

PROVIDER FREQUENTLY ASKED QUESTIONS (FAQS) MENTAL HEALTH PARITY AND ADDICTION ACT OF 2008 (MHPAEA)

GENERAL INFORMATION

Q. What is the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)?

A. The Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA) requires insurers and group health plans (Plans) to ensure that the coverage offered for Mental Health/Substance Abuse (MHSA) treatments and services is no more restrictive than the coverage offered for medical and surgical treatments and services. MHPAEA expanded the mental health parity requirements that had been in place since 1996. The Interim Rule was issued in February of 2010 and the Final Rule was issued on November 8, 2013.

Q. What is the effective date of the Final Rule?

A. The Final Rule becomes effective for Plan years beginning on or after July 1, 2014. For calendar year Plans, the effective date will be January 1, 2015. Provisions of the Interim Rule that were not changed in the final rule continue to apply without interruption.

Q. Did the Final Rule make significant changes from the Interim Rule?

A. No. The Final Rule clarified certain questions left open from the Interim Rule and incorporated FAQs that regulators have issued over the past three years.

Q. What type of plans are covered by the Final Rule?

A. MHPAEA generally applies to both fully insured and self-funded large group plans as well as individual and small group plans sold on and off the health insurance exchanges. MHPAEA does not apply to Plans obtaining a cost-based exemption; Self-insured state or local government plans that request a one-year exemption; Retiree-only plans; Medicare; and, VA and Tricare benefits.

Q. Are MHSA services now required to be covered under a Plan?

A. No. Plans do not have to cover MHSA benefits.

Q. Does MHPAEA apply to Medicare Advantage plans?

A. No. As was the case in the Interim Rule, members of Medicare Advantage are not subject to the provisions of MHPAEA and should not anticipate changes to current clinical management processes (e.g., prior authorization, other utilization management).

Q. Does MHPAEA apply to employee assistance programs (EAP) and health and wellness benefits?

A. No. As was the case in the Interim Rule, EAPs that qualify as excepted benefits will not be subject to MHPAEA or the Final Rule.

Q. What is the best way for providers to check a member's benefits that participates with ValueOptions?

A. It is important that providers verify a patient's benefit plan prior to requesting services via [ProviderConnect](#). Members' benefits can be accessed via [ProviderConnect](#) or by calling the appropriate telephone number located on the back of the member's benefit card.

MHPAEA & THE AFFORDABLE CARE ACT (ACA)

Q. What does the Final Rule clarify about mental health coverage and ACA?

A. The ACA indicates that Plans are foreclosed from having annual or lifetime dollar limits on the (ten) 10 essential health benefits, one of which is MHSA treatment.

UTILIZATION MANAGEMENT - INPATIENT CARE

Q. Did the Final Rule change utilization management processes for Inpatient and all Alternative Levels of Care (ALOC)?

A. Possibly. Plans and issuers must assign per the final rule all covered ALOC benefits to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if care in skilled nursing facilities or rehabilitation hospitals is classified as inpatient benefits, then any covered care in residential treatment facilities for mental health or substance use disorders must likewise be treated as an inpatient benefit. Similarly, if home health care is treated as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well. ALOC services are not mandated under the Final Rule. A specific and fulsome review of an applicable plan's ALOC offerings will occur once the final rule becomes effective.

UTILIZATION MANAGEMENT - OUTPATIENT CARE

Q. Did the Final Rule change utilization management processes in terms of Outpatient Care?

- A.** Not at this time. Providers should continue to follow the same Outpatient Therapy Services utilization management procedures established at the time of the Interim Rule.

As noted during the Interim Rule, authorization prior to beginning treatment is no longer required. As always, benefits vary by client for what is a covered benefit and what requires an authorization. We remind you of the importance of reviewing your member's benefit on the benefits tab on ProviderConnect or by calling the appropriate telephone number located on the back of the member's benefit card.

CLAIMS

Q. Are there any changes to claim processing as a result of the Final Rule?

- A.** No. Continue to follow the same claim procedures established at the time of the Interim Rule.

ADDITIONAL INFORMATION

Q. Where can I find additional information about MHPAEA and the Final Rule?

- A.** The Final Rule that implements MHPAEA can be found at <https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-27086.pdf>

DOL/EBSA materials, including technical FAQs, fact sheets, reports, videos, and links can be found at <http://www.dol.gov/ebsa/mentalhealthparity/>

The CCIO factsheet is available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

DISCLAIMER: Please be aware that these sites do not serve as or are in no way legal advice and should a provider have questions regarding this law he/she should consult legal counsel of their choosing, and that ValueOptions is not responsible for the information available on any such websites or for provider's access to information through such website links.