Ms. Jody Hougentogler, BIADE
Mr. Larence Kirby, Delaware Commission of Veterans Affairs
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

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CMS.gov
Centers for Medicare & Medicaid Services

The Center for Consumer Information & Insurance Oversight

The Mental Health Parity and Addiction Equity Act (MHPAEA)

Contents

Introduction

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

MHPAEA originally applied to group health plans and group health insurance coverage and was amended by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the "Affordable Care Act") to also apply to individual health insurance coverage. HHS has jurisdiction over public sector group health plans (referred to as "non-Federal governmental plans"), while the Departments of Labor and the Treasury have jurisdiction over private group health plans.

Employment-related group health plans may be either "insured" (purchasing insurance from an issuer in the group market) or "self-funded." The insurance that is purchased, whether by an insured group health plan or in the individual market, is regulated by the State's insurance department. Group health plans that pay for coverage directly, without purchasing health insurance from an issuer, are called self-funded group health plans. Private employment-based group health plans are regulated by the Department of Labor. Non-Federal governmental plans are regulated by HHS. Contact your employer's plan administrator to find out if your group coverage is insured or self-funded and to determine what entity or entities regulate your benefits.

MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly in connection with the Affordable Care Act's essential health benefit (EHB) requirements as noted below. The Protecting Affordable Coverage for Employees Act amended the definition of small employer in section 1304(b) of the Affordable Care Act and section 2791(e) of the Public Health Service Act to mean generally an employer with 1-50 employees, with the option for states to expand the definition of small employer to 1-100 employees. The Employee Retirement and Income Security Act and the Internal Revenue Code also define a small employer as one that has 50 or fewer employees. (Some states may have mental health parity requirements that are stricter than federal requirements. To view State specific information visit www.ncsl.org, and on the right hand side of the page enter "mental health parity" then select "State Laws Mandating or Regulating Mental Health Benefits".)

Summary of MHPAEA Protections

The Mental Health Parity Act of 1996 (MHPA) provided that large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits.

MHPAEA preserves the MHPA protections and adds significant new protections, such as extending the parity requirements to substance use disorders. Although the law requires a general equivalence in the way MH/SUD and medical/surgical benefits are treated with respect to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does NOT require large group health plans or health insurance issuers to cover MH/SUD benefits. The law's requirements apply only to large group health plans and health insurance issuers that choose to include MH/SUD benefits in their benefit packages. However, the Affordable Care Act builds on MHPAEA and requires coverage of mental health and substance use disorder services as one of ten EHB categories in non-grandfathered individual and small group plans.

Key changes made by MHPAEA

Key changes made by MHPAEA, which is generally effective for plan years beginning after October 3, 2009, include the following:

- If a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits (this is referred to as the "substantially all/predominant test").This test is discussed in greater detail in the MHPAEA regulation (linked below) and the summary of the MHPAEA regulation found below.
- MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits;
- If a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, and the plan or coverage provides for out-of-network medical/surgical benefits, it must provide for out-of-network MH/SUD benefits; and
- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD benefits must be disclosed upon request.

Exceptions

There are certain exceptions to the MHPAEA requirements.

Except as noted below, MHPAEA requirements do not apply to:

- Self-Insured non-Federal governmental plans that have 50 or fewer employees;
- Self-Insured small private employers that have 50 or fewer employees;
- Group health plans and health insurance issuers that are exempt from MHPAEA based on their increased cost (except as noted below). Plans and issuers that make changes to comply with MHPAEA and incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan or coverage or at least one percent in any subsequent plan year may claim an exemption from MHPAEA based on their increased cost. If such a cost is incurred, the plan or coverage is exempt from MHPAEA requirements for the plan or policy year following the year the cost was incurred. The plan sponsors or issuers must notify the plan beneficiaries that MHPAEA does not apply to their coverage. These exemptions last one year. After that, the plan or coverage is required to comply again; however, if the plan or coverage incurs an increased cost of at least one percent in that plan or policy year, the plan or coverage could claim the exemption for the following plan or policy year; and
- Large, self-funded non-Federal governmental employers that opt-out of the requirements of MHPAEA. Non-Federal governmental employers that provide self-funded group health plan coverage to their employees (coverage that is not provided through an insurer) may elect to exempt their plan (opt-out) from the requirements of MHPAEA by following the Procedures & Requirements for HIPAA Exemption Election posted on the Self-Funded Non-Federal Governmental Plans webpage (See http://www.cms.gov/CCIIO/Resources/Files/hipaa_exemption_election_instructions_04072011.html) and issuing a notice of opt-out to enrollees at the time of enrollment and on an annual basis. The employer must also file the opt-out notification with CMS.

Note, these exceptions do not apply to those non-grandfathered plans in the individual and small group markets that are required by Affordable Care Act regulations to provide EHB that comply with the requirements of the MHPAEA regulations.

MHPAEA Regulation

A final regulation implementing MHPAEA was published in the Federal Register on November 13, 2013. The regulation is effective January 13, 2014 and generally applies to plan years (in the individual market, policy years) beginning on or after July 1, 2014. See http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf for the full text of the final regulation. This followed an interim final regulation, which was published in the Federal Register on February 2, 2010 and generally applies to plan years beginning on or after July 1, 2010. See http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf for the full text of the regulation.

The final regulation applies to non-Federal governmental plans with more than 50 employees, and to group health plans of private employers with more than 50 employees. It also applies to health insurance coverage in the individual health insurance market. It does not apply to group health plans of small employers (except as noted above in connection with the EHB requirements). Like the statute, it does not require group health plans to provide MH/SUD benefits. If they do, however, the financial requirements and treatment limitations that apply to MH/SUD benefits cannot be more restrictive than the predominant requirements and limitations that apply to substantially all of the medical/surgical benefits.

The provisions of the regulation include the following:

1. The substantially all/predominant test outlined in the statute must be applied separately to six classifications of benefits: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network;

emergency; and prescription drug. Sub-classifications are permitted for office visits separate from all other outpatient services, as well as for plans that use multiple tiers of in-network providers. The regulation includes examples for each classification. Additionally, although the regulation does not require plans to cover MH/SUD benefits, if they do, they must provide MH/SUD benefits in all classifications in which medical/surgical benefits are provided.

2. The regulation requires that all cumulative financial requirements, including deductibles and out-of-pocket limits, in a classification must combine both medical/surgical and MH/SUD benefits in the classification. The regulation includes examples of permissible and impermissible cumulative financial requirements.

3. The regulation distinguishes between quantitative treatment limitations and nonquantitative treatment limitations. Quantitative treatment limitations are numerical, such as visit limits and day limits. Nonquantitative treatment limitations include but are not limited to medical management, step therapy and pre-authorization. There is an illustrative list of nonquantitative treatment limitations in the regulation. A group health plan or coverage cannot impose a nonquantitative treatment limitation with respect to MH/SUD benefits in any classification unless, under the terms of the plan (or coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification. The final regulation eliminated an exception that allowed for different nonquantitative treatment limitations "to the extent that recognized clinically appropriate standards of care may permit a difference."

4. The regulation provides that all plan standards that limit the scope or duration of benefits for services are subject to the nonquantitative treatment limitation parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy.

Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are not group health plans or issuers of health insurance. They are public health plans through which individuals obtain health coverage. However, provisions of the Social Security Act that govern CHIP plans, Medicaid benchmark benefit plans, and managed care plans that contract with State Medicaid programs to provide services require compliance with certain requirements of MHPAEA. See https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of for the final rule regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.

We anticipate issuing further responses to questions and other guidance in the future. We hope this guidance will be helpful by providing additional clarity and assistance.

If you have concerns about your plan's compliance with MHPAEA, contact our help line at 1-877-267-2323 extension 6-1565 or at phig@cms.hhs.gov. You may also contact a benefit advisor in one of the Department of Labor's regional offices at www.askebsa.dol.gov or by calling toll free at 1-866-444-3272.

Fact Sheets and FAQs

Regulations and Guidance

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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

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

[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.

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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 not ABP but are PROMISE	• Medicaid children under age 18
• DSHP adults who are ABP but not PROMISE	• DSHP adults who are also ABP and PROMISE	• Medicaid children age 18 – 21
• DSHP Plus adults who are not LTSS and not PROMISE	• DSHP Plus adults who are not LTSS but are PROMISE	• Children in separate CHIP (under Age 18)
• DSHP Plus LTSS adults who are not PROMISE	• DSHP Plus LTSS adults who are PROMISE	• 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.

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

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.

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 "i " 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.

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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	
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

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
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
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).