Washington State's Access to Behavioral Health Services Project

Association of Insurance Compliance Professionals

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Access to behavioral health services is essential

Results from the 2019 National Survey on Drug Use and Health

Mental Health

- Less than 50% of youth aged 12-17 with a past year major depressive disorder or major depressive disorder with severe impairment received treatment
    - Only 16.7% of these youth received treatment in a specialized mental health setting
- Less than 50% of adults with any mental illness in the past year received any mental health services
- About 2/3 of adults with a major depressive episode or serious mental illness in the last year were able to access treatment for their depression.
- 26% of adults reported an unmet need for mental health services in the past year
    - Among 18-25 year olds, 40% reported an unmet need

Suicide: in 2018, 2 million people had serious thoughts of suicide. Of these, 1.4 million attempted suicide

- The national suicide rate increased by almost half between 1999 and 2018 – from 10.5/100,000 to 14.2/100,000

Access to behavioral health services is essential

Substance use disorder treatment

- Among people aged 12 and older, almost 8% needed SUD treatment
- Among people 12 or older who had any SUD in the past year, **only 10% received any SUD treatment**
- In 2019, 70,630 drug overdose deaths occurred in the U.S. The age-adjusted rate of overdose deaths increased by over 4% from 2018 (20.7 per 100,000) to 2019 (21.6 per 100,000).

Co-occurring mental health and SUD disorders

- One third of youth with past year SUD and major depressive episode received **no** treatment
- Half of adults with a past year SUD and any mental illness received **no** treatment

In 2020 and 2021, the COVID 19 pandemic has only increased the need for access to behavioral health treatment

Access to behavioral health services is essential

Behavioral health disorders and medical costs (Milliman Research Report, August 2020):

- Of 21 million commercial lives, 2.1 million "high cost" individuals
- Of the high cost individuals, 57% were high cost behavioral health individuals (BH group)
- Average annual medical costs for the BH group were 2.8 to 6.2 times higher than individuals with no behavioral health condition
- Half of the BH group has less than $68 of annual costs for BH treatment
- Of total health care costs for the entire population, 4.4% were for BH treatment

MHPAEA Compliance

MHPAEA and NQTLs

Nonquantitative treatment limitations (NQTL) include:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;

45 CFR 146.136(c)(4)(ii)

MHPAEA and NQTLs

Nonquantitative treatment limitations (NQTL) include:

- Plan methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

45 CFR 146.136(c)(4)(ii)

MHPAEA and NQTLs

MHPAEA standard for evaluation of nonquantitative treatment limitations:

> A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

45 CFR 146.136(c)(4)(i)

MHPAEA and NQTL's

An "unequal" quantitative outcome does not, in and of itself, establish a parity violation. It can be a "red flag" or warning sign that a more in-depth examination of the carrier's policies and processes, as written and in operation, is necessary.

MHPAEA Compliance Guidance

Federal MHPAEA Regulatory Guidance:

- DOL 2020 Self-Compliance Tool DOL: Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (dol.gov)
- FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39 (2019)
- FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 31, MENTAL HEALTH PARITY IMPLEMENTATION, AND WOMEN'S HEALTH AND CANCER RIGHTS ACT IMPLEMENTATION (2016)

Consolidated Appropriations Act of 2021

Sec. 203, Strengthening Parity in Mental Health and Substance Use Disorder Benefits.

- Amends Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)), by adding parity compliance provisions (H.R. 133, pp. 1719 – 1736).
- Establishes greater enforcement of NQTL compliance, including time fames within which plans must voluntarily comply, and public disclosure to all plan participants if a plan fails to come into compliance within the statutory timeframes
- Issuers and SFGHP's must perform and document comparative analyses of the design and application of NQTLs – using five step NQTL analysis
- DOL guidance: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf

Consolidated Appropriations Act of 2021

- Multi-step NQTL analytic framework in the CAA provision is similar to approach used in Washington state's Second Market Scan
- Given what is asked for in the CAA and the themes that emerged from our review of Second Market Scan responses, improved responsiveness to Washington's market scan could yield more compliant responses to DOL or state inquiries under the new CAA provision

Washington – Access to BH Services

Access to Behavioral Health Services Grant

- Federal grant from CMS/CCIIO to examine access to behavioral health services in commercial fully-insured individual, small group and large group health plans
- Grant activities began 2018. Applied for additional federal funding to support our work into 2023
- Goals of the grant:
  - Uncover gaps in access to behavioral health services
  - Review carriers' implementation of and compliance with state and federal behavioral health statutes and rules
  - Develop recommendations to address identified issues

Access to Behavioral Health Services Grant

Key Activities:

- Established advisory committee
- First market scan & analysis – broad in scope
- Review of carrier responses by University of Washington, School of Medicine, Department of Psychiatry & Behavioral Sciences
- Second market scan & analysis: with Bowman Family Foundation
- Claims data analysis: medical/surgical and behavioral health claims data set
- Report and recommendations

Second Market Scan

Second market scan had carriers complete parity analyses using established MHPAEA compliance tools:

- MHTARI Model Data Request Form modified to "Model Data Definitions and Methodology"
- Kennedy Forum Six step parity compliance guide for nonquantitative treatment limitations (NQTL) requirements
- Carriers responded for their largest enrollment individual, small group and large group plans in Washington
- Responses received May 11, 2020

Second Market Scan

Focused: NQTL's as written and "in operation", including:

- Prior authorization for inpatient services
- Concurrent review for inpatient and outpatient services
- Provider credentialing for inpatient services
- Provider directory accuracy
- Provider payment rates

Second Market Scan

For each issue area requested:

- Six step NQTL analysis (Kennedy Forum)
- Quantitative data related to:
  - OON utilization of inpatient services
  - Denial rates for inpatient services
  - Denial rates for continued inpatient stays and denials of outpatient services
  - Provider reimbursement rates
  - Provider network directory accuracy

Initial impressions of Market Scans

Delegated Behavioral Health services:

- Carrier is responsible for parity compliance, regardless of whether BH services are delegated
- Differences in:
  - Provider credentialing requirements
  - Provider network adequacy monitoring
  - Provider rate setting methodologies
- Lack of clarity regarding assurance of parity compliance across carriers and delegated entities

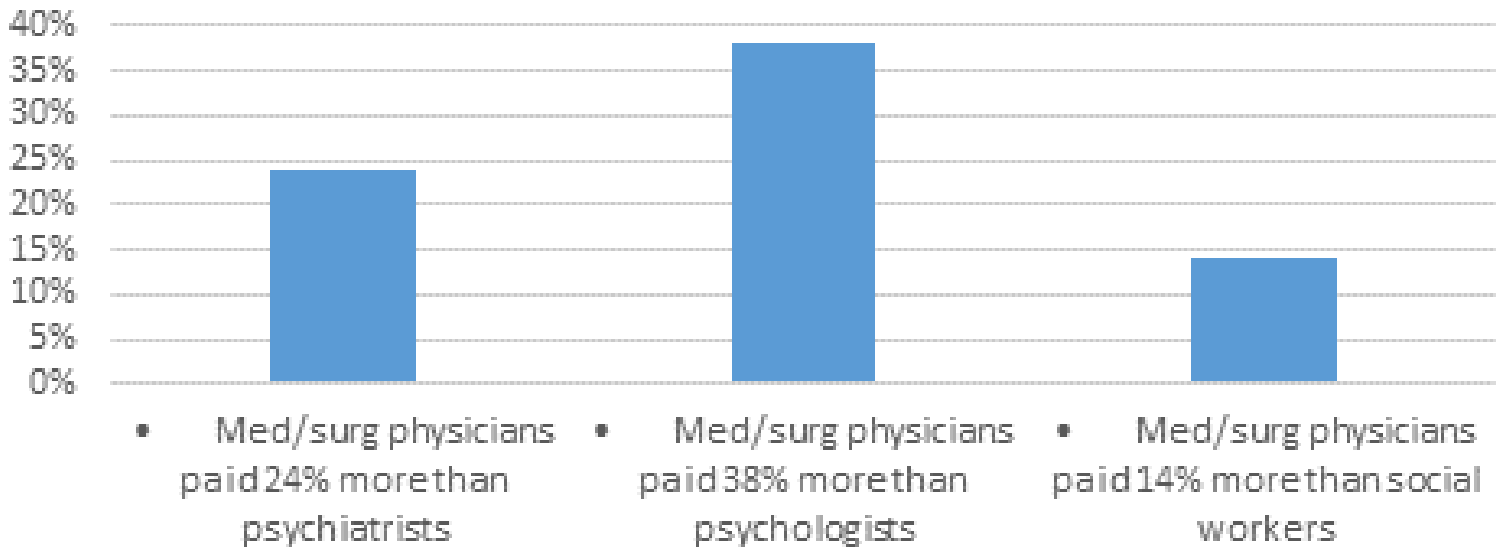
Impressions from Market Scans

Second market scan responses:

- Network provider claims indicate that few providers serve five or more plan enrollees:
  - 50-90% of network providers saw fewer than 5 plan enrollees over a 6-month period in 2018
- Provider reimbursement:
  - Relative to national Medicare fee schedule amounts, on average across carriers, behavioral health providers are reimbursed at lower rates than medical/surgical physicians

Impressions from Market Scans

- Average provider allowed amounts relative to National Medicare Fee Schedule amounts, expressed as a percentage for selected E&M CPT codes:



Claims Data Analysis

Claims data set includes medical/surgical and behavioral health denied and approved claims for the period of July 1, 2017 to December 31, 2018

Inpatient Services – OON Utilization

Market	Med/Surg Median	Behavioral Health Median	Minimum & Maximum Range for M/S	Minimum & Maximum Range for BH
Individual	0.2%	7.4%	0.01 – 0.7%	0.6 – 47.6%
Small Group	0.3%	25.2%	0 – 7.9%	1.1 – 55.0%
Large Group	0.2%	44.3%	0 – 1.2%	0.01 – 94%

Common issues: NQTL analysis/compliance

With the CAA provision and its required elements of NQTL analysis in mind:

- Plan responses frequently failed to define factors by evidentiary standards, especially the quantitative thresholds that are used to determine when to apply an NQTL
- Plan responses frequently failed to disclose the specific analyses conducted for the comparability of the factors, evidentiary standards, process for applying the NQTL, etc., the results of those analyses, as well as documenting how such results demonstrate comparability and no more stringency, both in writing and in operation, for the NQTL at issue

Common issues: NQTL analysis/compliance

Some carriers failed to address or even refer to the disparate quantitative outcomes data revealed in their responses to the MDDM data questions, despite large disparities in some cases.

Initial impressions

Best Practices and Positive Findings:

- Overall, good faith response to both market scans. Thousands of documents were submitted.

For some carriers:

- Provider/enrollee ratios are same for Primary Care and Mental Health services
- Common standards for updating and auditing provider directories across M/S, MH and SUD
- Uniform standards for provider credentialing across M/S, MH and SUD
- Common standards for setting provider rates across M/S, MH and SUD
- Common process for developing and carrying out prior auth/concurrent review

Next Steps

Cycle I: to September 2021:

- Issue final report in September 2021
- Continued market conduct activities

Cycle II: 2021-2023

- Continued market conduct activities/refine Market Scan & MDDM
- Consumer advocacy/education
- Policy change proposals

Around the nation….

State BH parity market oversight

State DOI enforcement actions related to behavioral health parity compliance:

- California, Delaware, Illinois, New Hampshire, Pennsylvania, Rhode Island, Oregon

Attorney General enforcement actions:

- Massachusetts, New York

Summary of state actions from The Kennedy Forum: https://www.paritytrack.org/resources/state-parity-enforcement-actions/

State parity compliance reporting laws

NQTL comparative analysis - statutes/rules:

- In effect: D.C., Delaware, Illinois, Tennessee, Colorado, Connecticut, New Jersey, Arizona, Indiana, Maryland, Oklahoma, Pennsylvania, West Virginia, Kentucky, Montana, North Carolina.
  Proposed: Massachusetts, Nevada, Oregon

Submission of red flag quantitative data re prior authorization, denial rates, etc:

- New York and Virginia

State Behavioral Health Parity Laws

State:

- Variability in state BH parity laws, mandated benefits and network adequacy requirements
- Washington state:
  - Unlike MHPAEA, requires carriers to offer behavioral health services if they cover medical services, with parity in treatment limitations (e.g. RCW 48.44.341)
  - WAC 284-43-7000 et seq.

NAIC MHPAEA Working Group

Established in response to strong state interest in BH parity compliance

Charges:

- Monitor, report and analyze MHPAEA developments, and make recommendations regarding NAIC strategy and policy with respect to those developments.
- Monitor, facilitate and coordinate best practices with the states, the DOL and HHS related to MHPAEA.
- Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts.
- Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.
- Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

Questions?

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