Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements

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Report in Brief
Date: March 2024
Report No. A-02-22-01016

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements

Why OIG Did This Audit

In 2021, nearly 58 million adults in the United States experienced some form of mental illness, and an estimated 46.3 million people aged 12 or older had a substance use disorder. Individuals seeking care for mental health and substance use disorder (MH/SUD) conditions often find that treatment operates in a separate, and often very disparate, system than treatment for medical/surgical care, even under the same health insurance coverage. Federal regulations were put in place to make it easier for people with MH/SUD conditions to access treatment and services by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than to medical/surgical benefits.

The objective of this audit was to determine whether CMS ensured that selected States complied with Medicaid managed care MH/SUD parity requirements.

How OIG Did This Audit

We selected eight States for review with Medicaid managed care contracts in effect on or after October 2, 2017 (the compliance date). We selected four States in which the State was required to conduct the parity analysis and four States in which managed care organizations (MCOs) were required to conduct the parity analysis. We reviewed CMS's approval of States' MCO contract provisions and its oversight of States' compliance with MH/SUD parity requirements.

What OIG Found

CMS did not ensure that selected States complied with Medicaid managed care MH/SUD parity requirements. For all eight States we reviewed, State contracts with Medicaid MCOs did not contain required parity provisions by the compliance date. Further, States and their MCOs did not conduct required parity analyses (five States), and States did not make documentation of compliance available to the public by the compliance date (eight States). In addition, all eight States may not have ensured that all services were delivered to MCO enrollees in compliance with MH/SUD parity requirements. Specifically, MCOs applied financial requirements (two States) and quantitative treatment limitations (six States) for MH/SUD services that were more restrictive than those for medical/surgical services in the same classifications and imposed nonquantitative treatment limitations (eight States) on MH/SUD benefits that were not comparable to, or were more stringent than, those for medical/surgical benefits in the same classifications.

What OIG Recommends and CMS Comments

We recommend that CMS improve its oversight of States' compliance with MH/SUD parity requirements and require States to improve their monitoring of MCOs' ongoing compliance with MH/SUD parity requirements.

In written comments on our draft report, CMS concurred with our recommendations and described actions that it plans to take to address them. Specifically, CMS stated that it will take steps to strengthen its followup procedures for monitoring States' compliance with MH/SUD parity requirements, including steps for: (1) verifying that States have performed required parity analyses, (2) following up with States that have identified noncompliance with MH/SUD parity requirements, and (3) maintaining documentation of its communications with States relating to compliance with parity requirements and actions taken to correct any identified deficiencies. In addition, CMS stated that it will issue guidance to States to ensure MCOs' ongoing compliance with parity requirements.

The full report can be found on the OIG website.

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INTRODUCTION

WHY WE DID THIS AUDIT

In 2021, nearly 58 million adults in the United States experienced some form of mental illness,[1] and an estimated 46.3 million people aged 12 or older had a substance use disorder.[2] Individuals seeking care for mental health and substance use disorder (MH/SUD) conditions often find that treatment operates in a separate, and often very disparate, system than treatment for medical/surgical care, even under the same health insurance coverage. Federal regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) were put in place to make it easier for people with MH/SUD conditions to access treatment and services by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than to medical/surgical benefits (i.e., parity in how the two types of benefits are covered by health insurers, including Medicaid managed care).

We conducted this audit as part of the Office of Inspector General's (OIG's) oversight work related to enrollees' access to health care services that deliver value, quality, and improved outcomes in Medicare and Medicaid.[3] Further, there is significant congressional interest in OIG's work that addresses enrollees' access to MH/SUD services, including the topic of parity.

OBJECTIVE

The objective of this audit was to determine whether the Centers for Medicare & Medicaid Services (CMS) ensured that selected States complied with Medicaid managed care MH/SUD parity requirements.

BACKGROUND

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

MHPAEA was intended to promote equal access to treatment for people with MH/SUD conditions by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than for medical/surgical benefits. Such limitations may include higher copayments, separate

[1] National Institute of Mental Health, "Mental Illness." Available online at https://www.nimh.nih.gov/health/statistics/mental-illness. Accessed on Oct. 4, 2023.

[2] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health*. Available online at https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf. Accessed on Oct. 4, 2023.

[3] See Appendix B for a list of related OIG reports.

deductibles, and stricter preauthorization or medical necessity reviews, as compared to other covered medical treatments.

Mental Health and Substance Use Disorder Parity Requirements

CMS issued a final rule in 2016 that addressed how MHPAEA MH/SUD parity requirements apply to Medicaid managed care organizations (MCOs).[4] Specifically, States and their MCOs were required to comply with parity requirements by October 2, 2017 (the compliance date).[5] The regulations required that States' MCO contracts included provisions for services to be delivered in compliance with MH/SUD parity requirements by the compliance date.[6] Also, States or their MCOs are required to conduct parity analyses to assess whether MH/SUD benefits are covered in a way that is no more restrictive than medical/surgical benefits.[7] According to CMS, as of April 2022, 43 States (including Puerto Rico and the District of Columbia) used MCOs to deliver services to Medicaid enrollees. Of these, 32 States are required to conduct a parity analysis. In the 11 other States, MCOs are responsible for conducting the parity analysis.

The parity analyses compare limitations on MH/SUD benefits with those for medical/surgical services in four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care).[8] As part of each parity analysis, each MH/SUD and medical/surgical benefit in a classification is identified and tested in five specific areas:

(1) aggregate lifetime and annual dollar limits;

(2) financial requirements, such as coinsurance, deductibles, copayments, and out-of-pocket maximums;

(3) quantitative treatment limitations (QTLs), including annual, episode, lifetime, day, and visit limits;

(4) nonquantitative treatment limitations (NQTLs), which are provisions not expressed numerically but otherwise limit the scope and duration of benefits, including limiting benefits based on medical necessity, medical management policies (e.g., prior authorization), and standards for provider participation in a network; and

[4] 81 Fed. Reg. 18390 (Mar. 30, 2016).

[5] Section 1932(b)(8) of the Social Security Act and implementing regulations at 42 CFR Part 438.

[6] 42 CFR §§ 438.3(n) and 438.930.

[7] 42 CFR § 438.920.

[8] 42 CFR §§ 438.905, 438.910, and 438.915. Parity does not mandate coverage of MH/SUD benefits. However, when coverage for MH/SUD benefits is provided, coverage must be provided in every classification in which medical/surgical benefits are provided.

(5) availability of information related to criteria for medical necessity determinations and reasons for any denials.

If a State offers all MH/SUD and medical/surgical benefits through MCOs, each MCO is responsible for completing a parity analysis. If MCOs in a State do not offer all MH/SUD benefits, the State is responsible for conducting the analysis across delivery systems to ensure that parity requirements are met. States must provide documentation of compliance with requirements to the public and were required to post this information on their State Medicaid website by the compliance date. States must also ensure that services delivered to MCO enrollees comply with parity requirements and update and resubmit the parity analysis to CMS prior to any change in MCO or State plan benefits.[9]

CMS is required to review and approve all MCO contracts.[10] As part of its MCO contract approval process, CMS reviews whether a contract contains required MH/SUD parity provisions and reviews States' parity analyses (if applicable).[11] States must provide documentation to CMS to demonstrate how parity requirements are met.[12]

HOW WE CONDUCTED THIS AUDIT

We judgmentally selected for review eight States with Medicaid managed care contracts in effect on or after October 2, 2017.[13] We based our selection on risk factors such as the prevalence of mental illness in States compared to rates of access to care,[14] as well as geographic location and whether States or MCOs were responsible for conducting parity analyses.[15] We selected four States (Arizona, New Jersey, New York, and Texas) in which the State was required to conduct the parity analysis and four States (Illinois, Kansas, Mississippi, and South Carolina) in which MCOs were required to conduct the parity analysis. We reviewed CMS's approval of States' MCO contract provisions (specifically, those related to parity for MH/SUD benefits) and its oversight of States' compliance with MH/SUD parity requirements. In

[9] 42 CFR § 438.920(b).

[10] 42 CFR § 438.3(a).

[11] CMS, *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval* (Jan. 20, 2017, section I.F.12.08).

[12] 42 CFR § 438.3(n)(2).

[13] In our findings, when referencing States, we are referring to these eight States.

[14] For this measure, we used data from Mental Health America's 2022 State rankings of the highest prevalence of mental illness with the lowest access to care, available online at https://mhanational.org/issues/2022/ranking-states. Last accessed on Oct. 4, 2023.

[15] We excluded from selection four States (California, Georgia, Idaho, and North Carolina), which CMS indicated that it is still working with to achieve compliance with parity requirements.

addition, we reviewed States' or MCOs' parity analyses and States' procedures for monitoring MCOs' ongoing compliance with MH/SUD parity requirements.

We did not review the overall internal control structure of CMS, the States, or the MCOs. Rather, we limited our review of internal controls to those applicable to our objective.

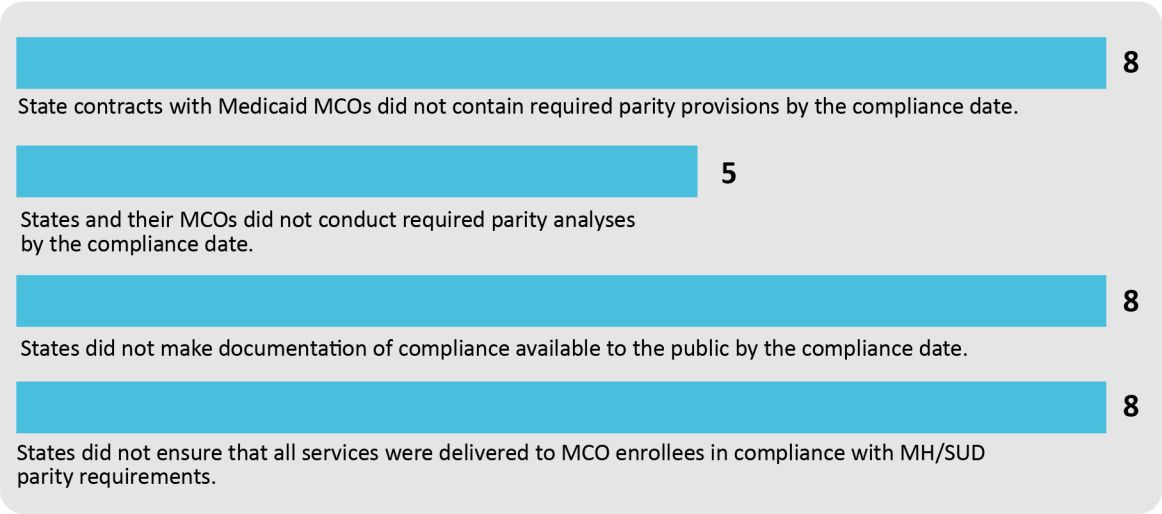
We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

CMS did not ensure that selected States complied with Medicaid managed care MH/SUD parity requirements, as detailed in the figure on the following page. For all eight States we reviewed, State contracts with Medicaid MCOs did not contain required parity provisions by the compliance date. Further, States and their MCOs did not conduct required parity analyses (five States), and States did not make documentation of compliance available to the public by the compliance date (eight States). In addition, all eight States may not have ensured that all services were delivered to MCO enrollees in compliance with MH/SUD parity requirements. Specifically, MCOs applied financial requirements (two States) and QTLs (six States) for MH/SUD services that were more restrictive than those for medical/surgical services in the same classifications and imposed NQTLs (eight States) on MH/SUD benefits that were more stringent than those for medical/surgical benefits in the same classifications.

Figure: Eight Selected States' Compliance With Mental Health and Substance Use Disorder Parity Requirements



MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY PROVISIONS WERE NOT INCLUDED IN MANAGED CARE ORGANIZATION CONTRACTS BY THE COMPLIANCE DATE

According to CMS's 2016 final rule that addressed how MHPAEA MH/SUD parity requirements apply to Medicaid MCOs, CMS must review and approve all MCO contracts (42 CFR § 438.3), and all MCO contracts must provide for services to be delivered in compliance with MH/SUD parity requirements at 42 CFR part 438 subpart K, when applicable (42 CFR § 438.3(n)).[16] Contracts with MCOs offering Medicaid State plan services to enrollees at the time of this final rule had to comply with parity requirements by the compliance date (42 CFR § 438.930).[17]

For all eight States we reviewed, State contracts with MCOs did not contain required MH/SUD parity provisions by the compliance date. Table 1 (next page) summarizes when the parity provisions were included in the eight States we reviewed.

[16] The relevant provisions regarding parity requirements from 42 CFR part 438 subpart K are 42 CFR §§ 438.905 and 438.910.

[17] In its final rule implementing parity requirements, CMS noted that it is common practice for States to amend MCO contracts mid-year and did not anticipate that it would cause an undue burden for States to make needed changes to their MCO contracts by the compliance date (81 Fed. Reg. 18390, 18422 (Mar. 30, 2016)).

Table 1: Mental Health and Substance Use Disorder Parity Provisions Included in Managed Care Organization Contracts

State	Provisions Included by the Compliance Date (Oct. 2, 2017)	Date Provisions Were Included in Contracts	Included in Current Contracts
AZ	No	10/2021	Yes
NJ	No	1/2018	Yes
NY	No	4/2019	Yes
TX	No	09/2022	Yes
IL	No	1/2018	Yes
KS	No	1/2019	Yes
MS	No	12/2020	Yes
SC	No	7/2018	Yes

SELECTED STATES AND MANAGED CARE ORGANIZATIONS DID NOT CONDUCT PARITY ANALYSES OR MAKE PARITY COMPLIANCE INFORMATION AVAILABLE TO THE PUBLIC BY THE COMPLIANCE DATE

States that did not offer all MH/SUD benefits through MCOs were required to conduct a parity analysis by the compliance date across delivery systems to ensure that it met parity requirements (42 CFR §§ 438.920(b) and 438.930).[18] For States that offered all MH/SUD and medical/surgical benefits through MCOs, the MCOs in those States were responsible for completing the parity analysis (42 CFR § 438.920(a)).[19] Further, States were required to provide documentation of compliance with the MH/SUD parity requirements to the public and to post this information on its State Medicaid website by the compliance date. States were also required to update and resubmit the parity analysis to CMS prior to any change in managed care or State plan benefits (42 CFR § 438.920(b)).

None of the four States that were required to conduct parity analyses across their delivery systems (Arizona, New Jersey, New York, and Texas) conducted these analyses or provided documentation of compliance to the public by the compliance date. Subsequently, between December 2017 and April 2019, the four States conducted their parity analyses and posted information about their compliance with parity requirements on their State Medicaid websites.

In the four States in which MCOs were required to perform the parity analyses (Illinois, Kansas, Mississippi, and South Carolina), MCOs in three States (Kansas, Mississippi, and South Carolina) conducted the parity analyses by the compliance date. The fourth State (Illinois) requested an extension from CMS for performing the parity analysis and provided a letter of compliance for

[18] CMS required compliance no later than 18 months after the Mar. 30, 2016, publication of the final rule.

[19] CMS, *An Implementation Roadmap for State Policymakers Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (Jan. 18, 2017).

its MCOs in May 2018.[20] In one of the States (Kansas), all MCOs conducted the parity analyses by the compliance date; however, the State contracted with a new MCO in 2019 to provide services to enrollees, and the new MCO had not performed a parity analysis as of the start of our audit fieldwork in September 2022. As a result of our review, the State required the new MCO to conduct a parity analysis, and in April 2023, the MCO submitted the results of its parity analysis to the State for review. Two States (Illinois and Mississippi) posted information about MCOs' compliance with parity requirements in November 2019 and July 2022, respectively.

Table 2 below summarizes when the parity analyses were conducted and posted in the eight selected States.

Table 2: Mental Health and Substance Use Disorder Parity Analyses and Posting of Compliance Information

State	Responsible for Parity Analysis	Parity Analysis Conducted			Date Posted to Public Website
		Conducted by the Compliance Date (Oct. 2, 2017)	Date Conducted	Extension[21]/Other	
AZ	State	No	12/2017	Yes	12/2017
NJ	State	No	12/2017	No	12/2018
NY	State	No	4/2019	Multiyear plan	4/2019
TX	State	No	12/2017	Yes	12/2017
IL	MCOs	No	5/2018*	Yes	7/2022
KS	MCOs	Yes	10/2017	No	Not Posted
MS	MCOs	Yes	10/2017	No	11/2019
SC	MCOs	Yes	5/2017	No	Not Posted**

* The State provided a letter of compliance with parity requirements to CMS in May 2018. By the end of the audit period, all MH/SUD benefits were delivered through MCOs and, as result, the MCOs were designated as the responsible party for completing the parity analysis. (See footnote 20.)

** We noted that the State added the following to its capitation rate handbook: "We are not aware of any considerable policy changes at this time that would require an adjustment to the State Fiscal Year 2018 capitation rate for compliance with Mental Health Parity standards."

[20] The State requested an extension from CMS to complete the MH/SUD parity analysis because it was undergoing a major procurement to expand its Medicaid managed care program. During the course of our audit, CMS stated that although Illinois provided a letter of compliance in May 2018 related to the MCOs' and the State's review of parity requirements, the parity analysis did not meet CMS's standard outlined in the Parity Compliance Toolkit. The State subsequently contracted with a health services advisory group to do a mental health parity analysis of its health plans.

[21] CMS granted extensions for three of the selected States to complete the parity analysis. These extensions were granted until Dec. 31, 2017, for two States (Arizona and Texas) and until Apr. 1, 2018, for one State (Illinois).

SELECTED STATES MAY NOT HAVE ENSURED THAT SERVICES WERE DELIVERED TO ENROLLEES IN COMPLIANCE WITH PARITY REQUIREMENTS

States must ensure that all services are delivered to MCO enrollees in compliance with Medicaid MH/SUD parity requirements (42 CFR § 438.920(b)). MCOs in a State that covers both MH/SUD and medical/surgical benefits under the State plan must not apply any financial requirement or QTL to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. MCOs may not impose an NQTL for MH/SUD benefits unless its application to MH/SUD benefits in any classification is comparable to, and applied no more stringently than, its application to medical/surgical benefits in the same classification (42 CFR § 438.910). Contracts with MCOs offering State plan services to enrollees were required to comply with parity requirements by the compliance date (42 CFR § 438.930).

In all eight States, the States may not have ensured that all services were delivered to MCO enrollees in compliance with parity requirements. Specifically, the State or its MCOs identified areas of noncompliance or potential noncompliance that would need to be addressed for them to comply with parity requirements; however, these noncompliant areas were not always corrected in a timely manner. MCOs did not comply with parity requirements for financial requirements in two States (Mississippi and South Carolina), for QTLs in six States (Arizona, Kansas, Mississippi, New York, South Carolina, and Texas), or for NQTLs in all eight States.

The States and their MCOs corrected some of the identified areas of noncompliance or potential noncompliance between December 2017 and July 2021.[22] However, in four States (Illinois, Kansas, New York, and South Carolina), some deficiencies were uncorrected as of the end of our audit fieldwork in June 2023.[23] For example, in one State (South Carolina), parity analyses completed by its contractor in 2017 identified noncompliance with financial parity requirements and several NQTL areas of noncompliance or potential noncompliance (e.g. prior authorizations and concurrent review). By 2021, the State and its MCOs had addressed the noncompliance with financial requirements for parity; however, as of the end of our audit fieldwork, the State did not have any information on how MCOs had addressed the NQTL areas of noncompliance or potential noncompliance. Another State (New York) identified several NQTL areas in which, as of the end of our fieldwork, its MCOs were not in compliance with

[22] We reviewed parity analyses that identified areas of noncompliance with parity requirements and any documented corrective actions taken to address the noncompliance (e.g., contract amendments, Medicaid State plan amendments, updated State regulations, updated parity analyses, correspondence between States and CMS). We did not review whether States' or MCOs' revised policies in operation ensured compliance with Federal parity requirements.

[23] In addition, in one State (Illinois), its contractor reported in July 2022 that one MCO "denied MH/SUD authorization requests at a statistically significantly higher rate than medical/surgical requests." A higher rate of denial for MH/SUD services does not necessarily mean noncompliance with parity requirements. Rather, a higher rate could be an indicator of potential noncompliance.

Federal parity requirements. Table 3 summarizes the areas of noncompliance identified by the parity analyses.

Table 3: Summary of Managed Care Organizations' Mental Health and Substance Use Disorder Areas of Noncompliance or Potential Noncompliance

State	Date Parity Analysis Conducted	Financial Requirements	Date Corrected	Quantitative Treatment Limitation(s)	Date Corrected	Nonquantitative Treatment Limitation(s)	Date Corrected
AZ	12/2017			X	Pending	X	3/2018
NJ	12/2017					X	7/2018
NY	4/2019			X	4/2020	X	Pending
TX	12/2017			X	1/2019	X	1/2019
IL	5/2018					X	Pending
KS	10/2017			X	12/2017	X	Pending*
MS	10/2017	X	1/2018	X	1/2018	X	1/2018
SC	5/2017	X	7/2021	X	Pending	X	Pending

* One NQTL was addressed in January 2019 regarding prior authorization for certain MH/SUD services. However, one MCO cited potential noncompliance with MH/SUD drug formulary design, and, by the end of our fieldwork, the State did not provide any documentation showing the potential noncompliance had been addressed. (A drug formulary is a list of prescription drugs, including both brand name and generic, which are covered by a health insurance plan.)

Managed Care Organizations Imposed Financial Requirements That Were More Restrictive for Mental Health and Substance Use Disorder Benefits Than Those for Medical/Surgical Benefits

In two States (Mississippi and South Carolina), parity analyses determined that MCOs imposed financial requirements on MH/SUD benefits that were more restrictive than those for medical/surgical benefits. For example, in one State (South Carolina), the parity analyses performed in 2017 identified that multiple MCOs imposed copayment requirements on certain MH/SUD benefits (i.e., inpatient and outpatient services and prescription drugs) that were more restrictive than those for medical/surgical benefits. By 2021, all MCOs in the State had corrected the deficiency by adjusting their application of copayments for MH/SUD services. In another State (Mississippi), one MCO's 2017 parity analysis identified that the out-of-network provider payment rate for behavioral health services was higher than the out-of-network provider payment rate for medical/surgical services in the same classification. In 2018, the MCO corrected the deficiency by adjusting the negotiated provider payment rate for behavioral health services to match the provider payment rate for medical/surgical services.

Managed Care Organizations Imposed Quantitative Treatment Limitations That Were More Restrictive for Mental Health and Substance Use Disorder Benefits Than Those for Medical/Surgical Benefits

In six States (Arizona, Kansas, Mississippi, New York, South Carolina, and Texas), parity analyses determined that the MCOs imposed QTLs on MH/SUD benefits that were more restrictive than those for medical/surgical benefits. For example, MCOs imposed annual limitations on the number of face-to-face sessions for smoking cessation, limitations on the number of group or individual counseling sessions, hourly limitations on partial hospitalization services, and limitations on the number of residential treatment services. In comparison, there were no such limitations for medical/surgical services in the same benefit classification.

By April 2020, four of the six States (Kansas, Mississippi, New York, and Texas) addressed the noncompliance by amending their Medicaid State plan, removing limits on MH/SUD services from benefits plans or certain services, and modifying State regulations and policies related to MH/SUD services. As of the end of our fieldwork, the two remaining States (Arizona and South Carolina) had not corrected the areas of noncompliance—limitations on certain MH/SUD services—that they had previously identified or did not provide documentation that MCOs had corrected the areas of noncompliance.

Managed Care Organizations Imposed Nonquantitative Treatment Limitations on Mental Health and Substance Use Disorder Benefits That Were Not Comparable to, or Were More Stringent Than, Those for Medical/Surgical Benefits

In all eight States, parity analyses determined that MCOs imposed or may have imposed NQTLs for MH/SUD benefits that were not comparable to, or were more stringent than, those for medical/surgical benefits. For example, MCOs: (1) imposed prior authorization requirements for MH/SUD services when there were no such requirements for medical/surgical benefits in the same classification, (2) required prior approval for planned out-of-network MH/SUD services but did not require the same for medical/surgical services, (3) used strategies for determining reimbursement rates for MH/SUD services that were not comparable to those used for medical/surgical services, (4) had more restrictive MH/SUD drug formulary designs than those for medical/surgical benefits, and (5) denied MH/SUD authorization requests at a significantly higher rate than medical/surgical requests.[24]

By January 2019, five of the eight States (Arizona, Kansas, Mississippi, New Jersey, and Texas) took actions to correct noncompliance by amending their Medicaid State plans, removing limits on MH/SUD benefits not imposed on medical/surgical benefits, and establishing minimum performance standards across all MCOs. In addition, some of the States required MCOs to submit correction plans to address identified noncompliance areas. However, one State (South Carolina) did not provide any information regarding the MCOs' possible corrective actions for

[24] As described in footnote 23, a higher rate of denial for MH/SUD services does not necessarily mean there is noncompliance.

areas of noncompliance identified in the State's 2017 parity analysis. Also, another State (New York) indicated that it has a multiyear strategy to achieve compliance and, in its latest parity report (dated March 2022), identified several areas of NQTL noncompliance by its MCOs (e.g., prior authorizations, medical necessity criteria, formulary design, and out of network coverage standards). In the report, the State described actions it plans to take to address its MCOs' noncompliance, including providing them technical assistance and considering penalizing noncompliant MCOs.

CAUSES OF SELECTED STATES' AND MANAGED CARE ORGANIZATIONS' NONCOMPLIANCE WITH PARITY REQUIREMENTS

CMS did not provide adequate oversight of States' compliance with parity requirements or their posting of this information to State websites. CMS provided guidance to States related to compliance with MH/SUD parity requirements and, as part of its review of States' MCO contracts, determined whether the contracts contained the required parity provisions and reviewed States' parity analyses, if applicable.[25] However, CMS did not review whether States added MH/SUD provisions to MCO contracts by the compliance date or whether States or their MCOs had performed the required parity analyses by that date. Instead, CMS stated that it put into practice a process to review the States' first contract actions (e.g., contract renewals and amendments) after the compliance date. CMS also stated that, in States where MCOs were responsible for performing parity analyses, CMS did not review information MCOs provided regarding compliance as part of its MCO contract approval process or communicate with the States regarding whether MCOs identified any noncompliance with parity requirements. Further, CMS did not always maintain documentation of its communications with States to address noncompliance identified in the States' parity analyses. CMS attributed this to its organizational structure in place prior to a 2019 reorganization, personnel turnover, and changes to internal information systems.

Additionally, the selected States did not provide adequate oversight and monitoring of MCOs' compliance with MH/SUD parity requirements. Specifically, most States had no formal procedures (e.g., written procedures for reviewing parity as part of MCO contract compliance

[25] To assist States in complying with MH/SUD parity requirements, CMS published several relevant guidance documents, including its *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* (Jan. 17, 2017), available online at https://www.medicaid.gov/sites/default/files/2019-12/parity-toolkit.pdf, and the *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval* (Jan. 18, 2022), available online at https://www.medicaid.gov/sites/default/files/2022-01/mce-checklist-state-user-guide.pdf (both accessed on Oct. 4, 2023). CMS also made available technical assistance to States through training webinars, peer learning sessions, Frequently Asked Questions, and a technical assistance mailbox.

reviews) in place to ensure MCOs' ongoing compliance with parity requirements.[26] Some States did not have separate procedures in place beyond the contract requirements, did not always require MCOs to conduct updated parity analyses to show that deficiencies were addressed, did not always require newly added MCOs to conduct parity analyses, or did not require MCOs to correct identified deficiencies in a timely manner. Also, some States indicated that staff turnover, changes in leadership, and lack of coordination among responsible State agencies made it difficult to obtain information regarding States' and MCOs' initial parity compliance efforts. States also noted that amending their Medicaid State plan or legislative changes, if required, involved processes that took a significant amount of time and was difficult to do by the compliance date. Additionally, some States mentioned challenges that they encountered with the quality of data submitted by MCOs performing parity analyses.[27] Further, some States mentioned that MCOs experienced challenges with the complexity of the parity requirements, which resulted in delays in completing analyses or making policy changes to address identified deficiencies.

Because CMS and the States did not ensure that MCOs complied with MH/SUD parity requirements by the compliance date, needed MH/SUD services may have been more difficult to obtain than medical/surgical services, delayed, or not received. Also, because States' Medicaid websites were not updated in a timely manner, the public may not have had information on whether MH/SUD benefits were delivered by MCOs in a way that was not more restrictive than delivery of medical/surgical benefits. While many of the selected States have worked with their MCOs to correct the deficiencies identified in parity analyses, parity deficiencies remain in some States, which could impact enrollees' access to necessary MH/SUD treatment and services.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- improve its oversight of States' compliance with MH/SUD parity requirements, including:
    - strengthening its followup procedures, including regular communication with States, to verify that States perform parity analyses across their MH/SUD delivery systems;

[26] Some States require annual MCO surveys/self-assessments to monitor continued compliance. For example, MCOs in some States are required to certify ongoing compliance with parity requirements on an annual basis. Other States require MCOs to complete and submit annual reviews of MH/SUD parity and submit results, including needed corrective actions. In addition, some States review compliance with parity requirements when there are changes to benefits or they contract with new MCOs.

[27] The States indicated that, over time, data quality is improving as a result of educating MCOs.

- requiring States in which MCOs are responsible for the parity analysis to submit information MCOs provided regarding compliance with parity requirements to CMS for its review as part of the contract approval process and, if necessary, seeking additional regulatory authority to do so;

- following up with any States that have identified any noncompliance with parity requirements to verify that the States have taken actions to address the noncompliance; and

- maintaining documentation of its communications with States related to compliance with MH/SUD parity requirements and actions taken to correct any identified deficiencies; and

- require States to improve their monitoring of MCOs' ongoing compliance with MH/SUD parity requirements by:

  - modifying State policies and procedures for reviewing MCOs' compliance with contract provisions to include written procedures for reviewing compliance with MH/SUD parity requirements,

  - requiring MCOs to update parity analyses when benefits change or deficiencies are corrected,

  - requiring newly added MCOs to conduct parity analyses, and

  - conducting followup in a timely manner with MCOs that have identified noncompliance with parity requirements to verify that the MCOs take corrective actions to address the noncompliance.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our recommendations and described actions that it plans to take to address them. Specifically:

- Regarding our recommendation to improve its oversight of States' compliance with MH/SUD parity requirements, CMS stated that it will take steps to strengthen its followup procedures to verify that States have performed the required parity analyses across their MH/SUD delivery systems. In addition, CMS stated that, for States in which MCOs are responsible for conducting the parity analysis, CMS will request that the States submit the information their MCOs provide regarding compliance with parity requirements. However, CMS stated that additional regulatory authority may be needed to require States to submit this information to CMS. Further, CMS stated that it will strengthen its procedures for following up with States that have identified noncompliance with the parity requirements and will work with the States identified in

the audit report to verify that they have taken actions to address the areas of noncompliance. Lastly, CMS stated that it will strengthen its procedures for maintaining documentation of its communications with States relating to compliance with parity requirements and actions taken to correct any identified deficiencies.

- Regarding our recommendation to require States to improve their monitoring of MCOs' ongoing compliance with MH/SUD parity requirements, CMS stated that it will issue guidance to States reminding them of CMS's expectations for: (1) reviewing MCOs' compliance with contract provisions to ensure compliance with parity requirements, (2) having MCOs update their parity analyses when benefits change or deficiencies are corrected, (3) having newly added MCOs conduct parity analyses, and (4) following up with MCOs that have identified noncompliance with parity requirements and for verifying that the MCOs have addressed the noncompliance.

Under separate cover, CMS provided technical comments, which we addressed as appropriate. We also modified one of our recommendations to address CMS's comment on requiring States to provide information from MCOs regarding compliance with parity requirements. CMS's comments, excluding its technical comments, are included as Appendix C.

We acknowledge CMS's cooperation throughout our audit and the actions it plans to take to address our recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We judgmentally selected for review eight States with Medicaid managed care contracts in effect on or after October 2, 2017. We based our selection on risk factors such as the prevalence of mental illness in States compared to rates of access to care, as well as geographic location and whether States or MCOs were responsible for conducting parity analyses. We selected four States (Arizona, New Jersey, New York, and Texas) in which the State was required to conduct the parity analysis and four States (Illinois, Kansas, Mississippi, and South Carolina) in which MCOs were required to conduct the parity analysis. We reviewed CMS's oversight of States' compliance with MH/SUD parity requirements, States' or MCOs' parity analyses, and related documentation of compliance with MH/SUD parity requirements.

We did not review the overall internal control structure of CMS, the States, or the MCOs. Rather, we limited our review of internal controls to those applicable to our objective. Specifically, we reviewed CMS's and the States' processes for overseeing and monitoring compliance with mental health parity requirements. For CMS, we reviewed its policies and procedures for reviewing MCO contract actions related to parity compliance and States' and their MCOs' compliance by the compliance date, technical guidance CMS provided to States, and CMS's policies and procedures for reviewing parity analyses submitted by States and followup for any noncompliance identified. For States, we reviewed their policies and procedures for monitoring MCOs' ongoing compliance with parity requirements, including States' procedures for reviewing MCO submissions related to parity compliance; States' followup with MCOs and corrective actions taken for any identified noncompliance; and guidance States provided to MCOs related to compliance with parity requirements.

We conducted our audit work from August 2022 through October 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- met with CMS officials to gain an understanding of CMS's processes for reviewing and approving MCO contracts and specific procedures related to compliance with parity requirements;
- obtained from CMS a listing of States with MCO contracts in effect on or after October 2, 2017;[28]

[28] The listing identified whether the States or MCOs were responsible for the parity analysis.

- judgmentally selected eight States for review using risk factors such as the prevalence of mental illness compared to access to care (see footnote 14), as well as geographic location and whether the State or its MCOs were responsible for performing parity analyses;[29]

- met with officials from each selected State to obtain, review, and discuss the State's policies and procedures for ensuring compliance with MH/SUD parity requirements and to obtain documentation of the State's communications with CMS and the State's MCOs regarding parity analyses and actions taken on any identified noncompliance;

- reviewed each selected State's MCO contracts, parity analyses, and records of communication with CMS or their MCOs to determine whether:

    - CMS ensured that the State's contracts included the required parity provisions by the compliance date;

    - the State ensured that required parity analyses were conducted, including whether it ensured that MCOs, if they were required to, performed parity analyses and informed the State of any changes needed to comply with parity requirements;

    - CMS reviewed the State's parity analyses or the State reviewed information its MCOs provided regarding compliance with parity requirements;

    - CMS or the State took action to address any noncompliance with parity requirements; and

    - the State made the required parity information available to the public by the compliance date by posting on its State Medicaid website;

- summarized the results of our audit; and

- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[29] We selected four States (Arizona, New Jersey, New York, and Texas) in which the State was required to conduct the parity analysis and four States (Illinois, Kansas, Mississippi, and South Carolina) in which MCOs were required to conduct the parity analysis.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
New York Did Not Ensure That a Managed Care Organization Complied With Requirements for Denying Prior Authorization Requests	A-02-21-01016	9/18/2023
Amerigroup Iowa's Prior Authorization and Appeal Processes Were Effective, but Improvements Can Be Made	A-07-22-07007	9/13/2023
High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care	OEI-09-19-00350	7/17/2023
Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization	A-03-20-00201	12/20/2022

APPENDIX C: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: January 22, 2024

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements (A-02-22-01016)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. As the largest single source of funding for mental health (MH) and substance use disorder (SUD) services in the United States, Medicaid fills a critical role in supporting access to services and treatment for millions of individuals struggling with these conditions. Ensuring compliance with federal parity requirements in Medicaid is fundamental to improving access to care for enrollees who need MH and/or SUD treatment.

Mental health parity requirements were originally applied to Medicaid managed care organizations (MCOs) through the Balanced Budget Act of 1997, which added section 1932(b)(8) to Title XIX of the Social Security Act (The Act). Section 1932(b)(8) of The Act incorporates requirements of the Mental Health Parity Act of 1996 (MHPA) into requirements for Medicaid MCOs. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) amended the 1996 MHPA parity requirements for large employer-sponsored health plans, and also added new standards, including requiring parity for coverage of SUD benefits. As noted in the OIG's report, MHPAEA generally prevents group health plans and health insurance issuers that provide MH or SUD benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. Most provisions of MHPAEA apply to coverage provided to enrollees of Medicaid MCOs, as well as coverage provided by Medicaid alternative benefit plans (ABPs) and the Childrens Health Insurance Program (CHIP).

To strengthen parity requirements in Medicaid and CHIP, CMS issued regulations in 2016 specifically focused on implementing the federal parity requirements that apply to Medicaid MCOs, CHIP, and Medicaid ABPs.[1] These regulations require that financial requirements, such as coinsurance or copayments, and treatment limitations imposed on MH or SUD benefits may not be more restrictive than those applied to substantially all medical or surgical benefits in a classification of benefits. Benefit classifications used for assessing parity compliance are inpatient, outpatient, emergency care, and prescription drugs. Treatment limitations may be quantitative treatment limitations (QTLs) which are

[1] Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans; Final Rule (81 FR 18390) (March 30, 2016)

numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment. Common NQTLs include, but are not limited to, concurrent review requirements, medical management standards, formulary design for prescription drugs, and standards for provider admission to participate in a network. To support implementation of the Medicaid and CHIP parity regulations by states CMS issued a detailed Parity Compliance Toolkit,[2] a Parity Implementation Roadmap,[3] as well as a Medicaid Fact Sheet and sets of Frequently Asked Questions.[4] CMS also hosted several webinars and regularly provides individualized technical assistance to state Medicaid and CHIP agencies.[5]

CMS regularly works with states to ensure compliance with federal requirements in Medicaid managed care. Regarding the application of parity requirements to Medicaid managed care, states must provide documentation of compliance when benefits for MCO enrollees are split between the MCO and another managed care plan (e.g., a Prepaid Inpatient Health Plan [PIHP] or Prepaid Ambulatory Health Plan [PAHP]) or when some benefits are provided through the MCO and some through fee-for-service (FFS). This documentation must be posted on the state agency's website and submitted to CMS with the MCO contract for review and approval. Alternatively, when a state's contract requires an MCO to provide all benefits to the Medicaid enrollee population, states are required to work with those managed care plans to ensure compliance, but submission of documentation of compliance with parity requirements to CMS is not required. Regardless of whether the state or MCOs are responsible for ensuring compliance with the parity requirements, CMS reviews and approves all Medicaid managed care plan contracts. In an effort to promote transparency and support states, CMS has published a guide that covers the standards used during its contract review process, including noting the contract provisions that must be present to comply with the parity requirements.[6]

As noted in the OIG's report, CMS regulations established an initial compliance date of October 2, 2017. However, in practice this compliance date was challenging for states to meet. Given the complexity of the analyses states were required to conduct, and the need for some states to update their managed care plan contracts to come into compliance, CMS offered states flexibility with regards to the compliance date. Specifically, CMS allowed states to come into compliance with the first contract action submitted to CMS for review and approval following October 2, 2017. While this meant that many states did not comply with the parity requirements until after the initial compliance date, states were working on the required analyses and ensuring the necessary contract provisions were in place well in

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[2] CMS, Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs. 2017. Accessed at: https://www.medicaid.gov/sites/default/files/2020-07/parity-toolkit.pdf

[3] CMS, An Implementation Roadmap for State Policymakers Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs. 2017. Accessed at: https://www.medicaid.gov/sites/default/files/2019-12/parity-roadmap.pdf

[4] CMS, Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP. 2016. Accessed at: https://www.medicaid.gov/sites/default/files/2019-12/fact-sheet-cms-2333-f.pdf; CMS, Frequently Asked Questions: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP. 2017. Accessed at: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/faq101117.pdf

[5] CMS, Webinar #1: Application of Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs. 2017. Accessed at: https://www.medicaid.gov/sites/default/files/2019-12/parity-webinar.pdf; CMS, Webinar #2: Application of Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs. 2017. Accessed at: https://www.medicaid.gov/sites/default/files/2019-12/parity-webinar-022317.pdf; CMS, Webinar #3: Application of Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs. 2017. Accessed at: https://www.medicaid.gov/sites/default/files/2019-12/parity-webinar-030917.pdf

[6] CMS, State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval. 2022. Accessed at: https://www.medicaid.gov/sites/default/files/2022-01/mce-checklist-state-user-guide.pdf

advance of October 2, 2017. CMS has, and will continue to, work closely with states to ensure that parity compliance is achieved, including working with states to address the issues identified in the OIG's report.

In recognition of the growth of the managed care delivery system in the Medicaid program, and the need to ensure the effective integration of managed care policy and operations, CMS established the Managed Care Group (MCG) within the Center for Medicaid and CHIP Services (CMCS) in June 2023.[7] MCG provides national leadership in the development and management of Medicaid program policy and operations regarding managed care programs and provides technical assistance to states and other stakeholders. In addition, MCG is the primary point of contact for policy questions on parity and the application of that policy in the review of documents provided by states. This recent organizational change allows for more effective management and oversight of the Medicaid program as well as a seamless state partner experience. CMS appreciates the information shared in the OIG's report and is committed to continuing to improve CMS's oversight of Medicaid managed care, including the coordination and documentation of CMS's review of states' compliance with parity requirements.

Recently, the Consolidated Appropriations Act, 2021 (CAA, 2021) amended MHPAEA, requiring private sector group health plans and health insurance issuers that provide both medical and surgical benefits, and MH or SUD benefits to perform and document comparative analyses of the design and application of any NQTLs applied to MH or SUD benefits. These health plans and insurance issuers are also required to make these analyses available to applicable federal and state regulators upon request. These most recent amendments to MHPAEA do not apply to Medicaid and CHIP. However, in light of these updates to the MHPAEA statutory provisions for private sector group health plans and health insurance issuers, as well as concerns raised by various stakeholders, CMS recently released a set of questions for comment on state processes for assessing compliance with MHPAEA.[8] CMS is currently reviewing the comments received, along with the information shared in the OIG's report, to identify areas for improvement in both CMS's and states' oversight of parity requirements.

The OIG's recommendations and CMS's responses are below.

OIG Recommendation 1

The OIG recommends that CMS improve its oversight of States' compliance with MH/SUD parity requirements, including strengthening its follow-up procedures, including regular communication with States, to verify that States perform parity analyses across their MH/SUD delivery systems.

CMS Response 1

CMS concurs with this recommendation. CMS will take steps to strengthen its follow-up procedures to verify that states have performed the required parity analyses across their MH/SUD delivery systems.

[7] Statement of Organization, Functions, and Delegations of Authority; Notice (88 FR 36586) (June 5, 2023)
[8] CMS, Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP. 2023. Accessed at: https://www.medicaid.gov/sites/default/files/2023-09/cmcs-mental-health-parity-092023.pdf

OIG Recommendation 2

The OIG recommends that CMS improve its oversight of States' compliance with MH/SUD parity requirements, including requiring States in which MCOs are responsible for the parity analysis to submit information MCOs provided regarding compliance with parity requirements to CMS for its review as part of the contract approval process.

CMS Response 2

CMS concurs with this recommendation. For states in which MCOs are responsible for the parity analysis, CMS will request that the states submit the information provided by their MCOs regarding compliance with parity requirements. However, additional regulatory authority may be needed to require states to submit this information to CMS.

OIG Recommendation 3

The OIG recommends that CMS improve its oversight of States' compliance with MH/SUD parity requirements, including following up with any States that have identified any noncompliance with parity requirements to verify that the States have taken actions to address the noncompliance.

CMS Response 3

CMS concurs with this recommendation. CMS will strengthen its procedures for following up with states that have identified non-compliance with the parity requirements. In addition, CMS will work with the states identified in the OIG's report to verify that actions were taken to address the areas of noncompliance.

OIG Recommendation 4

The OIG recommends that CMS improve its oversight of States' compliance with MH/SUD parity requirements, including maintaining documentation of its communications with States related to compliance with MH/SUD parity requirements and actions taken to correct any identified deficiencies.

CMS Response 4

CMS concurs with this recommendation. CMS will strengthen its procedures for maintaining documentation of its communications with states in relation to compliance with parity requirements and actions taken to correct any identified deficiencies.

OIG Recommendation 5

The OIG recommends that CMS require States to improve their monitoring of MCOs' ongoing compliance with MH/SUD parity requirements by modifying State policies and procedures for reviewing MCOs' compliance with contract provisions to include written procedures for reviewing compliance with MH/SUD parity requirements.

CMS Response 5

CMS concurs with this recommendation. CMS will issue guidance to states reminding them of CMS's expectations for their review of MCOs' compliance with contract provisions to ensure compliance with parity requirements.

OIG Recommendation 6

The OIG recommends that CMS require States to improve their monitoring of MCOs' ongoing compliance with MH/SUD parity requirements by requiring MCOs to update parity analyses when benefits change or deficiencies are corrected.

CMS Response 6

CMS concurs with this recommendation. CMS will issue guidance to states reminding them of CMS's expectations for having MCOs update their parity analyses when benefits change, or deficiencies are corrected.

OIG Recommendation 7

The OIG recommends that CMS require States to improve their monitoring of MCOs' ongoing compliance with MH/SUD parity requirements by requiring newly added MCOs to conduct parity analyses.

CMS Response 7

CMS concurs with this recommendation. CMS will issue guidance to states reminding them of CMS's expectations for newly added MCOs to conduct parity analyses.

OIG Recommendation 8

The OIG recommends that CMS require States to improve their monitoring of MCOs' ongoing compliance with MH/SUD parity requirements by conducting follow-up in a timely manner with MCOs that have identified noncompliance with parity requirements to verify that the MCOs take corrective actions to address the noncompliance.

CMS Response 8

CMS concurs with this recommendation. CMS will issue guidance to states reminding them of CMS's expectations for their follow-up with MCOs that have identified noncompliance with parity requirements, and for verifying that the MCOs have addressed the noncompliance.