Frequently Asked Questions Mental Health Parity

Please submit additional questions on Mental Health Parity using this link:
https://app.smartsheet.com/b/form/3f0912ce756d4a779dd5fef322eb3e7d
Any questions NOT RELATED TO MENTAL HEALTH PARITY have been removed. Please contact Trillium's service line or email below with specific questions not related to Mental Health Parity.

Trillium Health Resources:

Provider Support Services: 1-855-250-1539
NetworkServicesSupport@TrilliumNC.org

Question or Feedback	Response
February 14, 2025	
Does the Mental Health Parity cover BH-RBT services for all CPT codes?	Autism Spectrum Disorder (ASD) services are not included in the MH Parity requirements. Please refer to the list of services impacted by MH Parity that can be found here: https://www.trilliumhealthresources.org/sites/default/files/docs/MH-Parity-Addiction/NCDHHS-MH_Parity_Table_20241212.pdf
Will the requirement for EVV use for Individual Support go away?	EVV requirements are not impacted by MH Parity.
Could you provide more information on the 'clinical pathways' trainings or resources? This is not a resource I am familiar with.	Clinical Pathways will provide guidance about best practice interventions for specific diagnoses. Developing shared clinical pathways is the first step to a standardized approach to care. Please continue attending trainings and information sessions for more details.
February 10, 2025	
Is Therapeutic Leave, Therapeutic Foster Care, or CLFS effected by MH Parity? In what way?	Please refer to the list of services impacted by MH Parity that can be found here: https://www.trilliumhealthresources.org/sites/default/files/docs/MH-Parity-Addiction/NCDHHS-MH_Parity_Table_20241212.pdf

Question or Feedback	Response
With the MH Parity Rule, Will there be an end date or limits implemented to services not requiring a SAR?	Please review the NC Medicaid Clinical Coverage Policies at: https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies for information about prior authorization and other service limitations.
MH Parity and Autism. My understanding is parity was left in part to the states and NC chose to keep ASD off the list of MH dx in regard to parity (per DHB). Is this accurate? Personally, I see the problem with allowing wide open ABA limits, but I am wondering how the dx impacts OPT and Diagnostic services (if it does)? Up to each plan and the review against EPSDT regardless of DX? Example for reference - https://www.asdohio.com/parity-and-autism-law/	Yes, ASD is not included. OPT and Diagnosis will remain open access for Trillium as they have been regardless of diagnosis . Trillium considers EPSDT for all members 21 and under.
Evidence-based practices are very specific to the age and diagnosis of the client. For providers providing services to both children and adolescents, it is expected to implement more than 1 evidence-based practice.	Please continue to attend sessions related to Clinical Pathways. Clinical Pathways are based on the individual age and diagnosis of the member. You will have an opportunity to comment on the proposed clinical pathways in the coming weeks.
Is this being recorded and can we get a copy of the PowerPoint? If so, where can these items be found once the training is over?	Once Trillium completes the MH Parity Information Series, you will be able to refer to Trillium's MH Parity webpage where you will find information, including links to presentations: https://www.trilliumhealthresources.org/mental-health-parity-and-addiction-equity-act
How often is a CCA recommended for children?	A CCA should be completed in accordance with the provider agency's policies and procedures. Providers may do CCA addendums when something changes in the condition or presentation of the member that impacts the course of treatment.
What level of care tools other than ASAM will you require recommend to support enhanced services	We are not prescribing any specific tool.

Question or Feedback	Response
Are the pathways available to us know and where are they posted?	The next step for us is to post the first round of pathways for public comment. These will be published for comments through our normal communication channels.
Where do you find the recommendations for when follow up CCA frequency located?	A CCA should be completed in accordance with the provider agency's policies and procedures. Providers may do CCA addendums when something changes in the condition or presentation of the member that impacts the course of treatment.
Can specific examples of evidence-based practices be provided?	Providers can research evidence-based practices that fit their service delivery approach.
It seems that the Clinical coverage policy outcomes will drive delivery of services within an enhanced service more so than PCP, is that accurate?	Person Centered Planning assist the member to make decisions and choices about how they want to approach treatment and the goals they want to achieve by receiving treatment for a condition. Members want to engage in treatment that helps them achieve their outcomes and overcome the symptoms that prevent them from living their best live. Clinical Policy guides the service delivery approach to treatment to receive payment for the service.
What type of quality chart reviews will trillium be doing and is there a QI review form that trillium can share for providers to self assess regarding ongoing medical necessity	Trillium will share more information about our quality care strategy and the tools we will be using. Our approach is to assure that members are receiving quality care rooted in standards of care.
The need for training in evidence-based practices is evident. Will Trillium be able to provide training on different evidence-based practices or provide resource list where providers can find training in different evidence-based practices?	Trillium will provide training on the use of clinical pathways along with case studies.
Are the guidelines consistent with all TPs? Or is this just for Trillium?	All plans use Clinical pathways. Trillium is working to educate providers on the pathways as part of our quality-of-care strategy.

Question or Feedback	Response
Clinical Guidelines are based on diagnoses. Medical necessity for services are based on more than diagnoses and involve other entrance criteria. Will there be guidelines detailing or considering amount of services over time?	Providers will need to develop policies and procedures related to each service that demonstrates the amount and duration of services. Providers will be expected to follow their policies and procedures as it relates to how they determined the amount of services a person needs. Documentation of the assessment, PCP and service delivery notes will all be included in the review of services.
Will trillium work with providers to assist with moving from a fee for service model to a case rate model or sub capitation model being that we are focusing on delivery of outcome per medical necessity as opposed to frequency and length of stay	This approach does not move providers from a fee for service model.
Why is Trillium and Vaya not requiring prior auth for some services (H2012) Day Treatment but alliance and partners are requiring auths? Meaning if all MCO's are guided by parity, CCP updates, does there still exist MCO discretion as to whether to follow or be consistent?	Trillium has chosen at this time to continue no prior authorization required for Day Treatment. MCOs do have discretion on benefit administration.
Children receiving a 1915 service are not required to have a CCA (I'm not saying that don't have one or shouldn't have one but are not required to have one--they just need approval from Carelon). So if we are requesting CLS for a child with autism and anxiety or a 16 year old with Depression needing Individual Support, are we now required to have a CCA?	No, a CCA is not needed for 1915i services. If a child receives other services than yes, a CCA is needed

Question or Feedback	Response
Clarification---I guess they would need the CCA to give them a diagnosis but that CCA might not have the recommendation.	Correct, CCA is needed to diagnose all members 1915i assessment is needed for 1915i eligibility. This is not a change:)
Two things: What happens if the CCA that has been completed by another agency does not use a standardized tool. Secondly, you are asking a non clinician to evaluate the standardized tool and turn the results into a care plan. This may be a difficult task. And with hundreds of clients, the clinical supervisor cannot possibly attend to all of these. This will result in a huge delay in getting services	There are no limits for CCA. Tailored Care Managers develop a care management care plan and make referrals to services that the member needs. Providers of those services create a treatment plan based on an assessment. The care manager needs to understand how to make appropriate referrals not how to provide treatment. The member's entire care team should be involved in the development of the person-centered plan/care plan following standards of care. Services should be designed to treat the conditions the member has.
Just as with the child session this morning, I am concerned about having a QP being asked to perform more clinical functions (i.e. knowing what type therapy might benefit a client).	Providers are required to function within their scope of service. This is about quality care for our members and the right assessments are being performed. Clinician would be the one making the recommendations. CM would help with referral process.
How often would you recommend a CCA be completed (after the initial one)? Annually? Every other year unless the situation changes?	Annually unless Member's needs or situations change. This is based on CCP.
What is the timeline for implementation of suggested EBP?	The MHPAEA Final Rule was finalized September 9, 2024. Implementation compliance will be required by January 1, 2026. Trillium will share expectations for the timing of provider adoption and use of clinical pathways in the coming weeks.
February 3, 2025	

Question or Feedback	Response
For services that are bill through HHA, how will the prior authorization request for services be handled as the authorizations were previously added in HHA Exchange by UM?	Please contact the specific Tailored Plan with questions about services that do not require prior authorization but have Electronic Visit Verification (EVV) requirements.
Good morning. Please clarify. Is prior authorization required for S5145 service provision? Both initial and ongoing. My thanks in advance.	Please refer to the authorization guidelines for each Tailored Plan to learn about authorization requirements.
We will need to know how to process authorizations for each service that no longer requires an authorization. Meaning, does any paperwork need to be sent?	Providers do not need to submit authorization requests for services that do not require prior authorization. For services that do not require prior authorization, but have EVV requirements, please contact the specific Tailored Plan with questions.
January 27, 2025	
I am still confused on the roll out of the Act; are Medicaid Plans will be eliminating authorizations and limit visits for clients? Is UHC Plan included in this roll out? Will all Medicaid Plans follow the same guidelines?	Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are public health plans through which individuals obtain health coverage. Medicaid managed care plans that contract with State Medicaid programs to provide services must comply with certain requirements of Mental Health Parity and Addiction Equity Act (MHPAEA). On September 9, 2024, the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) released new final rules implementing MHPAEA. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations that set forth content requirements and timeframes for responding to requests for non-quantitative treatment limitations (NQTL) comparative analyses required under MHPAEA, as amended by the Consolidated Appropriations Act (CAA), 2021.

Question or Feedback	Response
	These final rules aim to further MHPAEA's fundamental purpose – to ensure that individuals in group health plans or group or individual health insurance coverage who seek treatment for covered MH conditions or substance use disorders (SUDs) do not face greater burdens on access to benefits for those conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or a surgical procedure. These final rules are critical to addressing barriers to access to MH/SUD benefits. See https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act for the final rule regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.
What does this look like for providers? I am still doing CCA's PCPs and crisis plans to support the need and also updating them monthly. There are many barriers such as transportation (Modivcare mainly) to assist the clients. Support seems to be very limited. Insurances are not on board unless you mention Parity. What support will we have to ensure that our clients are getting the best possible help?	The changes that the NC Department of Health and Human Services (NCDHHS) made to NC Medicaid Clinical Coverage Policies to ensure that they meet MHPAEA requirements did not change documentation requirements. Providers must continue to follow clinical policy and medical record standards.
What are your recommendations on how providers manage these services in the meantime? It seems that we have increased exposure and risk during the planning and implementation period.	Medical necessity requirements have not changed. Continue to follow your organization's established policies, procedures that ensure high quality services for members.
Will LCSWA's still need service orders signed by MD's to provide services?	Refer to your organization's policies and procedures. The changes to NC Medicaid Clinical Coverage Policies do not include changes to requirements for service orders.

Question or Feedback	Response
What are the authorization requirements and service limitations for Enhanced Mental Health Services, Crisis Services, Substance Use Services, IDD Services, Basic Outpatient Therapy Services, Medication Management Services, Labs (UDS and Blood draws)?	Please refer to the NC Medicaid Clinical Coverage policies for answers about Mental Health, Substance Use, and ID/D services. These are located at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.
What is MH Parity?	Mental Health Parity refers to the Mental Health Parity and Addiction Equity Act (MHPAEA). The aim of this legislation is to ensure that people don't have a harder time accessing mental health and substance use services in their insurance plan than they have accessing medical and surgical services. The Centers for Medicare and Medicaid Services (CMS) has additional information here: https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity
How will it impact consumer (SUD, MH, IDD) services?	The NCDHHS has recently updated NC Medicaid Clinical Coverage Policies for mental health and substance use services to ensure compliance with the MHPAEA. In many cases, these changes have eliminated prior authorization requirements for these services. The NC Medicaid Clinical Coverage Policies are located here: https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.
Which services have no limitations now?	Please review the NC Medicaid Clinical Coverage Policies at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies for information about prior authorization and other service limitations. You may also access Tailored Plans' authorization guidelines at the following sites: **Partners:** providers.partnersbhm.org/utilization-management/

Question or Feedback	Response
	Alliance: alliancehealthplan.org/tp-members/um-program-policy/ Vaya: vayahealth.com/about/policies/um-policy/ Trillium: trilliumhealthresources.org/for-providers/benefit-plans-service-definitions
Which services will be impacted in the future?	At this time, Tailored Plans have not identified any additional changes needed to ensure Mental Health Parity.
Where are the new service definitions?	NC Medicaid Clinical Coverage Policies are located here: https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.
What are the non-quantitative treatment limitations (NQTLs) standards, formularies, and provider reimbursement criteria?	Non-quantitative treatment limitations (NQTLs) are non-numerical limits on the scope or duration of treatment benefits. These include prior authorization requirements. More information about NQTLs is available in 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), and 45 CFR 146.136(c)(4)(ii) and 147.160.
What are the mental health substance use treatment service limitations?	Please review the NC Medicaid Clinical Coverage Policies at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies for information about prior authorization and other service limitations. You may also access Tailored Plans' authorization guidelines at the following sites: Partners: providers.partnersbhm.org/utilization-management/ Alliance: alliancehealthplan.org/tp-members/um-program-policy/ Vaya: vayahealth.com/about/policies/um-policy/ Trillium: trilliumhealthresources.org/for-providers/benefit-plans-service-definitions

Question or Feedback	Response
Please list the services that require no service authorization now and the services that will be implemented at a later date	Please review the NC Medicaid Clinical Coverage Policies at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies for information about prior authorization and other service limitations. You may also access Tailored Plans' authorization guidelines at the following sites: **Partners:** providers.partnersbhm.org/utilization-management/ **Alliance:** alliancehealthplan.org/tp-members/um-program-policy/ **Vaya:** vayahealth.com/about/policies/um-policy/ **Trillium:** trilliumhealthresources.org/for-providers/benefit-plans-service-definitions
What are the crisis treatment service limitations?	Please review the NC Medicaid Clinical Coverage Policies at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies for information about prior authorization and other service limitations. You may also access Tailored Plans' authorization guidelines at the following sites: **Partners:** providers.partnersbhm.org/utilization-management/ **Alliance:** alliancehealthplan.org/tp-members/um-program-policy/ **Vaya:** vayahealth.com/about/policies/um-policy/ **Trillium:** trilliumhealthresources.org/for-providers/benefit-plans-service-definitions
I believe that Mental Health Parity Laws passed sometime in 2011, how come it is taking this long to make these changes in North Carolina?	The MHPAEA Final Rule was finalized September 9, 2024, with an effective date of 1/1/2025. Implementation compliance is required by 1/1/26.

Question or Feedback	Response
	See https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act for the final rule regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.
For a particular plan, all our MH claims denied for no authorization.	Please reach out the particular plan directly to discuss your concerns.
Once a provider is credentialed with an LME-MCO plan, can they be credentialed to ALL OF THE LME-MCO's to avoid disruptions in care for members that move geographically to another LME-MCO plan. (For Example, if my agency is contracted with Trillium and I get a member that is from VAYA or Alliance, will there be cross-over capabilities since I have already contracted with Trillium to avoid DUPLICATION of enrollment. If my agency and providers are already enrolled in NCTracks, shouldn't my enrollment cross-over to other LME-MCO's plans. Please advice.)	Currently, NCDHHS performs provider credentialing for all the Tailored Plans. If a provider is credentialed in NCTracks you are credentialed with all of the plans. Please continue to share feedback like this with us. We are always open to considering ways to standardize processes.
Are these changes specific to Tailored plans only? What will happen to the Direct Medicaid plans?	The NC Standard Plans, Tailored Plans, and Pre-paid Inpatient Health Plans (PIHPs) are all required to implement MHPAEA (this includes NC Medicaid Direct). Learn more here: https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act The link above has information about how the requirements of MHPAEA apply to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.

Question or Feedback	Response
Do these rules only apply to consumers with Tailored Plan Medicaid or will they be applicable to standard plan Medicaid and IPRS as well?	The MHPAEA applies to NC Standard Plans, Tailored Plans and PIHPs operating NC Medicaid Direct plans. This applies to Medicaid services only. If these plans have adopted the NC Medical Clinical Coverage Policies as their clinical coverage policies for mental health and substance use services, the recent changes that NCDHHS has made will apply. Learn more here: On September 9, 2024, the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) released new final rules implementing MHPAEA. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations to set forth content requirements and timeframes for responding to requests for NQTL comparative analyses required under MHPAEA, as amended by the CAA, 2021. These final rules aim to further MHPAEA's fundamental purpose – to ensure that individuals in group health plans or group or individual health insurance coverage who seek treatment for covered MH conditions or SUDs do not face greater burdens on access to benefits for those conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or a surgical procedure. These final rules are critical to addressing barriers to access to MH/SUD benefits. See https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act for the final rule regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.

Question or Feedback	Response
For FCT Services Vaya and Trillium currently are unmanaged but Alliance and Partners are requiring authorizations to be submitted still. Is this correct?	Links to the Tailored Plans' authorization guidelines are here: Partners: providers.partnersbhm.org/utilization-management/ Alliance: alliancehealthplan.org/tp-members/um-program-policy/ Vaya: vayahealth.com/about/policies/um-policy/ Trillium: trilliumhealthresources.org/for-providers/benefit-plans-service-definitions
Does this standardization extend to PHP plans. If not now is that in the works?	PHPs (NC Standard Plans) are required to follow MHPAEA. This is a Federal mandate from the Centers for Medicare and Medicaid Services. Learn more here: Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are public health plans through which individuals obtain health coverage. Medicaid managed care plans that contract with State Medicaid programs to provide services require compliance with certain requirements of MHPAEA. On September 9, 2024, the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) released new final rules implementing MHPAEA. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations to set forth content requirements and timeframes for responding to requests for NQTL comparative analyses required under MHPAEA, as amended by the CAA, 2021. These final rules aim to further MHPAEA's fundamental purpose – to ensure that individuals in group health plans or group or individual health insurance coverage who seek treatment for covered MH conditions or SUDs do not face greater burdens on

Question or Feedback	Response
	access to benefits for those conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or a surgical procedure. These final rules are critical to addressing barriers to access to MH/SUD benefits. See https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act for the final rule regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.
Not for TFC level 2 Vaya has already been sending back auths as not to be processed	Please reach out to the respective LME/MCO directly.
Will this extend to TCM and Trillium inputting authorizations for services?	Please reach out to the LME/MCO directly with your question.
Curious how this will impact when members will need to move from a standard plan to a tailored plan to access these enhances services accessible only from the MCO's as this is a significant burden for members to access services quickly?	MH Parity changes will not impact the process of members' moving between Standard and Tailored Plans.
Just for clarification, will this provide some guidance on the amount of services to provide such as CST hrs. or is it up to providers still?	Clinical Pathways will provide guidance about best practice interventions for specific diagnoses. Please continue attending trainings and information sessions for more details.
Due to the new guidelines are we able to provide additional services/units per week outside of what was normally required and limited too?	Please review the NC Medicaid Clinical Coverage Policies at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies for information about prior authorization and other service limitations. You may also access Tailored Plans' authorization guidelines at the following sites:
Good Morning, I may have missed this question earlier. Will Alliance require PA after January 31st for Enhanced Services?	Please reach out directly to Alliance Health with your question.

Question or Feedback	Response
Which specific service will require pre authorizations?	Please review the NC Medicaid Clinical Coverage Policies at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies for information about prior authorization and other service limitations. You may also access Tailored Plans' authorization guidelines at the following sites: Partners: providers.partnersbhm.org/utilization-management/ Alliance: alliancehealthplan.org/tp-members/um-program-policy/ Vaya: vayahealth.com/about/policies/um-policy/ Trillium: trilliumhealthresources.org/for-providers/benefit-plans-service-definitions
I have also researched that the Authorization guidelines/Member benefit guidelines across the 4 LME/MCO's is not currently consistent with each service needing authorizations or not?	That is correct. The effort to develop shared clinical pathways is the first step to a standardized approach to care.
Is UHC Plan included in this roll out?	Please reach out to United HealthCare directly with your question about impacts of MHPAEA on their services. UHC is not part of the current effort to develop shared clinical pathways.
Is there any possibility that billing requirements will standardize across MCOs? Billing is an exceptionally frustrating process for individual providers (at least)	This is not a current effort but thank you for the suggestion. We are always open to hearing about ways we can standardize processes.
This is effective January 1, 2025?	Yes. Beginning 1/1/2025, NC Medicaid has implemented revised CCPs and proposed amendments to the Medicaid State Plan to comply with MHPAEA requirements across the SPs and TPs.
What is the timeline to provide answers? What do you suggest providers do in the mean time?	Please continue attending information sessions/trainings to learn more about the implementation timeline.

Question or Feedback	Response
If the service provided limit per week, was 20 units, now are we able to provide clients with additional services or units, if necessary, without approval or request	Please review the NC Medicaid Clinical Coverage Policies at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies for information about prior authorization and other service limitations. You may also access Tailored Plans' authorization guidelines at the following sites: Partners: providers.partnersbhm.org/utilization-management/ Alliance: alliancehealthplan.org/tp-members/um-program-policy/ Vaya: vayahealth.com/about/policies/um-policy/ Trillium: trilliumhealthresources.org/for-providers/benefit-plans-service-definitions
Does this also pertain to IPRS/State Funded contracts?	MHPAEA applies to Medicaid Funded Services Only.
Why are different LME 's requiring different procedure's for TFC family type? This is very confusing for providers. For example- Vaya has no prior authorization and Trillium does have one.	Each plan takes a different approach to managing care, and the reasons for differences in processes and requirements are unique to each plan. This effort is an attempt to bring a degree of standardization among plans.
I am in the process of submitting authorizations for Trillium for Peer Support. I just want to make sure I have to before taking the time.	Please reach out directly to Trillium Health Services with this question.
Will the LME be opening up state funded services to assist in helping those in the community?	Please reach out to your respective LME/MCO to discuss adding services to your contract. Outside the scope of this training/information session. https://www.trilliumhealthresources.org/contracting-trillium
Is this going to apply to all the other PHPS i.e. UHC community plan, healthy blue , WellCare, AHC NC?	PHPs are required to follow MHPAEA. This is a Federal mandate from the Centers for Medicare and Medicaid Services. This Rule applies to Medicaid services only.

Question or Feedback	Response
	Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are public health plans through which individuals obtain health coverage. Medicaid managed care plans that contract with State Medicaid programs to provide services require compliance with certain requirements of MHPAEA. On September 9, 2024, the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) released new final rules implementing MHPAEA. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations to set forth content requirements and timeframes for responding to requests for NQTL comparative analyses required under MHPAEA, as amended by the CAA, 2021. These final rules aim to further MHPAEA's fundamental purpose – to ensure that individuals in group health plans or group or individual health insurance coverage who seek treatment for covered MH conditions or SUDs do not face greater burdens on access to benefits for those conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or a surgical procedure. These final rules are critical to addressing barriers to access to MH/SUD benefits. See https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act for the final rule regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.
Are prior auths for TFC and IDD no longer needed as of 1/1/2025?	IDD services are considered a medical/surgical benefit under the MHPAEA.

Question or Feedback	Response
	Please review the NC Medicaid Clinical Coverage Policies at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies for information about prior authorization and other service limitations. You may also access Tailored Plans' authorization guidelines at the following sites: The Tailored plans are starting with evidence-based standards of care development and training. We are working toward a standardized approach.
How does this affect home health and hospice agencies and our patients? Also, with hospice inpatient facilities?	This work does not impact Home Health and Hospice providers.
What is the next thing we need to do?	Please continue checking the webpages for the LME/MCOS and register to attend future trainings/information sessions on Parity. https://www.trilliumhealthresources.org/sites/default/files/docs/Events/Trillium-Parity-Webinars-for-Providers.pdf, https://www.trilliumhealthresources.org/mental-health-parity-and-addiction-equity-act
According to the NC Medicaid Clinical Coverage Policy 8C Section 5.3.1.4 B: States the following: "A written service order by a Physician, Licensed Psychologist (doctorate level), Nurse Practitioner (NP) or physician assistant (PA) is required for Associate Level Professionals prior to or on the first date of treatment (excluding the initial assessment)." When will Doctor level LCSWs or other License professionals that have a PhD, PsD, or DSW be able to sign these service orders?	The NCDHHS offers providers the opportunity to provide feedback about revisions and updates to NC Medicaid Clinical Coverage Policies when they are under review and offers a Frequently Asked Questions archive. For more information, go to: https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

Question or Feedback	Response
Will parity apply to standard plans	PHPs (Standard Plans) are required to follow MHPAEA. This is a Federal mandate from the Centers for Medicare and Medicaid Services. Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are public health plans through which individuals obtain health coverage. Medicaid managed care plans that contract with State Medicaid programs to provide services require compliance with certain requirements of MHPAEA. On September 9, 2024, the U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) released new final rules implementing MHPAEA. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations to set forth content requirements and timeframes for responding to requests for NQTL comparative analyses required under MHPAEA, as amended by the CAA, 2021. These final rules aim to further MHPAEA's fundamental purpose – to ensure that individuals in group health plans or group or individual health insurance coverage who seek treatment for covered MH conditions or SUDs do not face greater burdens on access to benefits for those conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or a surgical procedure. These final rules are critical to addressing barriers to access to MH/SUD benefits. See https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act for the final rule regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.

Question or Feedback	Response