

Mental Health Parity FAQ

LDH wants to provide Medicaid enrollees with information requirements regarding mental health. Below are questions and answers that the Department hopes will help Medicaid Managed care members to better understand their rights to mental health benefits as it relates to parity requirements under Healthy Louisiana plans.

Since parity requirements began with commercial plans, how does it apply to public sector plans?

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.

The final Medicaid/CHIP parity rule applies most provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to coverage provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and Children's Health Insurance Programs (CHIPs). Parity requirements do not apply to mental health (MH) or substance use disorder (SUD) benefits for beneficiaries who receive only Medicaid non-ABP fee-for-service (FFS) state plan services.

How does this affect FFS benefits?

All people receiving any services through Medicaid and CHIP MCOs are protected by mental health parity requirements, even if some services are provided in fee-for-service (FFS). Parity requirements apply to all MH/SUD benefits provided to Medicaid MCO enrollees regardless of whether all MH/SUD and M/S benefits are provided by the MCO. If a Medicaid MCO enrollee receives some benefits on a fee-for-service (FFS) basis, MHPAEA applies to the FFS benefits too.

What if I have private or commercial insurance?

The information provided on this website is specific to Louisiana's parity requirements for Medicaid beneficiaries. While parity requirements do apply in the private/commercial market, please contact the Louisiana Department of Insurance Office of Consumer Services at 1-800-259-5300, or visit their [website](#).

What is Louisiana doing to meet compliance?

Louisiana is one of 11 states chosen to participate in the SAMHSA policy academy which gives us access to national consultants, resources, and trainings. In accordance with MHPAEA requirements, we are in the process of conducting both NQTL and QTL analysis on our current benefits delivered to members of our managed care organizations. That initial analysis will be completed by October 2, 2017 and published on our website. The state will conduct ongoing monitoring to ensure we maintain compliance with parity requirements.

How is LDH involving stakeholders?

LDH is working with the contract managed care entities to gather and analyze information to ensure parity compliance. The Department also created a website to provide information and additional resources for consumers receiving Medicaid benefits. There is a dedicated email address for consumers to ask further questions. Also, LDH is presenting on parity and the work required of the state to various advocacy groups and public meetings. LDH will post final documentation of compliance on its website by October 2, 2017.

What are quantitative treatment limits and financial requirements?

Under parity, it is prohibited to apply any FR or QTL to MH/SUD benefits in any classification that is more restrictive than the predominant FR or QTL of that type applied to substantially all M/S benefits in the same classification of benefits. Whether a FR or QTL is a predominant FR or QTL that applies to substantially all M/S benefits in a classification is determined separately for each type of FR or QTL.

Financial requirements (FRs) include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Quantitative treatment limitations (QTLs), which are expressed numerically (e.g., 50 outpatient visits per year), include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment.

Aggregate lifetime dollar limit (AL) means a dollar limitation on the total amount of specified benefits that may be paid under a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP).

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

What are non-quantitative treatment limits?

Under MHPAEA, certain utilization review, prior authorization and plan provisions may only be applied to mental health or substance abuse benefits if they meet the standards for the “comparable to and applied no more stringently than the limitations applied to medical/surgical benefits” rule.

What if I have additional questions about parity?

Medicaid beneficiaries with additional parity-related questions may submit their questions to LDH by contacting us at MHParity@la.gov.