Mental Health Parity and Addiction Equity Act Compliance Plan

Louisiana Parity Analysis

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Executive Summary

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that prevents health care service plans from imposing more restrictive benefit limitations on mental health and substance use disorder (MH/SUD) benefits than on medical/surgical (M/S) benefits.

Due to the recent integration of specialized behavioral health benefits into the physical health plans and an awareness of upcoming parity requirements, Louisiana was well-positioned to meet compliance expectations when Louisiana Medicaid and the Office of Behavioral Health completed a compliance review of services. Louisiana met the intent of parity and will work on a few areas identified as a concern as highlighted in this report. Louisiana and its managed care health plans must ensure that financial requirements and treatment limitations that apply to MH/SUD benefits are no more restrictive than the predominant requirements or limitations applied to M/S benefits. This initiative, and its ongoing monitoring requirements, will ensure Louisiana Medicaid recipients receiving Medicaid and CHIP services receive equal access to physical and behavioral health care.

Medicaid Mental Health Parity Final Rule Requirements

On March 29, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the Medicaid Parity Final Rule (Parity Rule) to strengthen access to mental health (MH) and substance use disorder (SUD) services for Medicaid beneficiaries. The Parity Rule aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to Medicaid and applied parity requirements to the coverage provided by Medicaid managed care organizations (MCOs), Alternative Benefit Plans (ABPs), and the Children's Health Insurance Programs (CHIP). Specifically, the Parity Rule included the following requirements:

- Aggregate lifetime and annual dollar limits;
- Financial requirements (FR);
- Quantitative treatment limitations (QTLs);
- Non-quantitative treatment limitations (NQTLs); and
- Information requirements.

A key objective of the Parity Rule is to ensure that restrictions or limits on MH/SUD services are not more substantively applied as compared to M/S services. Aggregate lifetime and annual dollar limits are limits on the total dollar amount a Medicaid program will pay for specified benefits over a beneficiary's lifetime or on an annual basis. These limits cannot be applied to MH/SUD benefits unless the limits apply to at least one third of all M/S benefits. In addition, such limits must either be applied to both M/S and MH/SUD benefits as a whole or the limits applicable to MH/SUD benefits must be no more restrictive than those applicable to M/S benefits. FRs and QTLs applied to MH/SUD benefits within a classification may not be more restrictive than the predominant FR or QTL that applies to substantially all M/S benefits in that classification.

A non-quantitative treatment limitation (NQTL) may not apply to MH/SUD benefits in a classification unless, under the policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification.

Further, the Parity Rule added requirements to make certain information pertaining to MH/SUD benefits available, specifically the criteria for medical necessity determinations and reason for denial of reimbursement or payment.

Parity requirements apply when a beneficiary is enrolled in a Managed Care Organization (MCO). At such point, the beneficiary's entire benefit package is subject to parity standards regardless of delivery system, which includes the M/S benefits and non-specialized MH benefits through MCO and fee-for-service (FFS), pharmacy benefits through the MCO and FFS, specialized MH/SUD benefits through the MCO, and waiver services. Louisiana's delivery system is described in greater detail below.

In Louisiana where some services for MCO enrollees are provided through a combination of managed care entities and FFS, the State has the responsibility of undertaking the parity analysis within the plans and across the delivery systems to determine if the benefits and any financial requirements or treatment limitations are consistent with the Parity Rule.

Louisiana Service Delivery System Overview

The Louisiana Medicaid and CHIP programs are administered under the authority of the Louisiana Department of Health, Bureau of Health Services Financing (La. Medicaid) and provide health care coverage for low-income individuals and families. Under 1915(c) of the Social Security Act, Louisiana also manages seven Home and Community Based Waivers, which includes one specific to behavioral health services, to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization.

In February 2012, Louisiana Medicaid initiated its transition from its legacy fee-for-service (FFS) program to a majority managed health care delivery system that offers medical services to most Louisiana Medicaid enrollees. The managed care programs use a Per-Member-Per-Month (PMPM) payment model, in which Louisiana Medicaid pays the managed care organizations a monthly fee to manage the health needs of the Medicaid population. Managed care providers are paid by the managed care health plans rather than being paid directly by Louisiana Medicaid. Fee-for-Service (FFS) is a model of payment in which Louisiana Medicaid pays each service provider directly based on the services provided to Medicaid recipients and only operates in an extremely limited capacity.

With Louisiana's implementation of Medicaid managed care in early 2012, specialized behavioral health services were covered through the Louisiana Behavioral Health Partnership (LBHP) managed by a single statewide management organization operating as a Prepaid Inpatient Health Plan (PIHP), Magellan, under a separate contract with OBH, while the MCOs were responsible for acute medical care and non-specialized behavioral health services. Magellan also manages care for children who are at risk for out of home placement under the Coordinated System of Care (CSoC) 1915 (c) waiver program.

In November 2014, LDH announced a plan to integrate Medicaid specialized behavioral healthcare services into its existing five (5) MCOs under the Medicaid managed care program effective December 1, 2015 with the Coordinated System of Care (CSoC) operating as a carve out program under a different managed care entity operating as a PIHP.

In July 2016, Louisiana implemented Medicaid expansion to low income adults based on provisions of the 2010 Affordable Care Act (ACA). One year after coverage began, more than 400,000 men and women have health care coverage under Medicaid expansion. Because of expansion, Louisiana's

uninsured rate has dropped from 21.7 percent in 2013, to below 12.5 percent; one of the largest reductions in the uninsured rate for any state.

For purposes of parity analysis, Louisiana Medicaid includes two managed care programs with behavioral health services: Medicaid Managed Care Program MCOs and the Coordinated System of Care (CSoC) PIHP. The following health plans are part of these programs:

1. Aetna Better Health, Inc.
2. Amerihealth Caritas Louisiana, Inc.
3. Healthy Blue
4. Louisiana Healthcare Connections, Inc.
5. United Healthcare of LA, Inc.
6. Magellan Health of Louisiana operates the carved out CSoC program

The managed care programs can have overlapping enrollment, and some managed care enrollees may receive services through FFS. In addition, Louisiana operates seven HCBS waivers:

1. Coordinated System of Care (CSoC) program - home and community-based services and supports provided to children who are either in or at risk of being in out-of-home placement;
2. Adult Day Health Care (ADHC) - home and community-based services and supports provided to elderly and adults with adult-onset physical disabilities who require a nursing facility level of care;
3. New Opportunities Waiver (NOW) – home and community-based services and supports to individuals with developmental disabilities who would otherwise require an ICF/IID LOC;
4. Children's Choice (CC) - home and community-based services and supports for children with developmental disabilities up to age 19 who would otherwise require ICF/IID;
5. Residential Options Waiver (ROW) – home and community-based services and supports focusing on self-care and self-sufficiency for individuals with developmental disabilities meeting an ICF/IID LOC, with a goal of allowing them to transition or remain in the community;
6. Supports Waiver – home and community-based services and supports focusing on vocational and community inclusion for individuals age 18 and older with developmental disabilities who meet ICF/IID LOC; and
7. Community Choices Waiver (CCW) – home and community-based services and supports to persons aged 65 and older or, persons with adult-onset disabilities age 22 or older, who would otherwise require nursing facility level of care.

Parity Policy Academy

In January 2017, Louisiana was one of eleven states invited to participate in the Medicaid and CHIP Parity Policy Academy. Participating state teams received assistance from national parity experts to develop a parity implementation strategy, undertake the parity analysis, develop contract language, state plan amendments, and other steps needed to implement parity and lay out ongoing monitoring and compliance activities for their Medicaid and CHIP programs. The Academy was conducted through virtual trainings, one-on-one coaching calls, and an in-person forum held in Rockville, Maryland.

Deadline Extension

Due to the predicted severe storms and flooding in Louisiana from Hurricane Harvey and anticipated responses necessary, the Director of the Louisiana Department of Health, Bureau of Health Services Financing requested the Centers for Medicare & Medicaid Services (CMS) exercise authority to waive the requirements of 42 CFR 438.930 with regard to the compliance date of October 2, 2017. Louisiana requested a two-month extension and committed to completing its analysis by December 2, 2017. On August 30, CMS granted the extension.

Parity Analysis Approach

Preliminary Efforts

Identifying Benefit Packages

The Louisiana Medicaid and CHIP programs are administered under the authority of the State's Louisiana Department of Health (LDH) and provide health care coverage for low-income individuals and families. Under 1915(c) of the Social Security Act, Louisiana also manages Home and Community Based Waivers to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization.

For the purpose of conducting the MHPAEA parity compliance, Louisiana has defined the following thirteen benefit packages:

1. Medicaid state plan adult
2. Medicaid state plan child
3. Nursing Facility Level of Care (NFLOC)
4. Children's Health Insurance Program (CHIP)
5. Alternative Benefit Plan adults – age 21 through 64
6. Alternative Benefit Plan young adults – age 19 and 20
7. Waiver – Coordinated System of Care (CSoC) program home and community-based services and supports provided to 2400 children and youth state wide at risk of out of home placement;
8. Waiver - Adult Day Health Care (ADHC) - home and community-based services and supports provided to elderly and adults with adult-onset physical disabilities who require a nursing facility level of care;
9. Waiver - New Opportunities Waiver (NOW) – home and community-based services and supports to individuals with developmental disabilities who would otherwise require an ICF/IID LOC;
10. Waiver - Children's Choice (CC) - home and community-based services and supports for children with developmental disabilities up to age 19 who would otherwise require ICF/IID;
11. Waiver - Residential Options Waiver (ROW) – home and community-based services and supports focusing on self-care and self-sufficiency for individuals with developmental disabilities meeting an ICF/IID LOC, with a goal of allowing them to transition or remain in the community;
12. Waiver - Supports Waiver – home and community-based services and supports focusing on vocational and community inclusion for individuals age 18 and older with developmental disabilities who meet ICF/IID LOC; and
13. Waiver - Community Choices Waiver (CCW) – home and community-based services and supports to persons aged 65 and older or, persons with adult-onset disabilities age 22 or older, who would otherwise require nursing facility LOC.

Defining Benefits

In order to determine whether MH/SUD benefits are provided in parity with M/S benefits, it was essential to identify which benefits are considered MH/SUD benefits and which are M/S benefits for the purpose of this parity analysis. Louisiana has selected the most current International Classification of

Diseases (ICD) manual as the “generally recognized independent standard of current medical practice” to define MH/SUD and M/S conditions. However, three exceptions within Chapter 5 were adopted that fall outside of behavioral health as identified for parity purposes: developmental disorders, autism, and mental disorders due to known physiological (dementia).

Defining Classifications

The Parity Rule specifies that financial requirements and treatment limitations apply by benefit classification. Moreover, in order to conduct the parity analysis, each medical/surgical, mental health, and substance use disorder benefit must be mapped to one of four classifications of benefits: Inpatient, Outpatient, Prescription Drugs, and Emergency Care.

However, the rule did not mandate how those classifications were defined. For purposes of mapping benefits in each classification during the parity analysis, LDH utilized the following classification definitions:

For the purpose of analysis for compliance with MHPAEA, inpatient benefits are defined as a hospital or clinic for treatment that requires at least one overnight stay. Note that this includes residential settings for purposes of parity analysis only.

For the purpose of analysis for compliance with MHPAEA, outpatient benefits are defined as all covered services or items, including medications, that are not provided in an emergency or inpatient setting as defined in these classifications and do not meet the definition of prescription drug.

For the purpose of analysis for compliance with MHPAEA, emergency care benefits are defined as all covered services or items (including medications) delivered in an emergency department (ED) or emergency room (ER) setting including free standing emergency rooms, other than prescription drugs. This does not include urgent care or walk in clinics, or mobile or community-based crisis services like crisis intervention or crisis stabilization, which are classified as outpatient for purposes of parity analysis only.

For the purpose of analysis for compliance with MHPAEA, prescription drug benefits are defined as a prescription drug or device which is a medication or mechanism that may only be dispensed by a licensed pharmacist only upon a prescription from a licensed practitioner and shall bear the "Rx Only" notation or any other designation of similar import required by law on the label of a commercial container; which include retail pharmacies, other than inpatient, outpatient, and emergency care settings. 1. Dispensing: prescription drugs or devices shall be dispensed only by a Louisiana licensed pharmacist. 2. Possession: prescription drugs or devices shall be procured and possessed in the course of the practice of pharmacy by a permitted pharmacy. 3. Storage: prescription drugs or devices shall be stored in a permitted pharmacy under the immediate control and responsibility of a pharmacist.

Mapping Benefits to Classifications

LDH assigned each service to one of the four required classifications. This required the State to compare medical/surgical services to mental health services and to substance use disorder services per benefit classification. For example, comparing inpatient medical/surgical services to inpatient mental health services and inpatient substance use disorder services. This avoids a benefit-to-benefit comparison which is not the intent of MHPAEA.

Once the four classifications were defined and all medical/surgical, mental health, and substance use disorder benefits were mapped to a classification, LDH moved on to the next part of the parity analysis, which entailed identification of financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations applied in each classification as described below.

Stakeholder Outreach

LDH began stakeholder outreach in June of 2017. OBH conducted internal and external presentations, developed consumer friendly FAQs and created a parity website and email address to field questions and concerns.

Parity 101 presentations were conducted for the Medicaid Administrative Simplification Committee and Medicaid Quality Committee as well as the Behavioral Health Advisory Council and Behavioral Health Integration Advocates quarterly meeting all consisting of providers of services, family members of people receiving services, and advocates.

- LDH parity website: http://ldh.louisiana.gov/index.cfm/page/2809
- LDH FAQs: http://ldh.louisiana.gov/assets/docs/BehavioralHealth/MHParity/LDHParityFAQ.pdf
- Medicaid Administrative Simplification Committee (http://ldh.louisiana.gov/index.cfm/page/2724)
- Medicaid Quality Committee (http://www.dhh.louisiana.gov/index.cfm/page/2175)
- Behavioral Health Advisory Council (http://ldh.louisiana.gov/index.cfm/directory/detail/327)

Responsibility for Parity Analysis

Parity requirements apply when a beneficiary is enrolled in a managed care organization. At such point, the beneficiary's entire benefit package is subject to parity standards regardless of delivery system. This includes the M/S benefits and MH/SUD benefits through the managed care plans and FFS, pharmacy benefits, and waiver services. If MH/SUD services for beneficiaries are provided through a combination of MCOs, PIHPs and the state, the state has the responsibility of undertaking the parity analysis within the plans and across delivery systems.

Louisiana must review the MH/SUD and M/S benefits provided through both its FFS and managed care coverage systems to ensure the full scope of services available to all individuals enrolled in Medicaid complies with parity. Louisiana provides Medicaid benefits through risk-based contracts with 5 MCOs, a non-risk contract with a PIHP and the FFS systems. While the managed care plans were required to provide information about limitations imposed by the health plan for each benefit package and classification as well as complete surveys designed to elicit assurances to ensure parity and compliance with applicable requirements, because of the multiple delivery systems, LDH is ultimately responsible for performing the parity analysis.

Technical Assistance and In-Depth Training

After LDH's attendance at the in-person Parity Policy Academy meeting in Maryland on March 23-24, the team was expanded to include specialized subject matter experts (SME). LDH held several weeks of internal meetings to refine the work plan, and weekly meetings with the parity academy coach, Julie Seibert with RTI International, began in May. LDH engaged a government consulting firm, Mercer Health and Benefits (Mercer), for technical assistance as well. On May 12, the team met with representatives from Mercer and began holding weekly conference calls with the Mercer team. Both of these weekly (and sometimes twice a week) hour-long calls remained in effect until October, with the Mercer calls

continuing on an as-needed basis. Throughout this time, the Louisiana team attended each academy webinar and training.

On June 15, the LDH team held a large parity overview meeting including a range of LDH staff focusing on OBH and Medicaid team members to ensure all staff were aware of the importance of parity, Louisiana's compliance plan and staff expectations. The parity team lead also presented parity updates at OBH and Medicaid leadership meetings (weekly and bi-weekly, respectively) throughout LDH's parity work.

Throughout July, Louisiana SMEs developed a complete and comprehensive benefits listing while also refining NQTLs and classification definitions. During this time, an introductory meeting was held with the managed care organization's CEOs and an additional parity overview was conducted for MCO staff. In August, once the RFIs were finalized, the team co-hosted a three hour-long webinar with Mercer to train the MCOs on their role in the parity compliance process and the RFI documents. During the time in which MCO representatives worked to complete the RFI documents, LDH held three TA calls at two hours each to assist the MCOs.

Prior to LDH's analysis of the MCO NQTL responses, a four-hour training with Jessica Osborne and Dr. Laura Nelson of Mercer was held to train the LDH subject matter experts performing the parity analysis.

MCO Surveys

As part of the FR and QTL review, LDH administered surveys to the six managed care entities to serve as confirmation of LDH research on state compliance in these areas and inquire into MCO policies and operations that may supplement LDH policies or contracts.

NQTL RFI Development

In order to thoroughly assess NQTLs, LDH developed extensive Request for Information (RFI) documents which were distributed to each managed care entity for response. LDH required each MCO to complete the RFI for each NQTL chosen for each classification. LDH conducted a training for the MCOs of each RFI in order to facilitate completion of the documents. LDH and consultants also conducted a training internal to LDH subject matter experts reviewing the RFI responses and making the parity conclusion. This training walked through the RFI and discussed expectations for complete responses, the process for review and documenting. LDH then held multiple technical assistance calls on the NQTL RFIs for the MCOs with all LDH SMEs in order to respond to questions on how to complete the documents. LDH also utilized the MHParity@la.gov email address to field MCO questions throughout the RFI response period in order to expedite responses to the MCOs.

Parity Analysis Outcomes/Findings

Financial Requirements

LDH conducted an analysis of the financial requirements that apply to each classification level for all benefit packages identified. This analysis was conducted by both LDH and then the managed care entities for confirmation.

The parity regulations describe financial requirements as fees charged to beneficiaries for services, including copayments, deductibles, coinsurance and out-of-pocket maximums. The regulations provide that no financial requirement be applied to MH/SUD benefits "in any classification that is more restrictive than the predominant financial requirement … of that type applied to substantially all M/S benefits in the same classification …." (42 C.F.R. § 438.910(b)(1)). Generally, the purpose of this requirement is to prevent beneficiaries from being charged more for MH/SUD services than for M/S services, which would create a barrier to beneficiaries accessing those services. In addition, the managed care entity may not apply any cumulative financial requirement for MH/SUD benefits in a classification that accumulates separately from any established for M/S benefits in the same classification.

After reviewing these financial requirements, there are no copayments, deductibles, coinsurance, out of pocket maximums or cumulative financial requirements that apply to MH/SUD services in any of the classification or benefit packages except for pharmacy.

The managed care organizations and Louisiana FFS apply co-pays for pharmacy. After a survey of the MCOs and internal examination on utilization of the pricing tiers, the co-pay is applied regardless of the treatment regimen of the drug. Pharmacy co-pays are based on cost of the drug, not on what it treats and are applied the same way for M/S as MH/SUD benefits. Even though co-payments are charged to Medicaid beneficiaries, Louisiana does not need to apply further analysis as per 42 CFR 438.910 because the determination of tiers is based on a reasonable method and specifically, the CFR states:

> (2) Special rules—(i) Multi-tiered prescription drug benefits. If a MCO, PIHP, or PAHP applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in paragraph (d)(1) of this section (relating to requirements for non-quantitative treatment limitations) and without regard to whether a drug is generally prescribed for M/S benefits or for mental health or substance use disorder benefits, the MCO, PIHP, or PAHP satisfies the parity requirements of this section for prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up/delivery.

As a result of this review, there are no concerns regarding financial requirement for parity compliance.
The State complies with these financial requirements because no financial requirements apply to MH/SUD services or, in the case of pharmacy, financial requirements do not apply exclusively because the drug is MH/SUD. For this reason, LDH did not need to perform the two-part test for financial requirements (i.e., Substantially All, Predominant Level). There are no compliance steps needed for these requirements.

Aggregate Lifetime and Annual Dollar Limits

Aggregate lifetime and annual dollar limits (AL/ADL) are limits on the total dollar amount a Medicaid program will pay for specified benefits over a beneficiary's lifetime or on an annual basis. These limits cannot be applied to MH/SUD benefits unless the limits apply to at least one third of all M/S benefits. In addition, such limits must either be applied to both M/S and MH/SUD benefits as a whole or the limits applicable to MH/SUD benefits must be no more restrictive than those applicable to M/S benefits.

LDH conducted an analysis of the aggregate lifetime and annual dollar limits that apply to each classification level for all benefit packages identified. This analysis was conducted by both LDH and then the managed care entities for confirmation.

As a result of this review, there are no concerns regarding aggregate lifetime and annual dollar limit parity compliance. The State complies with these requirements because after examining this area, there are no aggregate lifetime or annual dollar limits applied to MH/SUD benefits. There are no compliance steps needed for these requirements.

Quantitative Treatment Limitations

Quantitative Treatment Limitations (QTLs) are limits on the scope or duration of a benefit that are expressed numerically. This includes hard day, unit or visit limits with no opportunity to expand or continue the service past the identified limit. The general rule is that no QTL may apply to MH/SUD benefits in a classification if the QTL is more restrictive than the predominant treatment limitation of that type that applies to substantially all M/S benefits in the same classification.

LDH reviewed authority documents to ensure LDH had not mandated any hard limits and found no cases of a quantitative treatment limit for a specialized behavioral health service.

LDH then surveyed the managed care entities to inquire if they apply a QTL in operation or through official policy and reviewed the corresponding policy, if applicable.

As a result of this review, there are no concerns regarding QTL parity compliance. The State complies with these requirements because after examining this area, there are no hard QTL limits applied to MH/SUD benefits.

Non-Quantitative Treatment Limitations

A non-quantitative treatment limitation (NQTL) is a limit on the scope or duration of benefits, such as prior authorization or network admission standards. Soft limits, or benefit limits that allow for an individual to exceed numerical limits for M/S or MH/SUD benefits on the basis of medical necessity, are also considered NQTLs.

Parity prohibits states, MCOs and PIHPs from imposing an NQTL on MH/SUD benefits in any classification unless, under the policies and procedures of the state, MCO, or PIHP, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification.

With the help of LDH contracted consultants, Louisiana selected thirteen NQTLs. The following NQTLs were reviewed for initial parity analysis:

1. Prior Authorization: process used to determine if benefit coverage will be authorized. May include eligibility, coverage, medical necessity, medical appropriateness and/or level of care review. May occur prior to service delivery, after a designated number of services or amount of time, or between emergency room and inpatient levels of care.
2. Concurrent Review: process used to determine if benefit coverage will be authorized beyond the initial authorization (see prior authorization) within the same benefit year or treatment episode. May include eligibility, coverage, medical necessity, medical appropriateness and/or level of care reviews.
3. Retrospective Review: process used to determine if benefits will be covered after services have been delivered. May include eligibility, coverage, medical necessity, medical appropriateness and/or level of care reviews. May result in recoupment of payments.
4. Outlier Review: for services not requiring prior authorization, where services will be monitored via claims data.
5. Documentation Requirements: those which are conditions on the coverage or payment of a benefit, such as written treatment plans.
6. Step Therapy: requirement that lower cost or lower intensity benefits are tried before coverage is provided for higher cost or higher intensity benefits.
7. Application of Medical Necessity Criteria: the application of criteria against which benefit authorization requests are compared to determine whether the benefit is appropriate for the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
8. Requirements in Addition to Licensure or State Required Certification: Requirements for training, accreditation, fidelity to practice (or other factors) in excess of state licensure or state certification requirements (that also apply to providers outside of state Medicaid programs).
9. Requirements for Unlicensed/Uncertified Practitioners and Staff: provider requirements for training, education, experience, supervision, caseloads, optional certifications (or other factors) when no state licensure or required state certifications are applicable (e.g., network admission requirements for peer support specialists
10. Standards for Out-of-Network Coverage: standards (over and above federal requirements) that determine if out-of-network coverage will be provided (e.g., distance to closest in-network provider, availability of benefit in-network).
11. Provider Reimbursement: process by which provider reimbursement rates are established for in-network practitioners, group practices, agencies and facilities.
12. Formulary Development: process used to determine which (optional Medicaid) medications will be covered.
13. Pharmacy Lock In Programs: process for which a beneficiary may only receive pharmacy benefits from a specified provider(s) to address overutilization and potential medication abuse.

As described in numerous parity guidance documents, the NQTL analysis does not focus on whether the final result is the same, instead, compliance is based upon parity in application of the underlying process, strategies, evidentiary standards, or other factors, both in writing and in operation. Below is a discussion of the NQTL analysis.

Utilization Management NQTLs

LDH reviewed four NQTLs around utilization management looking at the process of evaluating appropriateness and efficiency of the use of services before, during and after services are received. For purposes of the parity analysis, although the responses were received and analyzed individually, the standards, processes and evidence used to apply prior authorization, retrospective review, concurrent review, and outlier review are very similar.

Prior authorization (PA) is the process used to determine if benefit coverage will be authorized. May include eligibility, coverage, medical necessity, medical appropriateness and/or level of care review. May occur prior to service delivery, after a designated number of services or amount of time, or between emergency room and inpatient levels of care.

Concurrent review (CR) is the process used to determine if benefit coverage will be authorized beyond the initial authorization (see prior authorization) within the same benefit year or treatment episode. May include eligibility, coverage, medical necessity, medical appropriateness and/or level of care reviews.

Retrospective review (RR) is the process used to determine if benefits will be covered after services have been delivered. May include eligibility, coverage, medical necessity, medical appropriateness and/or level of care reviews. May result in recoupment of payments.

Outlier review (OR) is for services not requiring prior authorization, where services will be monitored via claims data.

Not all delivery systems use all four of the utilization NQTLs. However, for purposes of parity, **when a plan used prior authorization, retrospective review, concurrent review, or outlier review, it was applied consistently across M/S and MH/SUD benefits being comparable and applied no more stringently, thus finding parity with one exception for outpatient concurrent review that requires further follow up. In addition, during LDH authority documents review, the state identified two areas in rule that needed to be changed to comply with parity. That process is almost complete.**

Documentation Requirements

Documentation requirements (outside of an eligibility determination, federal requirements, prior authorization, concurrent or retrospective review process) are those which are conditions on the coverage or payment of a benefit, such as written treatment plans. An example of documentation requirements are treatment plans or other particular documents that may be required to be submitted for review when requested by the Plan. If the outcome of this review can impact coverage or payment, this would be considered a documentation requirement. Any assessments that are used as part of the service authorization process or as part of the eligibility determination to obtain a service would not be considered documentation requirements.

For purposes of parity, it appears that all documentation requirements, if required, are comparable and applied no more stringently to MH/SUD than for M/S.

Step Therapy

Step therapy requires that lower cost or lower intensity benefits are tried before coverage is provided for higher cost or higher intensity benefits. For example, benefits such as electro shock therapy (ECT) and transcranial magnetic stimulation (TMS) often require beneficiaries to complete a trial on medications prior to receiving these benefits. For example, the member must try a medication for a certain number of weeks or participate in a therapy a certain number of times before moving on to the next step in treatment. LDH inquired as to both informal practice within the operation and formal application through policy, training, guidelines and set procedures. When step therapy is part of another NQTL (e.g., prior authorization), MCOs were asked to describe the development of the step therapy approach in the RFI.

All plans responded that step therapy does not apply for inpatient or emergency care classifications. No plans apply step therapy in the outpatient setting to MH/SUD. **For purposes of parity in the pharmacy classification, it appears that all elements are comparable and applied no more stringently to MH/SUD than for M/S**; plans didn't apply step therapy, or only applied it to M/S benefits.

Application of Medical Necessity Criteria (MNC)

The application of criteria against which benefit authorization requests are compared to determine whether the benefit is appropriate for the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Application includes development, modification, or addition of criteria.

All plans responded that MNC does not apply for emergency care classifications.

Based on the information gathered, parity is met in all other classifications as the same evidentiary standards, strategies, and processes are adopted for both MH/SUD and M/S in the application of medical necessity criteria for services across all benefit populations. **For purposes of parity, it appears that medical necessity criteria are comparable and applied no more stringently to MH/SUD than for M/S.**

Requirements in Addition to Licensure or State-Required Certification

This NQTL addresses requirements for training, accreditation, fidelity to practice (or other factors) in excess of state licensure, professional certifications or licensure required by the provider's professional organization, or state certification requirements (that also apply to providers outside of state Medicaid programs).

For inpatient, outpatient and, when applicable, emergency services and pharmacy, strategies and evidentiary standards used in the MH/SUD requirements in addition to licensure for services are comparable to and applied no more stringently than the processes, strategies and evidentiary standards used in applying the M/S requirements in addition to licensure for services. Any additional requirements for MH/SUD providers, for example with the waiver providers or for evidence-based practice (EBP) providers, are based on specialized services provided and are justified.

Requirements for Unlicensed/Uncertified Practitioners and Staff

Provider requirements for training, education, experience, supervision, caseloads, optional certifications (or other factors) when no state licensure or required state certifications are applicable (e.g., network admission requirements for peer support specialists).

LDH inquired as to unlicensed and uncertified staff participation in the networks and no delivery systems contract with unlicensed or uncertified providers.

Standards for Out-of-Network Coverage

Standards (over and above federal requirements) that determine if out-of-network (OON) coverage will be provided (e.g., distance to closest in-network provider, availability of benefit in-network) were reviewed.

As a result, the processes, strategies and evidentiary standards used in applying MH/SUD standards for out of network coverage for all classifications are comparable to and applied no more stringently than the processes, strategies and evidentiary standards used in applying the M/S standards for out of network coverage for inpatient services.

Provider Reimbursement

Provider reimbursement is the process by which provider reimbursement rates are established for in-network practitioners, group practices, agencies and facilities.

The processes, strategies and evidentiary standards used in applying MH/SUD provider reimbursement for all classifications and benefit populations are comparable to and applied no more stringently than the processes, strategies and evidentiary standards used in applying the M/S provider reimbursement. This is largely due to contractual requirements to pay providers no less than the Medicaid rate floor.

Formulary Development

Formulary development is the process used to determine which (optional Medicaid) medications will be covered.

For purposes of parity, it appears that formulary development is comparable and applied no more stringently to MH/SUD than for M/S.

Pharmacy Lock-In Programs

Lock-In is a process for which a beneficiary may only receive pharmacy benefits from a specified provider(s) to address overutilization and potential medication abuse.

For purposes of parity, it appears that all elements are comparable and applied no more stringently to MH/SUD than for M/S.

Availability of Information

The Parity Rule includes two (2) information requirements related to mental health and substance use disorder benefits.

The first requirement is that the criteria for medical necessity determinations for MH/SUD benefits must be made available upon request to MCO enrollees, potential enrollees, and contracted providers. If an MCO disseminates its practice guidelines in compliance with 42 CFR §438.236(c) to its providers and to its beneficiaries upon request it is deemed to be compliant with this requirement. MCOs disseminate practice guidelines per contract requirements upon request for behavioral health services, thus Louisiana is deemed to be in compliance with this requirement.

Current Medicaid managed care contract requirements state:

8.1.5. T*he MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.*

8.1.7. *UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request.* Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

In addition, medical necessity standards and practice guidelines are published in the provider handbook as per section 10.4.1.6 of the MCO contract.

The current CSoC PIHP managed care contract states:

9.4.7. The Contractor shall develop and disseminate clinical practice guidelines (CPGs) to all providers as appropriate and, upon request, to members and potential members in accordance with 42 CFR §438.236 and this RFP.

The second information requirement is to make available to beneficiaries the reason for any denial of reimbursement or payment for MH/SUD benefits. When a member is denied services, they receive a notice of action or adverse benefit determination letter. Therefore, Louisiana is in compliance with this requirement.

Current Medicaid managed care contract requirements for adverse benefit determination state:

8.5.4.1.2.1. The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210, Section 12 of this RFP for member written materials, and any agreements that the Department may have entered into relative to the contents of member notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.

8.5.4.1.2.2. The MCO shall notify the requesting provider of a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such written notification to the provider within two (2) business days of making the initial certification.

Further, the Notice of Action must explain the following:

13.5.2.1. The action the MCO or its contractor has taken or intends to take;

13.5.2.2. *The reasons for the action*, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes

medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

The current CSoC PIHP managed care contract language for denials state:

> 9.9.5.2.2.1. The Contractor shall notify the member in writing, using language that is easily understood at a fifth-grade reading level, of decisions and *reasons to deny* a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 16 of this contract. The notice of action to members shall be consistent with requirements in 42 CFR §438.404(a) and (c) and 42 CFR §438.210(b)(c)(d) for member written materials. The notice shall contain information regarding the Contractor's grievance and appeals process.
>
> 9.9.5.2.2.2. The Contractor shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested within one (1) working day as per RS 22:1128.

In addition to contract and federal requirements, Louisiana managed care entities are subject to the LDH Wells Settlement, the result of a class action law suit against the Louisiana Department of Health (LDH), which requires all LDH contractors (including all five Managed Care Organizations and Magellan) to include specific details in service denial notices and submit to monitoring of the notices for compliance. The Wells Settlement requires that enrollee service denial notices go above and beyond those requirements found in 42 CFR §438.404 outlining notice of adverse benefit determination requirements and §438.915 on parity requirements.

Notices must conform to the style and language guidance mandated in the settlement and in the templates provided by LDH. This includes the use of plain language explanations and the avoidance of overly clinical terminology. Content must include, among other details, a comprehensive explanation of why the request does not meet guidelines for care; appeal rights; the enrollees right to the materials used in the determination, free of charge; continuation of benefits, as applicable; and expedited decision options. Wells guidance, including the original settlement and subsequent resolutions, templates and a companion guide, can be found online at www.makingmedicaidbetter.com.

Alternative Benefit Plan

Medicaid Alternative Benefit Packages (ABPs) were required to comport with MHPAEA for the Affordable Care Act implementation. LDH assessed the ABP for comportment with MHPAEA and assured compliance by submission of ABP State Plan Amendment on March 31, 2016. CMS approved the ABP effective July 1, 2016. Therefore, the State's ABP is deemed to be compliant with the parity requirements for FRs, QTLs, and NQTLs with respect to beneficiaries entitled to ABP benefits.

CHIP

The Louisiana Children's Health Insurance Program (LaCHIP) is designed to bring quality health care to currently uninsured children and youth up to the age of 19 in Louisiana. Children can qualify for coverage under LaCHIP using higher income standards than traditional Medicaid. LaCHIP provides Medicaid coverage for doctor visits for primary care as well as preventive and emergency care, immunizations, prescription medications, hospitalization, home health care and many other health

services. LaCHIP is deemed in compliance due to the provision that the State covers EPSDT for the full EPSDT population.

Compliance Posting

To demonstrate parity compliance, the State is required to provide documentation of compliance to the general public by posting a summary of the parity findings and compliance recommendation on its website. LDH will post the parity final report summary on LDH's parity webpage located at http://ldh.louisiana.gov/index.cfm/page/2809 as well as the state Medicaid website at http://ldh.louisiana.gov/index.cfm/page/1582.

Ongoing Monitoring and Assessment

The Parity Rule requires states to develop and implement monitoring procedures, including a process for ongoing parity reassessment, once the initial Compliance Summary is complete. LDH will continue to develop, operationalize and refine the ongoing compliance and monitoring activities described below. LDH is currently making necessary updates to the initial audit tools for continued use based on lessons learned throughout the initial analysis. The current monitoring plan includes a multipronged approach to continuous review of parity compliance, at a frequency to be determined, which may include:

- Re-administration of current RFIs and survey tools
- Attestations from the managed care entities
- Implementation of internal LDH review through identified "triggers"
- Leveraging existing oversight activities for parity
- Additional MCO contract language
- Ongoing stakeholder education to encourage reporting

Re-administration of Current RFIs and Survey Tools

LDH will reissue select RFIs and survey tools at a frequency to be determined to the managed care plans as a confirmation of ongoing parity compliance. A similar process will be utilized as described above for the initial distribution.

Attestations from the Managed Care Entities

Due to the state's detailed and thorough initial analysis, LDH intends to require an attestation by the managed care entities that they have annually completed a similar review of their administrative, clinical and utilization practices and the plans remain in compliance with the necessary provisions of MHPAEA and no changes have been made, in policy or in operations, to the initial process, evidentiary standards or strategies initially assessed.

Specifically, the MCO must review their administrative and other practices, including the administrative and other practices of any contracted behavioral health organizations or third party administrators for compliance with the relevant provisions of the MHPAEA, regulations and guidance issued by state and federal entities.

Following completion of the analysis, the Plan must submit either:

- A certification stating that the MCO has completed a comprehensive review and believes that nothing has changed in policy and/or in operations since the previous year and therefore it complies with parity; or
- Documentation that policy and/or operations have changed, identifying the areas of change and certification that the MCO believes it complies with parity at which time LDH will validate the analysis; or
- Documentation that any administrative, clinical, and utilization practices were not in compliance with relevant requirements of the MHPAEA during the calendar year, including a list of the areas of non-compliance and a corrective action plan outlining how all relevant administrative and other practices will come into compliance with MHPAEA.

Implementation of Internal LDH Review through Identified "Triggers"

Assessments of parity compliance will be triggered by certain activities internal to LDH. These activities include utilization of questionnaires or checklists during the rule making process, provider manual edits and waiver or state plan amendments. Parity will be assessed during addition of any benefits to the state plan. In addition, contract renewals with managed care entities will be reviewed for parity compliance.

Leveraging Existing Oversight Activities for Parity

LDH will leverage the existing MCO contract compliance monitoring program to monitor for potential parity issues. LDH currently has a robust system for compliance monitoring of the MCO's performance. The system includes multiple reports by the MCOs to monitor various domains of process, quality and performance. MCO data is then reviewed for red flag issues that are utilized for program management. Specifically,

- Grievance and appeal data review for potential parity concerns
- Annual member surveys to address parity concerns

Additional MCO Contract Language

Louisiana added basic parity requirements to the contract with the MCOs in December 2015 in anticipation of compliance with MHPAEA. Additional language as instructed by CMS on the parity contract checklist will be added in the next MCO contract amendment. Further specific language may be added after completion of the initial analysis and implementation of ongoing monitoring.

Ongoing Stakeholder Education

LDH has established a proactive system to monitor for potential parity issues. While the approach is comprehensive it would be incomplete without considering the direct experience of Medicaid beneficiaries, providers and other stakeholders. LDH has established a dedicated e-mail address that stakeholders can use to report potential parity issues. Promotion of how to report a parity issue will be discussed during LDH member and provider stakeholder forums and established reoccurring OBH or Medicaid committee meetings:

The dedicated email address for reporting potential parity issues or concerns to LDH is MHParity@la.gov.

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