Supporting Statement – Part A
Medical Necessity and Contract Amendments Under Mental Health Parity
CMS-10556 (OCN 0938-New)

This package is associated with our mental health parity NPRM (CMS–2333–P; RIN 0938–AS24) which published in the Federal Register on April 10, 2015 (80 FR 19418).

Background

The current PRA submission relates to the proposed rule "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" (RIN 0938-AS24, CMS-2333-P). This proposed rule would amend the Medicaid and CHIP regulations to implement the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. The proposed rule would apply mental health parity requirements to Medicaid Managed Care Organizations (MCOs), Section 1937 Alternative Benefit Plans (ABPs), and the CHIP. Two provisions of this NPRM implicate PRA requirements:

- *Medical Necessity Disclosure*: Proposed sections 438.915(a), 440.395(c)(1), and 457.496(e)(1) of this NPRM would require that the medical necessity determination criteria used by MCOs, PIHPs, and PAHPs or other utilization management organizations under contract with the state with respect to MH/SUD benefits be made available to potential participants, beneficiaries, or contracting providers upon request. CMS is not proposing that a specific form be used for these disclosures.

- *Contract Requirements*: Proposed section 438.6(n) would to require states to include contract provisions in all applicable MCO, PIHP, and PAHP contracts to comply with the proposed requirements of this rule.

The burden resulting from these requirements can be found in section 12 of this Supporting Statement.

The proposed rule also contains provisions related to the disclosure of information related to the reason for denial of reimbursement or payment for MH/SUD benefits. However, this rule would not impose any new or revised third-party disclosure requirements and therefore, does not require additional OMB review under the authority of the Paperwork Reduction Act. The proposed text only clarifies the expectations for disclosing information concerning the denial of reimbursement or payment for MH/SUD benefits.

A. Justification

1 . Need and Legal Basis

This proposed rule addresses the application of certain provisions added to the Public Health Service Act (PHS Act) (mental health parity requirements) by the provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. 110–343) to: (1) Medicaid managed care organizations (MCOs) as described in section 1903(m) of the Act; (2) Medicaid benchmark and benchmark-equivalent plans (referred to in this proposed rule as Medicaid Alternative Benefit Plans) as described in section 1937 of the Social Security Act (the Act); and (3) Children's Health Insurance Program (CHIP) under title XXI of the Act.

Under section 1932(b)(8) of the Act, Medicaid managed care organizations (MCOs) are required to comply with the requirements of subpart 2 of part A of title XXVII of the PHS Act, to the same extent that those requirements apply to a health insurance issuer that offers group health insurance. Subpart 2 includes mental health parity requirements added by MHPAEA at section 2726 of the PHS Act (as renumbered; formerly section 2705 of the PHS Act). Under section 1937(b)(6) of the Act, Medicaid Alternative Benefit Plans (ABPs) that are not offered by an MCO and that provide both medical and surgical benefits and mental health and substance use disorder benefits are required to ensure that financial requirements and treatment limitations for such benefits comply with the mental health parity requirements of the PHS Act (referencing section 2705(a) of the PHS Act, which is now renumbered 2726(a) of the PHS Act), in the same manner as such requirements apply to a group health plan. The section 1937 provision applies only to ABPs that are not offered by MCOs; ABPs offered by MCOs are already required to comply with these requirements under section 1932(b)(8) of the Act. Section 2103(c)(6) of the Act requires that state CHIP plans that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that financial requirements and treatment limitations for such benefits comply with mental health parity requirements of the PHS Act (referencing section 2705(a) of the PHS Act, now renumbered as section 2726(a) of the PHS Act) to the same extent as such requirements apply to a group health plan. In addition, section 2103(f)(2) of the Act requires that CHIP benchmark or benchmark equivalent plans comply with all of the requirements of subpart 2 of part A of the title XXVII of the PHS Act, which includes the mental health parity requirements of the PHS Act, insofar as such requirements apply to health insurance issuers that offer group health insurance coverage.

2. Information Users

Medical Necessity Disclosure

Upon request, regulated entities must provide a medical necessity disclosure. Receiving this information will enable potential and current enrollees to make more educated decisions given the choices available to them through their plans and may result in better treatment of their MH/SUD conditions. MHPAEA also requires that plans and issuers provide the medical necessity disclosure to current and potential contracting health care providers. Because medically necessary criteria generally indicates appropriate treatment of certain

illnesses in accordance with standards of good medical practice, this information should enable behavioral health practitioners and organizations to structure available resources to provide the most efficient health care for their patients.

Contract Requirements

States use the information collected and reported as part of its contracting process with managed care entities, as well as its compliance oversight role. CMS uses the information collected and reported in an oversight role of State Medicaid managed care programs.

3. Use of Information Technology

This proposed rule allows but does not require the use of information technology to fulfill the information collection requirements.

4. Duplication of Efforts

Because this is the first rule to extend mental health parity requirements to Medicaid and CHIP programs, no duplication of efforts will be created by the information collection requirements of this rule.

5. Small Businesses

This proposed rule will not have a significant economic impact on a substantial number of small entities as that term is used in the RFA.

6. Less Frequent Collection

The frequency of disclosure of information regarding medical necessity depends on the number of enrollees who request such information, and is not at the discretion of CMS.

Contract amendments for MCOs, PIHPs, and PAHPs required by 438.6(n) are expected to be made one time only.

7. Special Circumstances

No special circumstances apply.

8. Federal Register/Outside Consultation

CMS-2333-P (RIN 0938-AS24) published in the Federal Register on April 10, 2015 (80 FR 19418) and is serving as the 60-day notice. Comments are due June 9, 2015.

No outside consultation has been conducted prior to the release of this NPRM.

9. Payments/Gifts to Respondents

No payments or gifts are associated with these ICRs.

10. Confidentiality

Disclosures of medical necessity criteria require regulated entities to provide information to enrollees and contracting providers. Issues of confidentiality between third parties do not fall within the scope of this information collection request.

Information regarding state contracts with MCOs, PIHPs, and PAHPs is not confidential and its release would fall under the Freedom of Information Act.

11. Sensitive Questions

These ICRs involve no sensitive questions.

12. Burden Estimates (Hours & Wages)

Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2013 National Occupational Employment and Wage Estimates for all salary estimates (www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

Proposed Hourly Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage	Fringe Benefit (at 100%)	Adjusted Hourly Wage
Business Operations Specialists	13-1000	$33.19/hr	$33.19/hr	$66.38/hr
Medical Secretaries	43-6013	$15.93/hr	$15.93/hr	$31.86/hr

We propose to adjust all our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Proposed Information Collection Requirements (ICRs)

ICRs Regarding the Availability of Information and the Criteria for Medical Necessity Determinations (§§ 438.915(a), 440.395(c)(1), and 457.496(e)(1))

Proposed §§ 438.915(a), 440.395(c)(1), and 457.496(e)(1) would require that the medical necessity determination criteria used by regulated entities with respect to MH/SUD benefits be made available to potential participants, beneficiaries, or contracting providers upon request.

In the November 13, 2013, MHPAEA final rule, the regulatory impact analysis (78 FR 68253 through 68266) quantified the costs to disclose medical necessity criteria. For consistency and comparability, we are using the same method for determining this rule's disclosure costs, with adjustments to account for Medicaid MCOs, ABP and CHIP and the population covered.

Labor Costs for Medical Necessity Disclosures. We are unable to estimate with certainty the number of requests for medical necessity criteria disclosures that will be received by regulated entities. However, the MHPAEA final rule's impact analysis did set forth assumptions that we believe are relevant for calculating costs for the Medicaid and CHIP program. In that impact analysis, it was assumed that each plan would receive 3 medical necessity criteria disclosure requests for every 1,000 beneficiaries. This assumption equated to .003 requests per enrollee. This assumption was applied to the number of enrollees enrolled in Medicaid (33.1 million), ABP (8.7 million) and CHIP (5.7 million) to project the number of expected requests: 99,328 for MCOs, 26,100 for ABPs and 16,975 for CHIP.

To estimate the time it will take a medical staff to respond to each request we used the same assumption as the MHPAEA final rule. Specifically, we assumed that it took a staff member (in this case, a Medical Secretary) 5 minutes to respond to the request. In this proposed rule, this results in a total annual burden of 11,867 hours for Medicaid and CHIP programs.

The adjusted hourly rate for Medical Secretaries responding to these requests is estimated to be $31.86/hr. Multiplying the total annual burden of 11,867 hours by the hourly wage yields an associated equivalent cost of about $378,083 for all requests to Medicaid and CHIP programs.

Mailing and Supply Costs. The MHPAEA final rule's impact analysis estimated that 38 percent of the requests would be delivered electronically with de minimis cost. The remaining requests would require materials, printing, and postage amounting to approximately 66 cents per request. We believe that the same mailing and supply costs per request will apply to the disclosure requirements of this rule.

The following table displays the added burden estimates, nationally and per program, for Medicaid MCOs and CHIP to comply with the proposed medical necessity determination criteria's disclosure procedures. The number of enrollees for MCOs/HIOs is based on the CMS national breakout as of July 2012 while the number for ABPs is based on the estimated enrollment growth due to Medicaid expansion ("National Health Expenditure Projections 2012–2022," CMS). CHIP enrollment is based on Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission's 2014 estimates.

National and Per Program Burden for the Proposed Medical Necessity Determination Criteria's Disclosure Requirements

Plan Type	Number of Enrollees	Number of Expected Requests (.003 requests per enrollee)	Time (@ 5 min/response	Labor Cost ($) @ $31.86/hr	Mailed Responses (62 % of expected enrollees)	Mailing and Supply Cost ($) @ $.66/mailing	Total Cost ($)
MCO/ HIO	33,109,462	99,328	8,277 hr	263,705	61,584	40,645	304,350
ABP	8,700,000	26,100	2,175 hr	69,296	16,182	10,680	79,976
CHIP	5,658,460	16,975	1,415 hr	45,082	10,525	6,947	52,029
TOTAL	47,467,922	142,403	11,867 hr	378,083	88,291	58,272	436,355

ICRs Regarding Contract Requirements (§ 438.6(n))

In § 438.6(n), states would be required to include contract provisions in all applicable MCO, PIHP, and PAHP contracts to comply with part 438, subpart K. We estimate a one-time state burden of 30 minutes for a Business Operations Specialist at $66.38/hr to amend each contract with the applicable requirements. In aggregate, we estimate 301 hours (602 contracts x 0.5 hours) and $16,049 (301 hours x $53.32/hr).

Summary of Proposed Burden Estimates

Proposed Annual Recordkeeping and Reporting Requirements

Regulation Section(s) Under Title 42 of the CFR	Respondents	Total Responses	Burden per Response	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($/hr)	Total Labor Cost of Reporting ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
438.915(a), 440.395(c)(1), and 457.496(e)(1)	602	142,403	5 min	11,867	31.86	378,082	40,645	436,355
438.6(n)	36	602	30 min	301	66.38	19,980	0	19,980
TOTAL	638	143,005	35 min	12,168	--	398,062	40,645	456,335

13. Capital Costs

No capital costs are associated with this proposed regulation.

14. Cost to Federal Government

No costs to the federal government are associated with this proposed regulation.

15. Changes to Burden

Not applicable. This is a new collection.

16. Publication/Tabulation Dates

    No publication or tabulation dates are associated with this proposed regulation.

17. Expiration Date

    This collection does not lend itself to the displaying of an expiration date.

18. Certification Statement

    There are no exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods

Not applicable. This information collection does not contain any questionnaires/surveys and does not employ any statistical methods.