Mental Health Parity and Addiction Equity Act (MHPAEA) Report for North Carolina Behavioral Health and Intellectual/Developmental Disabilities (BH I/DD) Tailored Plans

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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 Behavioral Health and Intellectual/Developmental Disabilities (BH I/DD) Tailored Plan, implemented on July 1, 2024.

Methodology

North Carolina conducted the parity analysis for the NC Medicaid Managed Care BH I/DD Tailored Plan 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.

Tailored Plan Benefit Packages

The NC Medicaid Managed Care BH I/DD Tailored Plan program provides integrated services for Medicaid and CHIP beneficiaries[2] with BH needs and I/DD, including individuals who are

[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

[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.

enrolled in the Innovations and the Traumatic Brain Injury (TBI) 1915(c) waivers. Four organizations serve as regional BH I/DD Tailored Plans (Tailored Plans). Since North Carolina's TBI waiver is currently only available in one region, only one Tailored Plan provides services to individuals enrolled in the State's TBI waiver.

The North Carolina Department of Health and Human Services (DHHS) identified 10 Tailored Plan benefit packages (see Table 1) subject to parity requirements.

There are only a few services carved out of the Tailored Plan 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 Tailored Plan Parity Analysis
Medicaid Adults[3] (21 years of age and older) enrolled in the Innovations waiver
Medicaid Children[4] (0 years to 20 years of age) enrolled in the Innovations waiver
Medicaid Adults (21 years of age and older) enrolled in the TBI waiver
Medicaid Children (18 years to 20 years of age) enrolled in the TBI waiver
Medicaid Adults (21 years of age and older) not enrolled in the Innovations or TBI waiver
Medicaid Children (0 years to 20 years of age) not enrolled in the Innovations or TBI waiver
Dual Eligible Adults (21 years of age and older) enrolled in the Innovations waiver
Dual Eligible Children (0 years to 20 years of age) enrolled in the Innovations waiver
Dual Eligible Adults (21 years of age and older) enrolled in the TBI waiver
Dual Eligible Children (0 years to 20 years of age) enrolled in the TBI waiver

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)

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

[4] 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).

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

- 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 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 (ED) 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 Tailored Plans (section V.B.2.i.(ii)(h)) 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, an I/DD, and/or a TBI, and the limit is applied identically regardless of whether the beneficiary has a SMI, SPMI, SUD, I/DD, and/or TBI diagnosis code. DHHS determined the Tailored Plans comply 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 with Tailored Plans (see section V.B.2.i.(x)(a)–(b) and (e)(3)), the Tailored Plans 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. Tailored plans 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 Tailored Plans comply 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 or TBI, and the limit is applied identically regardless of diagnosis. DHHS received written assurances from each of the Tailored Plans confirming that they do not apply QTLs other than the QTL for 1915(i) Respite Services. DHHS' parity analysis concluded such and determined the Tailored Plans comply 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 Tailored Plans to conduct the NQTL analysis,

including information on processes, strategies, and evidentiary standards.[5] Each questionnaire included prompts to help the Tailored Plans provide the information needed and to support consistency in the information gathered across the Tailored Plans. DHHS instructed the plans 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 Tailored Plans completed one questionnaire for all applicable benefits packages. Except for utilization management, the Tailored Plans completed one questionnaire for all applicable classifications. For utilization management, there were separate questionnaires for the inpatient, outpatient, emergency care, and prescription drug classifications.

DHHS reviewed the information provided by each plan and conducted follow-up with each Tailored 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.

[5] Since the Tailored Plans follow 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 plans' 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 Tailored Plans 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. Each of the plans stated that they did 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
*All plans said they do not apply retrospective review as a utilization management limit.
**No plan identified an additional NQTL.

Summary and Findings

Based on the analyses described above, DHHS determined the Tailored Plans comply 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 Tailored Plans 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 (I/DD or TBI), and the limit is applied the same regardless of a member's diagnosis. DHHS determined the Tailored Plans comply with parity requirements for ALs/ADLs.

- **Financial Requirements (FRs):** The Tailored Plans do 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 Tailored Plans comply with parity requirements for FRs.

- **Quantitative Treatment Limitations (QTLs):** The only quantitative treatment limitation (QTL) the Tailored Plans 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 (I/DD or TBI) diagnosis, and the limit is applied the same regardless of diagnosis. DHHS determined the Tailored Plans comply with parity requirements for QTLs.

- **Non-Quantitative Treatment Limitations (NQTLs) — Utilization Management in the Inpatient, Outpatient, and Emergency Care Classifications**: All Tailored Plans apply PA and CR to MH/SUD and M/S benefits in the inpatient and outpatient classifications. None of the plans apply PA or CR to MH/SUD benefits in the emergency care classification, and none of the plans 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 plans' PA and CR requirements are no more restrictive than the PA and CR requirements specified in the applicable State CCP.

  Each Tailored Plan completed five separate questionnaires (PA in the inpatient classification, CR in the inpatient classification, PA in the outpatient classification, CR in the outpatient classification, and RR in the emergency care classification). Upon review of the completed questionnaires, including follow-up with the plans, DHHS determined each 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:** All plans use medical necessity and appropriateness criteria (MNC) (e.g., State CCPs or nationally recognized third-party criteria such as InterQual or MCG) for their PA and CR. DHHS required each 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 plans, DHHS determined each 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 Tailored Plans to follow 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 Tailored Plan to follow DHHS' PDL. Since the plans follow the State's PDL,

DHHS' formulary design questionnaire collected information on each 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**: All Tailored Plans require providers of all MH/SUD and M/S benefits to meet credentialing and contracting requirements to participate in the plan's network. Each 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 plans, DHHS determined each plan's contracting and credentialing processes, strategies, and evidentiary standards are compliant with parity requirements.
- **NQTLs — Provider Reimbursement — In-Network:** All plans reimburse network providers for delivering MH/SUD and M/S benefits. Each plan completed a questionnaire regarding how the plan establishes reimbursement rates for network providers. Upon review of the completed questionnaires, including follow-up with the plans, DHHS determined each 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 Tailored Plans limit access to and coverage of benefits from OON providers for both MH/SUD and M/S benefits. DHHS required each plan to complete a questionnaire regarding how the plan limits access to OON providers. Upon review of the completed questionnaires, including follow-up with the plans, DHHS determined each 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.