Implementation of the Mental Health Parity and Addiction Equity Act in Medicaid and CHIP

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343), enacted by Congress in 2008, requires insurers that provide behavioral health benefits to cover mental health and substance use disorder (SUD) services in a manner that is no more restrictive than the coverage generally available for medical and surgical benefits. The intent of the law was to ensure that behavioral health services would be treated similarly to physical health services in terms of utilization management policies and other limits.

In 2016, the Centers for Medicare & Medicaid Services (CMS) clarified the application of MHPAEA to Medicaid and the State Children's Health Insurance Program (CHIP) in a final rule (81 FR 18389) that addressed aggregate lifetime limits, financial requirements, quantitative treatment limitations, non-quantitative treatment limitations, and availability of information. The rule also required states and their managed care organizations (MCOs) to analyze limits placed on mental health and SUD treatment benefits in Medicaid and CHIP.

While MHPAEA is aimed at reducing inequities in coverage between behavioral and physical health services, it does not require that payers cover behavioral health services (CRS 2011). With respect to Medicaid and CHIP, states and MCOs are not required under federal law to offer a full continuum of mental health or SUD services or to cover specific screening tools or treatment modalities (e.g., screening, brief intervention, and referral to treatment; intensive outpatient treatment; and assertive community treatment). But if states cover physical health services in any classification (e.g., outpatient, inpatient), then some type of behavioral health benefit must be covered in every classification in which medical surgical benefits are covered.

Despite state efforts to identify inequities in treatment limitations for behavioral health services, we found that MHPAEA does not appear to have substantially improved access to behavioral health care for Medicaid and CHIP beneficiaries. Parity analyses required under MHPAEA focused on a narrow set of barriers that may limit access to care (e.g., prior authorization, step therapy) and ultimately did not result in large-scale changes to behavioral health benefits. Moreover, states and MCOs found the required parity analyses, particularly for non-quantitative treatment limitations, to be complex and time consuming.

This issue brief examines the implementation of MHPAEA in Medicaid and CHIP. We provide a brief background on federal parity laws and describe Medicaid and CHIP requirements under MHPAEA. We then discuss findings from semi-structured interviews with Medicaid officials in three states. We also interviewed MCOs and beneficiary advocates from these states, as well as officials from CMS and representatives from other national organizations.[1] Our interviews focused on assessing whether parity improved access to behavioral health services and documenting challenges states and MCOs encountered when conducting their parity analyses.

Mental Health Parity Requirements

Federal mental health parity requirements have evolved through congressional action, federal rulemaking, and subregulatory guidance (Appendix 1).[2] Initial federal parity requirements were created by two laws: the Mental Health Parity Act of 1996 (MHPA, P.L. 104-204) and MHPAEA in 2008. In 2010, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) further expanded the reach of these requirements (CRS 2011). Below we briefly discuss federal parity requirements established by these laws. Next, we summarize implementing regulations for Medicaid and CHIP and discuss requirements for documenting compliance with parity rules for managed care, alternative benefit plans (ABPs), and CHIP.[3] (Other federal mandates regarding behavioral health coverage in Medicaid and CHIP are summarized in Appendix 2.)

Federal parity laws

MHPA required parity in annual and aggregate lifetime limits between medical and surgical benefits and mental health benefits.[4] Subsequently, MHPAEA expanded the scope of MHPA by:

- applying federal parity protections to SUD benefits;
- requiring health plans that provide behavioral health benefits to provide coverage for behavioral health benefits that is no more restrictive than the coverage that is generally available for medical and surgical benefits; and
- establishing parity protections related to treatment limitations, financial requirements, and in-and-out-of-network covered benefits.

The ACA applied MHPAEA to benefits in Medicaid ABPs that are delivered outside of an MCO, as well as individual health insurance coverage.[5] Medicaid ABPs must cover the 10 essential health benefits, which include mental health and SUD services. The ACA also required individual and small group plans, including those offered by state and health insurance exchanges, to provide coverage of the essential health benefits and to meet federal parity requirements (CMS 2016a).

Parity regulations in Medicaid and CHIP

In 2016, CMS issued a final rule related to MHPAEA and coverage offered by Medicaid MCOs, ABPs, and CHIP. The rule took effect on October 1, 2017. Once an individual is enrolled in an MCO, their entire benefit package is subject to parity, including any services delivered through another type of managed care plan or via fee for service (FFS). These requirements do not apply to beneficiaries who only receive state plan services under FFS arrangements, or who are enrolled in a prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP) or primary care case management (PCCM) but are not also enrolled in an MCO (CMS 2016a).[6]

The final rule also required states using Medicaid MCOs to provide documentation of compliance with parity (commonly referred to as a parity analysis) to the general public and post it on the state's Medicaid website by October 2, 2017 (42 CFR § 438.930) (CMS 2016a). Many states requested an extension, and as of July 2021, CMS was still working with three states on this documentation (Kuhn 2021). States that do not use managed care do not have to conduct a parity analysis.

A parity analysis must compare limitations on behavioral health benefits with those used for medical and surgical services within four benefit classifications (inpatient, outpatient, prescription drugs, and emergency

care). To do so, states and MCOs group each mental health, SUD, medical, and surgical benefit into one of these classifications, and then identify and test each benefit in five specific areas:

- **Aggregate lifetime and annual dollar limits.** Generally, such limits cannot be applied to behavioral health benefits unless they apply to at least one-third of medical and surgical benefits (42 CFR § 438.905).[7]
- **Financial requirements.** Financial requirements such as copayments may not be more restrictive than the predominant financial requirements that apply to substantially all behavioral health benefits in that classification (e.g., outpatient, inpatient) (42 CFR § 438.910(c)).[8]
- **Quantitative treatment limitations.** These are numerical limits (e.g., day limits) on the scope or duration of benefits. Such limits may not be more restrictive than the predominant quantitative treatment limits that apply to substantially all behavioral health benefits in that classification (42 CFR § 438.910(c)).
- **Non-quantitative treatment limitations.** These include medical management standards, provider network admissions standards, payment rates, fail-first policies, and other limits on the scope and duration of benefits. A non-quantitative treatment limitation may not apply to behavioral health benefits in a classification unless the same factors (e.g., strategies, evidentiary standards, processes), as written and in operation, used in applying those limitations are comparable to and no more stringent than the factors used in applying limitations for medical and surgical benefits (42 CFR § 438.910(d)).
- **Availability of information.** Criteria for medical necessity determinations regarding behavioral health benefits must be made available to beneficiaries, potential beneficiaries, and contracting providers upon request (42 CFR § 438.915). In addition, beneficiaries must be provided with information about the reasons whenever coverage of behavioral health benefits is denied (CMS 2016a).

States must document and post findings from their parity analysis, including any follow-up activities, applicable to the benefits provided to MCO enrollees (42 CFR § 438.920). They must also make any changes needed to meet parity requirements (e.g., changes to the Medicaid state plan, ABP state plan, MCO contract) and establish procedures to identify when changes in benefit design or operations could affect compliance and require an updated analysis (CMS 2016a).

Conducting parity analyses in managed care. Either the state or the MCO may complete the parity analysis depending on how benefits are provided (42 CFR § 438.920). The MCO must complete the analysis when it provides all Medicaid benefits—both medical and mental health and SUD benefits—and inform the state what contract changes are needed to comply (CMS 2016b). The state must complete the parity analysis if benefits are provided through multiple delivery systems (e.g., multiple MCOs, or under FFS) and provide the analysis to CMS for review (CMS 2016a).

Documenting parity compliance in ABPs and CHIP plans. States must document that ABPs and CHIP plans comply with parity requirements (42 CFR § 449.395). As of July 2021, nine outstanding CHIP parity state plan amendments (SPAs) were under review (Edwards 2021).[9]

Ongoing parity requirements. After the initial parity analysis, CMS reviews parity provisions in MCO contracts as part of its routine contract review process. CMS encourages states to include provisions in their MCO contracts to ensure adequate oversight, monitoring, and compliance of ongoing parity activities, such as ensuring the state can see the MCO's parity analysis. As of July 2021, all states with MCOs have updated their contracts to address parity (Kuhn 2021).

Generally, states are required to update and resubmit parity documentation to CMS when there are changes in the delivery system, including major network changes, or when there are changes to benefits. As of July 2021, CMS was working with four states to revise their parity analyses to account for changes to behavioral health benefits or the delivery system (Kuhn 2021).

Lessons Learned in Analyzing Parity

There are two major lessons from state and MCOs experiences in implementing parity. First, states, MCOs, and beneficiary advocates agree that MHPAEA has not improved access to behavioral health services. Additionally, states and MCOs found that parity analyses were complex and challenging to undertake. Specifically, states and MCOs reported parity analyses for non-quantitative treatment limitations to be the most complex to analyze.[10]

Parity has not improved access to behavioral health

Based on our interviews, MHPAEA does not appear to have increased access to behavioral health services for individuals with Medicaid or CHIP coverage. In part, this may be due to how parity compliance is assessed and documented. MHPAEA does not require states or MCOs to document and facilitate access to behavioral health services. Rather, it focuses on a narrow set of barriers that may limit access (e.g., prior authorization, step therapy). As such, states and MCOs have not had to make large-scale changes to behavioral health benefits as a result of parity analyses. Changes were mostly modest: some states changed quantitative treatment limits from hard to soft limits, while others removed certain non-quantitative treatment limitations (HHS 2017).[11] Of the states MACPAC interviewed, one state did not have to make any changes, while the other two made minor changes to their non-quantitative treatment limitations.

Stakeholders agreed that MHPAEA has helped raise awareness regarding access to behavioral health care; however, it is a difficult tool for states, consumers and providers to use. The current regulations outlining the four categories of services—inpatient, outpatient, prescription drugs, and emergency care—are extremely complex and difficult to operationalize. For example, placing behavioral health benefits into one of the four service categories is not always straightforward. In addition, one advocacy organization noted that providers continue to be challenged by vastly different non-quantitative treatment limitations across MCOs, and availability of information (i.e., criteria for medical necessity determinations regarding behavioral health benefits) remains a problem within Medicaid, particularly as it relates to services for children and youth. Making federal parity requirements more transparent would help stakeholders and patients identify parity violations. However, consumers may not know who to contact if a parity violation has occurred.

Another factor limiting MHPAEA's effect on access is that it does not require coverage of specific behavioral health services. As such, the states we interviewed noted that they did not make substantial changes to their benefits as a result of their parity analysis. One stakeholder noted that since MHPAEA does not mandate coverage of behavioral health services, other policies are more relevant in ensuring access to community-based services. For example, Medicaid beneficiaries with serious mental illness and certain SUDs are entitled to receive necessary mental health treatment in the most integrated setting possible under the Supreme Court's decision in *Olmstead v. L.C.* 119 S. CT 2176 (1999).[12]

Some stakeholders noted that they had hoped MHPAEA would address historically low payment rates for behavioral health services, but the law does not. CMS advises that a disparity in payment rates is not evidence of failure to comply with parity requirements. States and MCOs may set payment rates for behavioral health services lower than medical and surgical services if the factors used to develop such rates

(e.g., demand for services, Medicare payment rates, and experience and licensure of providers) are comparable (CMS 2016).[13]

Conducting parity analyses requires substantial staff time and expertise

Many stakeholders, including CMS, indicated that parity analyses were resource intensive for states and MCOs, requiring staff with a wide range of expertise. Specifically, states, MCOs and others noted that they underestimated the scope of federal requirements when initiating their parity analyses, perhaps due to lack of prior expertise. One state noted that it took significant time for staff to understand the specificity and depth of what was required. Going forward, those staff must consider how changes in the state plan or delivery system reforms will affect parity compliance. Ultimately, the state plans to standardize the process to document parity compliance when programmatic changes occur. Parity analyses were particularly time consuming in states with multiple MCOs. In one state, this involved working with 16 different managed care entities.

Other factors further affected the level of staff time and expertise needed by MCOs to conduct parity analyses. Plans often had to respond to multiple requests for information from states and some states changed data collection tools over the course of conducting their analyses. Moreover, for MCOs that operate in multiple states, plans had to use different data collection tools based on the states' approach to the parity analysis.

Analyzing non-quantitative treatment limitations is particularly difficult

The most common difficulty that states and plans faced when conducting parity analyses was documenting compliance with non-quantitative treatment limitations. In part, this was because they had to examine numerous policies for each behavioral health benefit, including:

- utilization review strategies (e.g., prior authorization, concurrent and retrospective review, step therapy or fail-first policies);
- medical necessity criteria;
- written treatment plan requirements; and
- network design (e.g., standards for coverage of out-of-network providers, payment, network participation criteria).

Collecting and summarizing these policies for each behavioral health benefit was a new process and required reviewing a high volume of information about multiple complex policies. CMS and states also indicated that data collection and analysis were difficult due to the complexity of treatment systems. For example, states with many MCOs or multiple PIHPs, or multiple benefits carved out, had to analyze significantly more information than other states. In addition, when MCOs subcontract to administer behavioral health benefits, the state must understand the role of the subcontractor and how its processes affect parity compliance. States also noted that in some instances, MCOs did not always provide sufficient detail to assess compliance, requiring several additional data requests.

Another challenge noted by interviewees was that non-quantitative treatment limitations were assessed and interpreted differently within and across states. For example, one state noted that MCOs, stakeholders, and state staff had different opinions on what constituted a non-quantitative treatment limitation. It took time and resources, including the assistance of hired consultants, to develop a shared understanding of what MHPAEA required. Another MCO operating in multiple states noted that much of the confusion related to

non-quantitative treatment limitations stemmed from a lack of experience with new federal requirements and an understanding of how to conduct required analyses.

Analysis of non-quantitative treatment limitations can be particularly complicated if payment methodologies for behavioral and medical and surgical benefits differ. For example, many inpatient medical and surgical services may be paid using diagnostic related groups (DRGs) with payment based on factors such as diagnosis, treatment, and age. Hospitals are then paid a fixed amount regardless of the total cost and time needed to treat the patient. Under DRG-based payment methodologies, hospitals are incentivized to reduce the average length of stay and associated service costs (Berenson et al. 2016).

By contrast, inpatient behavioral health treatment is often paid through a per-diem rate. Per diem payments promote longer inpatient stays, and concurrent reviews may be appropriate to ensure services provided are medically necessary (Berenson et al. 2016, MACPAC 2011). However, services that are paid under DRGs do not require concurrent review because hospitals are paid the same rate, no matter how long the patient is in the hospital. In this example, the use of concurrent review for inpatient psychiatric stays may be viewed as a parity violation if it is considered a more restrictive policy when compared to non-quantitative treatment limitations used for medical and surgical services. However, one MCO noted that this difference in payment structures necessitates an additional level of review for behavioral health services.

Interviewees reported similar challenges in assessing non-quantitative treatment limitations within the private insurance market.[14] Despite shared challenges related to MHPAEA implementation and compliance, collaboration between insurance commissioners and state Medicaid agencies has been limited.

CMS officials are aware of these challenges and reported that they will continue working with states to educate them on MHPAEA requirements and how compliance should be documented. In this vein, CMS has published various resources such as a toolkit with data collection templates, guidance documents, and presentations. However, states were not required to use CMS templates, and all of the states we spoke with developed their own data collection processes.[15] CMS also hired technical assistance contractors to help states complete their parity analyses.

Endnotes

[1] From January to August 2020, MACPAC conducted interviews with representatives from Hawaii, Maryland, Oregon, Bazelon Center for Mental Health Law, Legal Action Center, National Alliance for Mental Illness Oregon, National Association of Insurance Commissioners, Oregon Council for Behavioral Health, PacificSource, WellCare, and CMS. We also interviewed Adrienne Ellis, who previously managed the Maryland Parity Project.

[2] More recently, the Consolidated Appropriations Act, 2021 (P.L. 116-159) strengthened parity requirements for non-quantitative treatment limitations, such as medical necessity requirements, or fail-first or step therapy protocols, by requiring health plans to conduct additional parity analyses. However, Medicaid MCOs are generally exempt from these requirements if they comply with applicable federal Medicaid regulations (42 CFR Part 438 Subpart K and Section 438.3(n)).

[3] As an alternative to traditional Medicaid benefits, states were given state plan authority under the Deficit Reduction Act of 2005 (P.L. 109-171) to enroll certain groups in benchmark and benchmark-equivalent benefit packages. This is defined as coverage that is equal to the Blue Cross and Blue Shield standard provider plan under the Federal Employees Health Benefit Program; a plan offered to state employees; the largest commercial health maintenance organization in the state; or other

coverage approved by the Secretary of the U.S. Department of Health and Human Services appropriate for the targeted population (MACPAC 2021).

[4] MHPA was originally scheduled to sunset in 2001 but received annual extensions through the end of 2008 when the sunset provision was repealed.

[5] Even before the ACA, ABPs delivered through an MCO were required to comply with parity requirements under Section 1932(b)(8) of the Social Security Act.

[6] Section 1932(b)(8) of the Act does not provide authority to apply parity protections to beneficiaries who are not enrolled in an MCO and section 1937 of the Act limits the application of parity requirements to ABPs (CMS 2016a).

[7] Aggregate and annual dollar limits are prohibited with respect to mental health and SUD benefits that are covered as essential health benefits, regardless of the delivery system used by Medicaid ABPs. ABP and CHIP benefits that are offered through an MCO, or through a PIHP or PAHP that provides coverage to MCO enrollees, are also subject to the prohibition on lifetime and annual limits (CMS 2016a).

[8] Regardless of whether services are delivered in managed care, all Medicaid ABPs, including benchmark equivalent and Secretary-approved benchmark plans, and CHIP plans are required to meet the financial requirements and treatment limitations components of mental health parity (CMS 2016a).

[9] For certain CHIP plans and ABPs, the state does not have to complete a full parity analysis. Because CMS has reviewed all approved ABPs for parity compliance and states have attested to their compliance with MHPAEA in ABP SPAs, states with approved ABPs were not required to conduct a new parity analysis. For beneficiaries under the age of 21, CHIP state plans that provide full coverage of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services are deemed to be in compliance with parity requirements (CMS 2016c). States must demonstrate that EPSDT benefits are covered by their CHIP plans through documents such as member handbooks. It is important to note that the state or MCO would still have to conduct a parity analysis to ensure that plan benefits for beneficiaries who are ineligible for EPSDT benefits satisfy parity requirements.

[10] Although MHPAEA regulations required states to assess compliance with parity in five areas (aggregate lifetime and dollar limits, financial requirements, quantitative treatment limitations, non-quantitative treatment limitations, and availability of information), aggregate lifetime and dollar limits and financial requirements are not commonly used in state Medicaid programs and CHIP, including those in the three states we interviewed. Moreover, state officials noted that assessing quantitative treatment limitations, such as day limits, was a fairly straightforward process because they are not commonly used in Medicaid and CHIP.

[11] Soft limits allow for an individual to exceed benefit limits based on medical necessity (CMS 2016a). In comparison, hard limits (i.e., quantitative limits on services) may not be exceeded due to medical necessity.

[12] The Americans with Disabilities Act (ADA, P.L. 101-336) extends protections to individuals with a mental health condition that "substantially limits" one or more major life activities (e.g., bipolar disorder, schizophrenia, major depression) (42 USC § 12102).

[13] MHPAEA permits states and MCOs to consider a wide array of factors when determining provider payment methodologies and rates for both behavioral health and medical and surgical services. When constructing provider rates, these factors must be applied comparably to and no more stringently than those applied to medical and surgical services (CMS 2016a).

[14]The National Association of Insurance Commissioners (NAIC) noted that assessing such limitations has been challenging for their members. NAIC has worked closely with the U.S. Department of Labor and CMS on the development of a non-quantitative treatment limitations list for the purposes of parity enforcement. This has led to the creation of forms and templates to document parity-related complaints, review networks, and determine parity compliance. Some states, including Colorado, Rhode Island, Pennsylvania, and Washington, have developed templates for parity compliance that NAIC is starting to share across the country.

[15] One state hired a contractor to assist with data collection, while another required its MCOs to purchase a specific tool to collect the data needed for its parity analyses. The third state we spoke with developed its own template to request information from its MCOs.

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APPENDIX 1. Federal Behavioral Health Policies

TABLE 1. Key Milestones in Federal Behavioral Health Parity Policies in Medicaid and CHIP, 1996 – 2020

Year	Action
1996	Congress enacts the Mental Health Parity Act of 1996 (MHPA, P. L. 104-204), requiring parity in aggregate lifetime and annual dollar limits for mental health and medical benefits and applies to employment related group health plans and health insurance coverage offered in connection with a group health plan.
1997	The Balanced Budget Act of 1997 (BBA, P. L. 105-33) applies MHPA to Medicaid managed care organizations (MCOs) and the State Children's Health Insurance Program (CHIP).
2008	Congress enacts the Mental Health Parity and Addiction Equity Act (MHPAEA, P.L. 110-343), which extends parity requirements to include substance use disorder (SUD) benefits and adds rules regarding financial and nonfinancial limits. Health plans must ensure parity in day and visit limits, copays, coinsurance, and out-of-pocket maximums, the application of care management tools and medical necessity criteria, and coverage of out-of-network providers.
2009	MHPAEA takes effect.
2009	The Centers for Medicare & Medicaid Services (CMS) issues subregulatory guidance informing states that parity requirements in MHPAEA apply to comprehensive Medicaid MCOs.
2009	Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P. L. 111-3) requires CHIP plans that provide both mental health and SUD benefits to comply with MHPAEA.
2010	Congress enacts the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), adding mental health benefits and prescription drug coverage to the list of benefits that must be included in benchmark-equivalent coverage, including alternative benefit plans (ABPs).
2013	CMS releases subregulatory guidance regarding the implementation of MHPAEA for Medicaid and CHIP.
2015	CMS publishes a proposed rule describing how certain requirements of MHPAEA apply to Medicaid and CHIP.
2016	CMS issues a final rule related to MHPAEA and coverage offered by MCOs, Medicaid ABPs, and CHIP.
2017	States must be in compliance with the final parity rule by October 1, 2017.
2020	The Consolidated Appropriations Act, 2021 (P.L. 116-159) modified the Public Health Services Act, the Employee Retirement Income Security Act, and federal tax code to require group health plans to formally analyze non-quantitative treatment limitations and make such analyses available upon request to the secretaries of the U.S. Department of Health and Human Services, the Department of Labor, and the U.S. Department of the Treasury. The secretaries must request and review the analyses conducted by at least 20 group health plans per year. Medicaid MCOs, alternative benefit plans, and certain CHIP plans will be deemed to satisfy the Act's requirements if the plans comply with existing MHPAEA standards.

Sources: Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. 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 benefits plan. Final rule. *Federal Register* 81, no. 61. (March 30): 18390 – 18445. https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/2016-06876.pdf.

APPENDIX 2. Medicaid Behavioral Health Coverage Requirements

Below we briefly summarize behavioral health coverage requirements under Medicaid and the State Children's Health Insurance Program (CHIP) and the degree to which states offer certain behavioral health services.

Coverage requirements for adults

Medicaid's role in covering and financing behavioral health treatment varies among Medicaid eligibility groups. Generally, all state Medicaid programs are required to cover certain behavioral health services for adults, including medically necessary inpatient hospital services, outpatient hospital services, rural health clinic services, nursing facility services, home health services, and physician services. However, many other services used for the treatment of mental health conditions are optional. These include clinic services; other diagnostic, screening, preventive, and rehabilitative services; case management; and personal care services (SAMHSA 2013). In states that expanded Medicaid to the new adult group, these beneficiaries are entitled to coverage of 10 essential health benefits, including behavioral health treatment services (CMS 2016).

In 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment Act (SUPPORT Act, P.L. 115-271) temporarily expanded behavioral health benefits related to substance use disorder (SUD). It requires states to include medications used to treat opioid use disorder (MOUD) as a Medicaid-covered service for a five-year period beginning October 1, 2020. MOUD is defined as a service combining any drug approved by the U.S. Food and Drug Administration, including methadone, or any biological product licensed under the Public Health Service Act, to treat opioid use disorders and counseling services or behavioral therapy. States can be exempted from this requirement if before October 1, 2020, they demonstrate that covering all eligible individuals in the state is not feasible due to a shortage of qualified MOUD providers or treatment facilities willing to provide services under contract either with the state or with a managed care organization working with the state under Section 1903(m) or Section 1905(t)(3) of the Social Security Act.

In practice, most states have gaps in their behavioral health coverage. In 2018, MACPAC found that most states had gaps in their SUD coverage, covering six out of 9 levels of care described by the American Society of Addiction Medicine (ASAM). Nearly half of states (24) provided four to seven levels of care. Only 12 states offered the full continuum of care, that is, each of the nine ASAM levels of care. The largest gaps in state clinical service coverage are for partial hospitalization and residential treatment (MACPAC 2018).

In 2020, we found that most states have gaps in mental health service coverage, covering 12 out of 15 services on average. (These 12 services include: case management or care coordination; mental health screening and assessment services; outpatient mental health care; partial hospitalization or day treatment services; assertive community treatment; psychosocial rehabilitation services; residential services; inpatient psychiatric treatment; peer support; supported employment; skills training and development; emergency crisis services; mobile crisis services; and residential crisis services.) All states cover mental health screening and assessment services, some form of outpatient mental health treatment, and inpatient psychiatric care. The largest gaps in coverage exist for supported employment (covered by 25 states), residential services (covered by 28 states), and crisis residential services (covered by 29 states) (MACPAC 2021).

Coverage requirements for children

Medicaid, including Medicaid-expansion CHIP, must cover medically necessary behavioral and other health services for enrollees under age 21 as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of whether the required services are covered in the state plan.

Effective October 24, 2019, behavioral health coverage is now a required CHIP benefit. The CHIP statute specifically requires states to provide child health and pregnancy-related assistance that includes coverage of mental health services and SUD. CMS guidance issued in March 2020, indicates that states are now required to do the following:

- provide coverage of all the developmental and behavioral health-related screenings and preventive services recommended by the American Academy of Pediatrics Bright Futures periodicity schedule, as well as those with a grade A or B by the U.S. Preventive Services Task Force;
- use age-appropriate, validated screening tools;
- demonstrate that CHIP benefits are sufficient to treat a broad range of behavioral health systems and disorders;
- cover MOUD and tobacco cessation benefits;
- identify a strategy for the use of validated assessment tools and specify tools in use; and
- deliver behavioral health services in a culturally and linguistically appropriate manner regardless of delivery system (CMS 2020).
- States must submit a CHIP state plan amendment to demonstrate compliance with the new behavioral health coverage provisions outlined in guidance issued by CMS on March 2, 2020 (CMS 2020).

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