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# Standard Medicaid and MHPAEA Gold Standards

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THE KENNEDY FORUM

LAC LEGAL ACTION CENTER
*Breaking Barriers. Defending Dignity.*

# Contents

# Parity Compliance in Medicaid and Benchmark Plans

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) applies to Medicaid managed care organizations (MCOs), alternative benefit plans (ABPs), and Children's Health Insurance Program (CHIP) plans.[1] Like in commercial insurance plans, this law protects Medicaid beneficiaries from discrimination in coverage of mental health (MH) and substance use disorder (SUD) benefits, as compared to medical benefits and surgical procedures (M/S).

However, oversight of MHPAEA in these plans has been limited to date. The HHS Office of Inspector General found that every state it reviewed failed to comply with parity requirements in Medicaid managed care, and that CMS failed to ensure compliance.[2] Without parity compliance and enforcement, fewer Medicaid beneficiaries get access to lifesaving MH/SUD care. This brief offers guidance on these issues to better ensure mental health parity in states nationwide.

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# Enforcing Parity Compliance

Enforcing parity is both a legal obligation and a sound fiscal strategy; as states face increasing budget pressures, especially in light of drastic cuts to Medicaid,[3] robust MHPAEA enforcement helps ensure taxpayer funds are spent efficiently and appropriately. Holding Medicaid plans accountable for compliance prevents wasteful expenditures on denied or delayed care and, in some cases, enforcement actions and fines can recover costs and ensure appropriate reinvestment in access to MH and SUD care.

The structure of compliance oversight under MHPAEA is critical:

- CMS is responsible for ensuring that states meet parity requirements,
- States are responsible for overseeing compliance by their Medicaid MCOs, ABPs, and CHIP plans,[4] and
- Medicaid managed care contracts must provide for benefits to be delivered to enrollees in compliance with MHPAEA.[5]

Clear lines of accountability must be maintained and enforced so that Medicaid enrollees can access the MH/SUD benefits to which they are legally entitled.

State agencies overseeing these Medicaid MCOs, ABPs, and CHIP plans must embed clear, enforceable parity compliance obligations directly into contracts and conduct active oversight to ensure implementation. This issue brief reviews the best practices and recommendations for oversight of MHPAEA in Medicaid.

# Parity Compliance Best Practices

Since MHPAEA was enacted in 2008, states and the federal government have experimented with practices to ensure health insurance plans are complying with these non-discrimination protections to ensure equitable access to MH and SUD care. Over the past decade, the majority of states have adopted a stepwise comparative analysis approach, which requires commercial insurance plans to analyze and document how the treatment limitations they apply to MH and SUD benefits compare to those for M/S benefits.[6]

As a result, Congress included a provision in the Consolidated Appropriations Act of 2021 (CAA, 2021) requiring commercial health plans to perform and document such a comparative analysis. Although Medicaid plans were not subject to this requirement, it is undoubtedly a best practice to ensure not only that plans are complying with the law, but that they are regularly reviewing their policies, procedures, and access to care, and that they are remedying any discriminatory practices that are uncovered.

In the years since the CAA, 2021 was signed into law and this practice has been employed, the federal agencies that regulate MHPAEA have found consistent non-compliance and rampant violations among commercial health plans.[7] As a result, they have succeeded in removing discriminatory barriers for millions of individuals across the country in tens of thousands of health plans.[8] Many states that have meaningfully enforced MHPAEA have similarly found routine non-compliance and taken the necessary steps to correct for them.[9]

A handful of states have likewise adopted this approach for their Medicaid plans, recognizing that these comparative analyses are the most effective way to get the necessary information and data from plans to assess parity compliance, as written and in operation, and remove discriminatory practices.[10] Incorporating such a requirement into state law, regulations, and contracts with Medicaid plans is a critical way for these plans to truly comply with MHPAEA, and for the state agencies to conduct the level of oversight required by federal law and regulations.

# Ensuring Parity Compliance in Contracts

State Medicaid contracts, EHB benchmark plan contracts, and managed care boilerplate contracts need to ensure parity compliance. State Medicaid agencies overseeing these processes should include in their contracts the following best practices, which should regularly be reviewed by the relevant regulatory agencies.[11]

- **Explicit NQTL Comparative Analysis Requirements**: Amend boilerplate contracts to explicitly require plans to perform and document comparative analyses of all NQTLs applied to MH/SUD benefits.
- **Data Evaluation Standards that Include NQTLs**: Define clear standards for evaluating the design and application of NQTLs to ensure parity, including:
  - **Network composition** in access to MH/SUD as compared to M/S providers.
  - **Reimbursement parity** between MH/SUD and M/S services.
  - **Coverage and provision of behavioral health services**.
  - **Utilization management protocols** (denials, prior authorization, step therapy).
  - **Appeals, grievances, and complaints** specific to behavioral health.

  *See our* **Data Collection, Evaluation, and Reporting Gold Standard Toolkit** *for a comprehensive list of data evaluation elements.*
- **Mandated Regulator Access**: Include provisions that require MCOs to provide NQTL comparative analyses to regulators each year and to beneficiaries upon request.
- **Corrective Action and Notification Procedures**: Specify procedures for timely corrective actions and participant notifications in cases of non-compliance.

  *For details and examples, see our* **Corrective Enforcement Actions Gold Standard Toolkit**.

# 10 Points to Ensure Parity Compliance

To ensure parity compliance in these contracts, states should do all of the following:

### 1. Require Comprehensive and Regular MHPAEA Compliance Analyses

- Mandate that MCOs, CHIP plans, and ABPs conduct detailed comparative analyses for each NQTL in every classification of care.
- Align analytic and documentation standards with CAA, 2021 and FAQ 45 from the Departments of Labor, Treasury, and HHS.
- Require an updated comparative analysis before any benefit, reimbursement, or utilization management change, and at least annually.
- Analyses must test design, application, and outcomes, including in operation parity data.

### 2. Incorporate Parity Obligations Directly into Contracts

- Embed explicit MHPAEA compliance language into managed care contracts, requiring:
  - Ongoing compliance with parity standards.
  - Perform and document parity analyses with any contract or benefit change.
  - Corrective action plans when violations are found.

**Example:**

**Ohio Medicaid MCO** *contracts require submission and review of parity analyses as a contract deliverable (See* **Appendix I***)*

### 3. Strengthen State Oversight and Accountability

- States should:
  - Review and compile outcomes data from existing comparative analyses.[12]
  - Submit consolidated parity compliance reports to CMS no less frequently than every 3 years.
  - Develop and enforce corrective actions, including reprocessing claims and administrative penalties.

- Require plans demonstrate parity compliance to qualify for open RFP processes.

### 4. Build MHPAEA Expertise

- Establish dedicated MHPAEA enforcement staff or contract with external parity experts.
- Participate in CMS-hosted parity training and include MHPAEA as a focus in Medicaid and CHIP Learning Collaboratives.
- Partner with state departments of insurance (DOIs) to leverage and strengthen parity compliance tools, templates, and resources.

### 5. Standardize and Expand Public Transparency

- Publicly post:
  - Parity analyses and state reviews.[13]
  - Provider reimbursement rates[14] and methodologies (including use of national benchmarks).
  - Network composition and adequacy metrics. [15]
- Require MCOs to report provider directory accuracy, billing activity, and access measures by MH and SUD vs. M/S.

States like **Georgia**, **Maryland**, and **North Carolina** have all used the web effectively to organize and report out on analyses for centralized, user-friendly, helpful resources for all.

### 6. Create Rigorous Complaint and Appeals Infrastructure

- Standardize parity complaint investigation processes across all MCOs.
- Establish parity-specific reporting, tracking, and resolution infrastructure with clear points of contact.
- Engage community stakeholders to identify systemic violations through consumer feedback loops.

### 7. Strengthen EPSDT Oversight for Youth

States should move beyond simple EPSDT attestations and instead require verifiable evidence that all medically necessary MH and SUD services are available and covered for beneficiaries under age 21.

States should ensure coverage for the full continuum of care, including early psychosis intervention, intensive outpatient (IOP) and partial hospitalization programs (PHP), residential treatment, medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD), and crisis services by conducting state reviews of compliance on these – and other specialty MH and SUD – services.

To do this, states can analyze claims data and diagnosis codes to monitor utilization of key MH/SUD services for children and adolescents. Regular review of this data enables states to identify gaps in access, pinpoint systemic barriers, and verify that EPSDT requirements are being met in practice.

### 8. Prioritize Key NQTLs and Services for Enforcement

Focus audits and analysis on high-risk and high-impact areas:

- Network composition and adequacy, especially ghost networks,
- Prior authorization, step therapy, and concurrent review,
- Reimbursement rates (e.g., MH/SUD underpayment),
- Service scope limitations, especially for SUD and co-occurring care,
- Prescription drug limitations and formulary design, especially for MOUD and naloxone.

### 9. Conduct Data-Driven, Random, and Periodic Audits

States should use data to prioritize oversight and target enforcement toward the lowest-performing plans or those showing persistent parity violations. By focusing limited resources where compliance gaps are largest, states can achieve greater systemic improvement.

States should:

- Require routine and unannounced audits, similar to state insurance departments' market conduct exams.

- Adopt model data collection tools[16] for parity monitoring.
- Require quantitative outcome reporting (e.g., denial rates, time-to-treatment, network wait times) disaggregated by MH and SUD vs. M/S.

### 10. Leverage Secret Shopper Surveys to Assess Parity Compliance

The 2024 Managed Care Access Rule requires states to conduct annual independent secret shopper surveys to verify Medicaid provider directory accuracy. States should use the results from these surveys to specifically assess MH/SUD network adequacy and parity compliance, mirroring federal approaches. The 2024 MHPAEA Report to Congress demonstrated that secret shopper audits can uncover disparities between MH/SUD and M/S networks—such as ghost networks, inaccurate directories, and significantly lower appointment availability for MH/SUD.

Using these secret shopper surveys, states should:

- Compare MH/SUD vs. M/S appointment availability, wait times, and provider responsiveness.
- Use findings to trigger corrective actions, reprocessing of claims, or penalties where parity violations are identified.

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**EBSA's 2024 MHPAEA Secret Shopper Methodology**

EBSA conducted calls to a randomized sample of providers listed in MH/SUD and M/S directories and compared (1) accuracy of provider contact information; (2) acceptance of new patients; and (3) wait time to first available appointment. Survey results in the 2024 MHPAEA Report to Congress found that MH/SUD networks had significantly lower appointment availability and more inaccurate directory listings than M/S. The survey findings triggered corrective actions with plans to remediate network gaps and improve directory accuracy.

States should use this same framework, leveraging the data from the secret shopper surveys, to measure MHPAEA compliance in their Medicaid plans.

# Building MHPAEA Compliant Plan Model Language

To support states in ensuring that MCOs, ABPs, and CHIP plans comply with MHPAEA, this section provides best-practice guidelines that states may incorporate into contracts, ABP benefit descriptions, or oversight frameworks. Because state Medicaid programs vary in structure and statutory authority, some states may need to use a State Plan Amendment (SPA) or §1115 demonstration waiver to align benefits or operational policies with these best practices. Our suggested language is adapted to the Medicaid regulatory structure, using appropriate terminology and removing employer-market concepts. Not all of the recommendations are federal regulatory requirements, but they reflect the strongest approaches used by high-performing parity enforcement programs and address common barriers to MH/SUD treatment. As with other Medicaid policies, states may adopt stronger protections as long as they remain consistent with federal Medicaid law.

The following recommendations are not an exhaustive list of plan model language, but rather a selection of best practices based on common discriminatory barriers to MH/SUD treatment, which states should proactively seek to address.

### 1. MH/SUD Coverage in All Classifications of Care

States should require Medicaid MCOs, ABPs, and CHIP plans to provide MH/SUD benefits in every classification (inpatient, outpatient, emergency care, and prescription drugs) in which M/S benefits are offered (42 C.F.R. § 438.910(b)(2), 440.395(c)(2)(ii), 457.496(d)(2)(ii)).[17] States should ensure that such coverage is meaningful – that is, if a core treatment is covered for M/S in a given classification, then core treatments for MH/SUD must be covered in that classification as well, rather than limiting coverage to auxiliary benefits or just screenings for a given condition. For this requirement, states may need approval from CMS if they are not already covering an appropriate scope of services to meet the MH/SUD needs of their beneficiaries.

### 2. Quantitative Treatment Limits Applied to MH/SUD only When Applied to Medical/Surgical

Under MHPAEA, a quantitative treatment limitation (QTL) on MH/SUD services is permissible only if the same limitation applies to *substantially all* comparable M/S benefits within the *same classification* (42 C.F.R. §§ 438.910, 440.395, 457.496).[18] For example, a plan cannot limit the number of MH or SUD visits a Medicaid beneficiary can have in a given time period if the same numerical limitation is not placed on M/S benefits.

### 3. Facility- and Provider-Based Limits Targeting MH/SUD

Non-quantitative treatment limitations (NQTLs) in Medicaid include medical management standards, prior authorization rules, provider credentialing or network admission requirements, reimbursement methodologies, scope-of-service limitations, fail-first policies, and other non-numerical practices that affect access to services.

States frequently restrict MH/SUD services to home or school-based settings or limit which provider types can deliver MH/SUD care. These are NQTLs and must meet parity standards.[19]

Plans must demonstrate that any such limits were designed and applied using comparable processes, strategies, evidentiary standards, and factors as those used for M/S benefits, and that they are no more stringent in practice.

### 4. Medical Necessity Criteria Disclosures

Plan contracts should describe how medical necessity for MH/SUD services is defined or disclosed and the criteria used to determine medical necessity for MH/SUD benefits.[20] These criteria should be publicly available, as well as available to beneficiaries, providers, and others upon request within a timely manner.

### 5. Prior Authorization Language Not Described for M/S

If prior authorization for MH/SUD is listed or required, there should be a comparable requirement stated for analogous M/S services in the relevant classification.[21] The same applies for other utilization management practices, such as concurrent review and retrospective review or post-payment audits. As a best practice, states should strive to prohibit unnecessary prior authorization and other utilization management requirements and ensure that MH/SUD care is available in a timely manner.

### 6. No Separate Limits by Condition

Benefit coverage should be available for all MH/SUD conditions, not restricted to select conditions or diagnoses (e.g., autism).[22]

States should also ensure that limitations on MH/SUD benefits for children and adolescents are consistent with EPSDT requirements, which guarantee coverage of all medically necessary services for the treatment of conditions identified during periodic screenings, regardless of parity classifications.

*See* **Appendix II** *for MHPAEA compliant contract language implementing (1) – (6).*

# Appendix

*Appendix I.* **Parity-Compliant Medicaid MCO Contract Example: Ohio**

*Ohio Medicaid MCO Contract:*

- *Requires MCOs to submit NQTL analyses as a condition of contract compliance.*
- *Incorporates corrective action procedures and CMS reporting timelines.*
- *Aligns contract oversight with CAA 2021 requirements.*

*Ohio Department of Medicaid Provider Agreement for Managed Care Organization*

***8. Mental Health Parity and Addiction Equity Act (MHPAEA) Requirements***

*(a) The MCO must comply with Mental Health Parity and Addiction Equity Act requirements outlined in 42 CFR Part 438 Subpart K, with regard to services provided to managed care members. The requirements apply to the provision of all covered benefits and additional services (i.e., value-added and in lieu of services) to all populations included under the terms of this Agreement.*

*i. The MCO must participate in ODM-requested meetings, respond to ODM information requests, work with ODM to resolve compliance risks, and notify ODM of any changes to benefits or limitations that may impact compliance with MHPAEA.*

*ii. The MCO must conduct ongoing monitoring to determine compliance with MHPAEA and report compliance analysis and determinations using the MHPAEA Compliance Assessment Tool (MHPAEA Tool) provided and required by ODM.*

*iii. The MCO must submit an updated MHPAEA Tool and written attestation of MHPAEA compliance to ODM:*

*1. At least 30 calendar days prior to the proposed effective date for implementing any new clinical coverage policy or changes to previously approved clinical coverage policies;*

2. *At least 30 calendar days prior to the proposed effective date to apply a financial requirement (co-payment);*

3. *At least 30 calendar days prior to the effective date of a change to benefits or limitations that may impact MHPAEA compliance;*

4. *Annually, as specified in Appendix P, Chart of Deliverables; and*

5. *Upon ODM's request.*

iv. *The MCO's annual updated MHPAEA Tool must include an annual summary of self-monitoring activities that describes:*

1. *The MCO's processes for reviewing and analyzing changes to benefit packages, service delivery structures, operational requirements, and policies to ensure ongoing parity compliance; and*

2. *The MCO's processes for monitoring parity compliance in operation on a regular basis, including:*

a. *The data/information monitored by the MCO to identify potential parity compliance concerns, the frequency of the MCO's review of the data/information;*

b. *How the MCO determines when further analysis is necessary; and*

c. *The process used by the MCO to conduct further analysis when the data/information suggests the possibility of a parity compliance concern.*

v. *The MCO will work with ODM to ensure all members are provided access to a set of benefits that meets the MHPAEA requirements regardless of which behavioral health services are provided by the MCO.*

## *Appendix II.* **Gold Standard Parity-Compliant Plan Contract Language**

### 1. MH/SUD Coverage in All Classifications of Care

*"MH/SUD benefits shall be provided in every classification in which M/S benefits are provided, including: inpatient, outpatient, emergency care, and prescription drugs. MH/SUD coverage shall be offered to the same extent as for M/S benefits, consistent with federal Medicaid parity."*

**2. Quantitative Treatment Limits Applied to MH/SUD only When Applied to Medical/ Surgical**

"*The plan shall not impose any quantitative treatment limitations on MH/SUD benefits unless the same limitation is applied to substantially all comparable M/S benefits in the same classification and satisfies the requirements of 42 C.F.R. §§ 438.910, 440.395, and 457.496.*"

**3. Facility-Based Limits Targeting MH/SUD**

"*The plan shall not impose facility-type, setting-based, or provider-type limitations on MH/SUD services unless comparable limitations are applied to M/S services. Any such limitations must comply with Medicaid MHPAEA NQTL standards, including evidentiary standard comparability and proportionality in design and application.*"

**4. Medical Necessity Criteria Disclosures**

"*The plan shall make publicly available, and provide to enrollees, providers, and authorized representatives within 30 days upon request, the medical necessity criteria used to evaluate MH/SUD services. These criteria must be developed using generally accepted medical standards and applied no more stringently than the medical necessity criteria for M/S services.*"

**5. Prior Authorization Language Not Described for M/S**

"*Any prior authorization, concurrent review, retrospective review, or other utilization management practice applied to MH/SUD services shall be comparable to, and applied no more stringently than, those applied to M/S services within the same classification. The plan must demonstrate evidentiary standard comparability and parity compliance consistent with 42 C.F.R. §§ 438.910(d), 440.395(d), and 457.496(e).*"

**6. No Separate Limits by Condition**

"*The plan shall provide MH/SUD benefits for all conditions recognized under the most recent editions of the DSM and ICD-diagnostic criteria, and shall not limit coverage to select diagnoses unless comparable limitations apply to M/S conditions in the same classification.*"

# Resources

1 42 C.F.R. § 438.920(a) (for managed care organizations, including when some benefits are delivered to enrollees in managed care plans through other delivery systems such as fee-for-service Medicaid); 42 C.F.R. § 440.395(e) (for alternative benefit plans); 42 C.F.R. § 457.496(f) (for CHIP).

2 **https://oig.hhs.gov/reports/all/2024/cms-did-not-ensure-that-selected-states-complied-with-medicaid-managed-care-mental-health-and-substance-use-disorder-parity-requirements/**

3 Public Law 119-21, the budget reconciliation act passed in the summer of 2025

4 42 C.F.R. § 438.920(b)(2), 42 C.F.R. § 440.395(e)(1), 42 C.F.R. § 457.496(f)(1).

5 42 C.F.R. § 438.3(n)(1).

6 **https://www.paritytrack.org/reports/**

7 See, e.g., "2024 MHPAEA Report to Congress," Department of Labor, Department of Health & Human Services, Department of the Treasury (Jan. 2025), **https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2024.pdf**.

8 Id.

9 See, e.g., The Kennedy Forum & Legal Action Center, "Corrective Enforcement Actions, The Kennedy Forum 4 (Sept. 2025), **https://www.thekennedyforum.org/app/uploads/2025/09/Gold-Standard-Corrective-Enforcement-Actions_V2.pdf** at 4.

10 *See, e.g., "Compliance with the Mental Health Parity and Addiction Equity Act Comprehensive Report: New York Medicaid Managed Care, Alternative Benefit Plan, and Children's Health Program," New York Department of Health (Mar. 14, 2022)/.*

[11] Including State Medicaid, State Departments of Insurance, and State-based Marketplaces.

[12] *States can build data dashboards that track parity compliance indicators across all plans and identify gaps in real time. See parityindex.org*

[13] *42 C.F.R. § 438.920(b)(1). For example, Georgia posts the analysis submitted by each plan on a single website:* **https://dch.georgia.gov/mental-health-parity-compliance-reports**. *Maryland, which carves out MH/SUD from its managed care plans, has a website where it posts its annual parity analyses:* **https://health.maryland.gov/mmcp/pages/mental-health-parity.aspx**. *North Carolina recently established a Medicaid Mental Health Parity website, which includes the most recent parity analyses as well as links to additional resources, including the clinical coverage policies:* **https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies/mental-health-parity.**

[14] 42 C.F.R. § 447.203.

[15] 42 C.F.R. § 438.68.

[16] For example, see the Bowman Family Foundation's model and the Model Data Request Form

[17] Aligns with §2590.712(c)(2)(ii)(A)

[18] Aligns with §2590.712(c)(3)(i)–(ii)

[19] Aligns with §2590.712(c)(4)(ii)(H)

[20] Aligns with §2590.712(d)(1)–(2)

[21] Aligns with §2590.712(c)(4)(ii)(A) and (F) (medical management and fail-first policies)

[22] Aligns with §2590.712(a)–(b)