Mental Health Parity and Addiction Equity Act (MHPAEA) Report for North Carolina Children and Families Specialty Plan (CFSP)

October 29, 2025

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Introduction

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that requires health insurers and group health plans to provide the same level of benefits for mental health (MH) and substance use disorder (SUD) services as they do for medical/surgical (M/S) services. On March 29, 2016, the Centers for Medicare & Medicaid Services (CMS) published a final rule to apply certain provisions of the MHPAEA to Medicaid managed care organizations (MCOs), Medicaid alternative benefit plans, and the Children's Health Insurance Program (CHIP) (see 42 CFR Part 438, Subpart K, 42 CFR §440.395, and 42 CFR §457.496). The rule prohibits states and MCOs from applying financial requirements (FRs) and treatment limitations to MH and SUD benefits that are more restrictive than those applied to M/S benefits within the same classification. This report details the State of North Carolina's compliance with these requirements for the NC Medicaid Managed Care Children and Families Specialty Plan (CFSP) that will be implemented on December 1, 2025.

Methodology

North Carolina conducted the parity analysis for the NC Medicaid Managed Care CFSP following the CMS parity toolkit, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs,"[1] and included the following steps:

1. Identifying all benefit packages to which parity applies
2. Determining whether the State or the MCO is responsible for the parity analysis
3. Defining MH, SUD, and M/S benefits
4. Defining the four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care) and mapping MH, SUD, and M/S benefits to these classifications
5. Determining whether any aggregate lifetime or annual dollar limits (AL/ADLs) apply to MH/SUD benefits
6. Determining whether any financial requirements (FRs) or quantitative treatment limitations (QTLs) apply to MH/SUD benefits and testing any applicable FRs/QTLs for compliance with parity
7. Identifying and analyzing non-quantitative treatment limitations (NQTLs) that apply to MH/SUD benefits

The report is organized according to this framework to illustrate the State's approach to each step of the parity analysis.

[1] Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs, https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf

Children and Families Specialty Plan Benefit Packages

The NC Medicaid Managed Care CFSP is a single, statewide health plan that will provide integrated services for Medicaid and CHIP beneficiaries[2] who are currently and formerly served by NC Child Welfare. One organization will serve as the statewide health plan.

The North Carolina Department of Health and Human Services (DHHS) identified two CFSP benefit packages (see Table 1) subject to parity requirements.

There are only a few services carved out of the CFSP benefit packages (i.e., Children's Developmental Service Agency [CDSA] services, dental services, eyeglasses, orthodontic services, and outpatient specialized services by local education agencies). Since there are benefits carved out of each benefit package, the State is responsible for the parity analysis for all benefit packages.

Table 1: Benefit Packages for CFSP Parity Analysis
CFSP-Qualifying Medicaid Adults[3] (21 years of age and older) not in Innovations or Traumatic Brain Injury (TBI) Waiver[4]
CFSP-Qualifying Medicaid Children[5] (0 years to 20 years of age) not in Innovations or TBI Waiver[6]

Definition of MH/SUD and M/S Conditions and Benefits

For the parity analysis, DHHS defined MH/SUD benefits as services for the conditions listed in the International Classification of Diseases (ICD)-10-CM, Chapter 5, "Mental, Behavioral, and Neurodevelopmental Disorders," with the following exceptions:

- The conditions listed in subchapter 1, "Mental disorders due to known physiological conditions" (F01–F09)
- The conditions listed in subchapter 8, "Intellectual disabilities" (F70–F79)
- The conditions listed in subchapter 9, "Pervasive and specific developmental disorders" (F80–F89)

For the parity analysis, MH/SUD benefits are services for the conditions listed in the following subchapters of Chapter 5:

[2] Prior to April 1, 2023, North Carolina had a combination CHIP program; however, as of April 1, 2023, the State transitioned to a Medicaid expansion CHIP program.

[3] Reference to "Medicaid Adults" includes but is not limited to individuals in the new adult group who are age 21 or older.

[4] CFSP-Qualifying Medicaid Adults not in Innovations or TBI Waiver includes: Beneficiaries enrolled in the Former Foster Youth Eligibility Group (age 21 –26 years), parents, caretaker relatives, guardians, and custodians of children in foster care, adults identified on an open Child Protective Services In-Home Family Services Agreement case, and adults identified in an open Eastern Band of Cherokee Indians Department of Public Health and Human Services Family Safety program case.

[5] Reference to "Medicaid Children" includes but is not limited to individuals who are 19 and 20 in the new adult group (and individuals in North Carolina's CHIP program who are under age 19).

[6] CFSP-Qualifying Medicaid Children not in Innovations or TBI Waiver includes: Beneficiaries in foster care; beneficiaries receiving adoption assistance; minor children beneficiaries in foster care, beneficiaries receiving adoption assistance, and beneficiaries enrolled in the Former Foster Youth Group (when the parent remains enrolled); minor siblings of beneficiaries in foster care; minors living in the same home of adults identified on an open Child Protective Services In-Home Family Services Agreement case; and any children living in the same home as adults identified in an open Eastern Band of Cherokee Indians Department of Public Health and Human Services Family Safety program case.

- Subchapter 2, “Mental and behavioral disorders due to psychoactive substance use” (F10–F19)
- Subchapter 3, “Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders” (F20–F29)
- Subchapter 4, “Mood [affective] disorders” (F30–F39)
- Subchapter 5, “Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders” (F40–F48)
- Subchapter 6, “Behavioral syndromes associated with physiological disturbances and physical factors” (F50–F59)
- Subchapter 7, “Disorders of adult personality and behavior” (F60–F69)
- Subchapter 10, “Behavioral and emotional disorders with onset usually occurring in childhood and adolescence” (F90–F98)
- Subchapter 11, “Unspecified mental disorder” (F99)

For the parity analysis, DHHS defined M/S benefits as services for the conditions listed in ICD-10-CM Chapters 1–4; subchapters 1, 8, and 9 of Chapter 5; and Chapters 6–20.

For the parity analysis, benefits to treat intellectual/developmental disabilities (I/DD), including autism spectrum disorder, are defined as M/S benefits.

Benefit Classifications

DHHS developed the following definitions for each of the four benefit classifications specified in the Medicaid/CHIP parity rule. North Carolina Medicaid covers MH and SUD benefits in each classification in which there is an M/S benefit.

- **Inpatient**: Benefits (including medications) provided to a member while in a setting (other than a home- and community-based setting as defined in 42 CFR Part 441) that provides treatment 24 hours per day
- **Outpatient**: Benefits (including medications) provided to a member that do not otherwise meet the definition of inpatient, emergency care, or prescription drugs
- **Emergency Care**: Benefits (including medications) provided in an emergency department setting
- **Prescription Drugs**: Pharmaceuticals that legally require a prescription to be dispensed and are dispensed by a pharmacy

Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)

Except for 1915(i) Community Transition services, North Carolina does not apply any aggregate lifetime or annual dollar limits (AL/ADLs) on the total amount of MH/SUD Medicaid benefits, and the State’s contract with the plan (Section V.C.1.b.(viii)) states that the plan shall not impose AL/ADLs on the total amount of specified benefits that may be paid under the plan. North Carolina’s 1915(i) State Plan and clinical coverage policy (CCP) for 1915(i) Community Transition states community transition expenses cannot exceed $5,000 and can

only be provided to a beneficiary once per five years. This benefit is available to beneficiaries with a serious mental illness (SMI), a severe and persistent mental illness (SPMI), a severe SUD, and/or an I/DD, and the limit is applied identically regardless of whether the beneficiary has a SMI, SPMI, SUD, and/or I/DD diagnosis code. DHHS determined the plan complies with parity requirements for AL/ADLs.

Financial Requirements (FRs)

North Carolina's Medicaid State Plan has copayments for certain services (e.g., doctor visits and outpatient visits) and prescriptions drugs. North Carolina exempts behavioral health services from the copayments for services. The only copayment applicable to MH/SUD benefits is the copayment for prescription drugs.

Per the State's contract for the CFSP (see section V.C.1.k.(i)–(ii) and (v)(3)), the plan shall impose the same cost-sharing amounts as specified in North Carolina's Medicaid State Plan and shall not impose cost-sharing on Medicaid BH, I/DD and TBI services, as defined by the Department. The plan cannot apply copayments to MH/SUD benefits other than for prescription drugs. The copayment for prescription drugs is $4 per prescription, is the same for both MH/SUD and M/S drugs, and is applied regardless of diagnosis. There are certain exceptions to the copayment specified by federal law or based on the need to remove barriers to medication therapy and to support public health, without regard to whether the member has a MH/SUD or M/S diagnosis. DHHS determined the plan complies with parity requirements for FRs.

Quantitative Treatment Limitations (QTLs)

North Carolina revised its Medicaid State Plan, effective January 1, 2025, to remove quantitative treatment limitations (QTLs) from all MH/SUD only benefits. The State retained a QTL for 1915(i) Respite services — no more than 1,200 units (300 hours) per plan year. This benefit is available to beneficiaries ages three to 21 with a diagnosis of serious emotional disturbance (SED) or SUD and beneficiaries ages three or older with an I/DD, and the limit is applied identically regardless of diagnosis. DHHS received a written assurance from the plan confirming that they do not apply QTLs other than the QTL for 1915(i) Respite Services. DHHS' parity analysis concluded such and determined the plan complies with parity requirements for QTLs.

Non-Quantitative Treatment Limitations (NQTLs)

Identifying NQTLs, Information Collection, and NQTL Analysis

Based on the illustrative list of NQTLs in the final Medicaid/CHIP parity rule and input from CMS, the Department identified several NQTLs for analysis (see "List of MH/SUD NQTLs" below), including NQTLs related to utilization management, provider network, and prescription drugs.

The Department developed an NQTL questionnaire for each NQTL and classification (as applicable) to collect information from the plan to conduct the NQTL analysis, including

information on processes, strategies, and evidentiary standards.[7] Each questionnaire included prompts to help the plan provide the information needed. DHHS instructed the plan that if there were differences in how the plan applies the NQTL by benefit package or classification (if the questionnaire was applicable to more than one classification), the plan must complete a separate questionnaire for each benefit package/classification. If there were no differences by benefit package/classification, the plan could complete one questionnaire for all applicable benefit packages/classifications. For each of the NQTLs, the plan completed one questionnaire for all applicable benefits packages. Except for utilization management, the plan completed one questionnaire for all applicable classifications. For utilization management, there were separate questionnaires for the inpatient, outpatient, and prescription drug classifications.

DHHS reviewed the information provided by each plan and conducted follow-up with the plan as needed, including interviews and/or written follow-up. DHHS used the information from the completed questionnaires and plan follow-ups to determine whether the processes, strategies, evidentiary standards, and other factors used in the application of each NQTL to MH/SUD benefits were comparable and no more stringently applied to MH/SUD benefits than to M/S benefits.

List of MH/SUD NQTLs

To support the NQTL analysis, DHHS developed the following definitions for each of the NQTLs analyzed.

- **Prior Authorization (PA):** Review by the plan to determine whether benefit coverage will be authorized. May include review of eligibility, coverage, medical necessity, medical appropriateness, and/or level of care (LOC). May occur prior to service delivery or after a designated number of services.
- **Concurrent Review (CR):** Review by the plan to determine whether benefit coverage will be authorized beyond the initial authorization (see PA above) within the same benefit year or treatment episode. May include review of eligibility, coverage, medical necessity, medical appropriateness, and/or LOC.
- **Retrospective Review (RR):** Review initiated by the plan as a utilization management strategy to determine whether benefits will be covered after services have been delivered. May include review of eligibility, coverage, medical necessity, medical appropriateness, and/or LOC.
- **Medical Necessity and Appropriateness Criteria (MNC)**: The selection and development of medical necessity and appropriateness criteria to conduct utilization management.
- **Prior Authorization of Prescription Drugs (RxPA)**: Review by the plan to determine if a particular drug will be authorized. May include review of eligibility, coverage, medical necessity, and/or medical appropriateness.

[7] Since the plan follows the State's preferred drug list (PDL) and clinical policies, DHHS' prior authorization of prescription drugs (RxPA) and formulary design questionnaires collected information on the plan's processes for prior authorization and formulary design, and DHHS provided information on strategies and evidentiary standards.

- **Formulary Design**: The process used to determine how prescription drugs are covered, including the development of a preferred drug list (PDL), trial and failure (T/F) requirements, and quantity limitations (QLs).
- **Provider Admission — Credentialing and Contracting**: Credentialing and contracting limitations on provider admission to and ongoing participation in the plan's provider network.
- **Provider Reimbursement — In-Network**: The process by which provider reimbursement rates are established for network providers.
- **Provider Network — Access to Out-of-Network (OON) Providers**: Limitation on access to and coverage of benefits from OON providers.

In addition, DHHS requested the plan to identify and define any NQTL the plan applies to MH/SUD benefits other than the NQTLs identified and analyzed by DHHS and complete a plan-identified NQTL questionnaire that included generic prompts. The plan stated that they do not apply any additional NQTLs.

Table 2: NQTLs by Classification

NQTL	Classification			
	IP	OP	EC	PD
Prior Authorization	✓	✓		
Concurrent Review	✓	✓		
Retrospective Review*				
Prior Authorization of Prescription Drugs (RxPA)				✓
Provider Admission — Credentialing and Contracting	✓	✓	✓	✓
Provider Network — Access to Out-of-Network Providers	✓	✓	✓	✓
Medical Necessity and Appropriateness Criteria	✓	✓		
Provider Reimbursement — In-Network	✓	✓	✓	✓
Formulary Design				✓
Plan-Identified NQTL**				

IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drugs
*The plan said they do not apply retrospective review as a utilization management limit.
**The plan did not identify an additional NQTL.

Summary and Findings

Based on the analyses described above, DHHS determined the plan complies with federal parity requirements. Key findings of the parity analysis are summarized below.

- **Aggregate Lifetime and Annual Dollar Limits (AL/ADLs):** The only dollar limit the plan can apply on a MH/SUD benefit is the dollar limit for 1915(i) Community Transition services. 1915(i) Community Transition is available to members with MH/SUD and/or M/S diagnoses, and the limit is applied the same regardless of a member's diagnosis. DHHS determined the plan complies with parity requirements for ALs/ADLs.

- **Financial Requirements (FRs):** The plan does not apply financial requirements (FRs) to MH/SUD benefits other than copayments for prescription drugs. The copayment for prescription drugs is the same for MH/SUD and M/S drugs and is applied the same regardless of diagnosis. There are certain exceptions to copayment requirements, but those are also applied without regard to whether the member has a MH/SUD or M/S diagnosis. DHHS determined the plan complies with parity requirements for FRs.
- **Quantitative Treatment Limitations (QTLs):** The only quantitative treatment limitation (QTL) the plan can apply on a MH/SUD benefit is a maximum number of hours/units for 1915(i) Respite services. 1915(i) Respite is available to members with a MH/SUD and/or M/S diagnosis, and the limit is applied the same regardless of diagnosis. DHHS determined the plan complies with parity requirements for QTLs.
- **Non-Quantitative Treatment Limitations (NQTLs) — Utilization Management in the Inpatient, Outpatient, and Emergency Care Classifications**: The plan applies PA and CR to MH/SUD and M/S benefits in the inpatient and outpatient classifications. The plan does not apply PA or CR to MH/SUD benefits in the emergency care classification, and does not use retrospective review (RR) as a utilization management limit for any MH/SUD benefit. As of January 1, 2025, for MH/SUD benefits with an applicable State clinical coverage policy (CCP), the plan's PA and CR requirements are no more restrictive than the PA and CR requirements specified in the applicable State CCP. Additional UM limits applied by the plan not specified in State CCPs were reviewed by DHHS, and DHHS determined the plan complies with parity requirements for NQTLs.

  The plan completed four separate questionnaires (PA in the inpatient classification, CR in the inpatient classification, PA in the outpatient classification, and CR in the outpatient classification). Upon review of the completed questionnaires, including follow-up with the plan, DHHS determined the plan's PA and CR processes, strategies, and evidentiary standards are comparable and no more stringently applied to MH/SUD benefits than to M/S benefits in the inpatient and outpatient classifications.
- **NQTLs — Medical Necessity and Appropriateness Criteria:** The plan uses medical necessity and appropriateness criteria (MNC) (e.g., State CCPs or nationally recognized third party criteria such as MCG) for their PA and CR. DHHS required the plan to complete a questionnaire regarding how the plan selects and/or develops MNC to conduct utilization management for both MH/SUD and M/S benefits. Upon review of the completed questionnaires, including follow-up with the plan, DHHS determined the plan's processes, strategies, and evidentiary standards for MNC are comparable and no more stringently applied to MH/SUD inpatient and outpatient benefits than to M/S inpatient and outpatient benefits.
- **NQTLs — Prior Authorization of Prescription Drugs (RxPA):** DHHS has established clinical prior authorization criteria for some MH/SUD and M/S drugs, and DHHS requires the plan follows these clinical PA requirements. Using a questionnaire, DHHS collected information regarding each plan's PA processes for prescription drugs and combined that information with State information on processes, strategies, and evidentiary standards. Upon review of the combined information, DHHS determined the processes, strategies, and evidentiary standards for establishing clinical PA for prescription drugs are comparable to and no more stringently applied to MH/SUD drugs than to M/S drugs.

- **NQTLs — Formulary Design:** DHHS has established a preferred drug list (PDL) and requires the plan to follow DHHS' PDL. Since the plan follows the State's PDL, DHHS' formulary design questionnaire collected information on the plan's processes related to formulary design, and DHHS combined that information with State information on processes, strategies, and evidentiary standards. Upon review of the combined information, DHHS determined the processes, strategies, and evidentiary standards for formulary design are comparable and no more stringently applied to MH/SUD drugs than to M/S drugs.
- **NQTLs — Provider Admission — Credentialing and Contracting**: The plan requires providers of all MH/SUD and M/S benefits to meet credentialing and contracting requirements to participate in the plan's network. The plan completed a questionnaire regarding how the plan applies credentialing and contracting requirements to providers of MH/SUD and M/S benefits. Upon review of the completed questionnaires, including follow-up with the plan, DHHS determined the plan's contracting and credentialing processes, strategies, and evidentiary standards are compliant with parity requirements.
- **NQTLs — Provider Reimbursement — In-Network:** The plan reimburses network providers for delivering MH/SUD and M/S benefits. The plan completed a questionnaire regarding how the plan establishes reimbursement rates for network providers. Upon review of the completed questionnaire, including follow-up with the plan, DHHS determined the plan's processes, strategies, and evidentiary standards for establishing reimbursement rates are comparable and no more stringently applied to network providers of MH/SUD benefits than to network providers of M/S benefits.
- **NQTLs — Provider Network — Access to OON Providers:** The plan limits access to and coverage of benefits from OON providers for both MH/SUD and M/S benefits. DHHS required the plan complete a questionnaire regarding how the plan limits access to OON providers. Upon review of the completed questionnaires, including follow-up with the plan, DHHS determined the plan's processes, strategies, and evidentiary standards for limiting access to and coverage of benefits from OON providers are comparable and no more stringently applied to OON providers of MH/SUD benefits than to OON providers of M/S benefits.

DHHS will monitor parity compliance, including both in writing and in operation, and will update its analysis and this report as needed to reflect changes that may impact compliance with parity.