Mental Health Parity – Medicaid

- 29 USC 1185a states the Mental Health Parity statutory provisions. In gist, a group health plan must ensure that the restrictions it places on mental health or substance abuse disorders are no more restrictive that the restrictions on medical / surgical benefits. This would include pharmacy.

- 42 CFR 440.395 states the Mental Health Parity rules for Medicaid. Specifically, subsection (b)(2) provides:

  "(2) *General parity requirement*—(i) *General rule.* A State may not apply within an ABP any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification."

- Medicaid is to also treat all similarly situated enrolled members equally.

- There is a special provision for dealing with pharmacy benefits that specifies how differential prescriptions should be handled based on certain factors. See 42 C.F.R. 440.395 (b)(3)(iii) (copied below as well.) The applicable factors are cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up/delivery. The identification of a specific category of provider is not one of the identified factors.

- As a result, there is a potential for CMS to not allow a restriction in formulary solely based on the credentials of the prescribing provider unless there is a similar allowance on the medical / surgical side.

- The costs for such loss of control is financial.

Medicaid Drug Formulary for Drug Rebates

- To receive drug rebates, a state Medicaid program needs to follow certain statutory requirements specified by 42 USC 1396r-8.
- Specifically, in regards to the formulary for use in a drug rebate program, §1396r-8 (d)(4)(A) provides:

  " (4) Requirements for formularies.—A State may establish a formulary if the formulary meets the following requirements:

(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State (or, at the option of the State, the State's drug use review board established under subsection (g)(3)).”

- Since this specifies that the committee is appointed by the Governor of the state, a legislative mandate for a certain method for establishing a formulary is contrary to specific federal Medicaid statute.

- Per well-accepted U.S. and Kansas Supreme Court caselaw, a state Medicaid program who has a State Plan with federal Medicaid authorities has agreed to comply with applicable federal Medicaid statutes and regulations. See *Wilder v. Virginia Hospital Asso.*, 496 U.S. 498, 502 (1990); *Village Villa v. Kansas Health Policy Authority*, 296 Kan. 315, Syl. ¶ 1, 291 P.3d 1056 (2013).

- As a result, a differing method of establishing authority over a formulary than the one specified by federal Medicaid statute potentially jeopardizes Medicaid drug rebate funds.

42 C.F.R. 440.395 (b)(3)(iii)

(ii) *Special rules*—(A) *Multi-tiered prescription drug benefits.* If a State or plan administrator applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in paragraph (b)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations) and without regard to whether a drug is generally prescribed for medical/surgical benefits or for mental health or substance use disorder benefits, the ABP satisfies the parity requirements of this paragraph (b) for prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up/delivery.