Mental Health Parity: What it Means for Counties as Providers

County Ideas that Work

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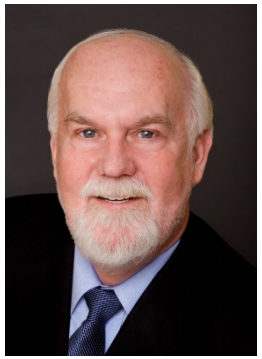
Today's Speakers



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How many people are attending this webinar from your computer?

a. 1

b. 2

c. 3

d. 4

e. 5 or more

Are you a(n)…

a. Elected county official

b. Behavioral health care official/staff

c. Health and/or human services official/staff

d. Other

Are you familiar with the Mental Health Parity law and regulations?

a. Yes

b. No

c. Not sure

Parity – What is it and Why are we talking about it now?

- Parity is the concept that benefits for mental health and substance use disorders (MH/SUD) be provided and administered on a basis that is equal to or similar to how medical/surgical benefits are provided and administered.
  - The general rules: Benefit limits (elements that operate to limit the scope or duration of benefits/treatment) in plan design or operation must be no more restrictive than those applied to medical/surgical benefits.
- Parity isn't new but recent key developments have placed renewed emphasis and priority on addressing parity:
  - Public focus on mental health issues in wake of significant events (e.g. Sandy Hook) and substance use disorder trends
  - Release of finalized regulations for parity in late 2013 that began to take effect in July 2014
  - Transformational efforts across the health care system driving new need and demand for behavioral health

Parity Evolution Timeline

2008

Federal Mental Health Parity and Addiction Equity Act (MHPAEA)

- Removal of visit and day limits
- Parity application to substance use & out-of-network services
- Clear quantitative reimbursement requirements for behavioral health services
- Parameters for scope of diagnosis included or excluded

2009

Patient Protection and Affordable Care Act (PPACA)

- Inclusion of MH/SUD for essential benefits as a significant development
- Title I, Part A, Subpart II, Sec. 2714 extends health care coverage for young adult children under their parent's health plan up to the age of 26

2010

MHPAEA Interim Final Rule (IFR)

- Prescriptive numeric, data-intensive tests for quantitative requirements: “substantially all” & “predominant”
- Non-quantitative treatment limitations: “comparable” & “no more stringent”
- Organized by six classifications
- Clinical exception
- Disclosure of criteria and reason for any reimbursement decisions to providers and members

2011

Compliance Checklist Tool & FAQs

- DOL Compliance Checklist tool
- Comparability parameters for choice of medical mgmt techniques
- Use of comparable analysis, evidentiary standards or methodologies to set thresholds and areas to manage
- Documentation of medical mgmt analysis and methodologies
- Extent of application of a medical mgmt technique

2014

MHPAEA Final Rule (FR)

- Published in November 2013, effective starting July 1, 2014
- Preserved scope of plans from IFR and clarified small group/individual impact from ACA
- Incorporated safe harbors and prior FAQ guidance
- Addresses tiered networks
- Removes NQTL clinical exception
- Expands disclosure requirements

MHPAEA Final Rules - Basics

- The Mental Health Parity & Addiction Equity Act (MHPAEA) Final Rules (FR) serve to update and replace the Interim Final Rules (IFR) as each affected plan renews on or after **July 1, 2014**.
- Key elements of the applicability of the Final Rules – apply broadly:
  - Insurer and employer group plans with 2 or more employees (self insured & fully insured) as well as commercial individual plans, except for grandfathered small group plans under PPACA
  - Medicaid managed care plans, alternative benefit plans and SCHIP plans are subject to MHPAEA but not the IFR or FR. Separate Medicaid rules are coming (no timetable), although in January 2013 CMS indicated they will apply parity to Medicaid plans.
  - Cost exemption provision
  - Non-federal government plans (e.g. state employee plan, municipalities, school districts) opt-out provision

MHPAEA Final Rules – Basics cont.

- Parity Rules address limits in two broad categories and apply different standards to the two categories:

Quantitative Limits/Financial Requirements	Non Quantitative Treatment Limitations
• Day/visit limits • Episode limits • Penalties for lack of prior auth • Copayments/coinsurance • Deductibles/OOPMs	• Medical management strategies (e.g., UM, concurrent review, prior auth, medical necessity criteria) • Network admission and reimbursement methodologies • Fail-first and step therapy protocols • Exclusions and limitations

Final Rules – Benefit Classifications

The Final Rules organize benefits by six classifications – parity is determined classification by classification:

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3a. Outpatient, In-Network – Office
3b. Outpatient, In-Network – Non-office
4a. Outpatient, Out-of-Network – Office
4b. Outpatient, Out-of-Network – Non-office
5. Pharmacy
6. Emergency

Benefit Classifications:

- If benefits for medical/surgical are offered in a classification THEN mental health or substance use disorder benefits must be provided (if covered) in that classification
- If a plan does not have a network structure, all benefits are considered out-of-network

Limit Types:

- The FR require comparison of **Limit Type** to **Limit Type** – copayment is compared to copayment ONLY etc.

Sub-classification for network tiers are permitted if offered for Med/Surg

Key Changes:
Interim Final Rules (IFR) → Final Rules (FR)

- **Classifications – Intermediate Levels of Care:** Intermediate levels of care which are covered must be defined by the plan and assigned to one of the six classifications in same way medical intermediate care benefits are assigned to classifications.
- **Quantitative Treatment Limits - Sub-Classification of Office Visits**: For Quantitative Limits & Financial Requirements testing, the safe harbor allowing subdivision of Outpatient classifications (in-network and out-of-network) is now incorporated into the FR.
- **Quantitative Treatment Limits - Sub-Classification for Network Tiering**: Plans may have tiers within a classification and test these tiers separately for the QTL/Financial requirements.
- **Non-Quantitative Treatment Limits – "Clinical Standards" Exception**: The exception to the "comparable" and "applied no more stringently" parity standard for NQTLs has been removed.
- **Non-Quantitative Treatment Limits – Added Specific NQTL Examples**: The FR adds additional examples of NQTLs that include exclusions/limitations based on geographic location, specific types of facilities or provider specialty.

Key Changes:
Interim Final Rules (IFR) → Final Rules (FR)

- **Non-Quantitative Treatment Limits – Provider Reimbursement**: The FR clarified that reimbursement may be based on a variety of factors that must be applied comparably but that disparate results in actual reimbursement do not per se violate parity.
- **Disclosure of Plan Processes, Strategies & Evidence:** Plans must provided within 30 days of request – disclosure documents which define the plan's processes, strategies and evidence supporting the application of NQTLs for both medical and behavioral benefits.
- **Interaction with ACA Provisions:** FR addresses interaction with EHB requirements, annual/lifetime limit prohibitions and preventative care mandates.
- **Enforcement by States**: FR addresses primary enforcement by states as primary insurance regulators and DOL for self-funded plans.

Why Parity is Important to Counties

- Counties provide a variety of social services and parity will affect the costs of those services:
  - Emergency services
  - Criminal justice
  - Social safety net services
- Counties are responsible for public health and safety, which benefit when people have early access to treatment

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Continuum and Emerging Practices

Parity helps spur development across the continuum of care:

- Prevention and early intervention
  - Health care navigators and peer services
  - Primary care screenings for depression and substance use disorder
  - Integrated primary and behavioral health in schools
  - Mental Health First Aid training
- Intermediate
  - Assertive Community Treatment Teams
  - Mobile Crisis Outreach Teams
  - Extended observation units
  - Permanent supportive housing
- Crisis
  - Detox
  - Inpatient psychiatric care

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Community Impacts

- Economic impacts on emergency services, jails
  - If people receive needed treatment earlier, they are less likely to experience a crisis that leads to emergency or criminal justice systems interaction
- Rates of uncompensated care provided by public hospitals should reduce
- Resources can be saved for circumstances in which they are truly necessary
- Better financial health for individuals and families
  - With coverage, mental illness is not as devastating – people can get the care they need without worrying about bankruptcy
- Improved health outcomes for individuals, especially children
  - Early intervention provides the best chance for recovery

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Impact of Parity on Counties as Employers

- Employee Assistance Programs (EAPs) – these are not part of employee health plans, but could help defray any additional costs for plans complying with parity requirements
- EAPs can also help connect people who have more substantial behavioral health needs to available outside resources
- When counties purchase plans they must ensure that they comply with parity – employers are liable and will be subject to any penalties assessed for non-compliance
  - Best to conduct an annual audit of plan to ensure continued compliance

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Potential Challenges

- Having a right to treatment doesn't necessarily equate to having access
- Workforce shortages may limit access, especially for low-income and rural populations
- States are primarily responsible for enforcement in most circumstances, potentially leading to inconsistent application
- The public needs more education on parity and the rights it provides
- States that chose not to expand Medicaid under the ACA will still have many uninsured people to whom parity won't apply
  - ACA Plans purchased through the Marketplace must include mental health and substance use services as Essential Health Benefits (EHB) and coverage must comply with parity
  - No lifetime or annual limits on treatment
  - No denial of coverage based on preexisting conditions

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Potential Benefits

- Behavioral health and physical wellbeing are treated as equally important
- Furthers the integration of physical and behavioral health, allowing more comprehensive treatment
  - July 2014 – $54.6M via ACA to Federally Qualified Health Centers to provide additional mental health and substance use services
- May help normalize and destigmatize behavioral health services, making people more likely to seek help
- Early access leads to better outcomes
- Transparency – parity requires insurance companies to explain coverage decisions
- Federal parity statutes and regulations provide a floor – states can enact laws to provide additional coverage. This may lead to innovations that can spread to other states

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Additional Parity Resources

- www.samhsa.gov
- www.hhs.gov/healthcare
- www.cms.gov
- http://www.dol.gov/ebsa/mentalhealthparity/index.html
- http://parityispersonal.org/
- Ron Manderscheid, Executive Director, National Association of County Behavioral Health & Developmental Disabilities Directors, www.nacbhdd.org

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Parity Changes Impacting Provider & Provider Agencies

Network Admission & Credentialling

- Removal of experience based criteria
- Elimination of geographic limitations
- Elimination of provider licensure type restrictions

- Historic “clinical experience” requirements for behavioral providers eliminated

- Geographic restrictions still exist – example HMO service area restrictions – but must be comparable in scope and application
  - Issue of “destination” providers

- Proliferation of licensure types, removal of restrictions based solely on licensure
  - Scope of licensure under state law
  - Independent practice
  - Similar to state “any willing provider” concept

Parity Changes Impacting Provider & Provider Agencies

Claims & Reimbursement

- Alignment of reimbursement methodologies
- Elimination of disparities in use and reimbursement of codes

- Reimbursement methodologies:
  - In-network – fee schedules and factors in development
  - Out-of-network – variety in methodologies (e.g. Medicare, UCR etc.)

- Reimbursement alignment for providers that cut across both medical and behavioral
  - E/M Codes
  - Neuropsychologists

Parity Changes Impacting Provider & Provider Agencies

Utilization Review

- Reduction in prior authorization/pre-certification requirements
- Medical necessity development & application
- Alignment of concurrent review processes

- Prior authorization
  - Inpatient
  - Outpatient
    - Routine
    - Non-routine

- Medical necessity
  - Criteria – development
  - Criteria – application
    - Level of care versus fail-first concept

- Concurrent review

Parity Changes Impacting Provider & Provider Agencies

Benefit Provisions

- Exclusions & Limitations
  - Condition vs. Service
  - Failure to Complete a Course of Treatment
  - "Fail First" – Distinguishing from Medical Necessity

- Exclusion for all services for a condition (Not a NQTL) vs. Exclusion of particular services for a condition (NQTL)
  - Example: Autism & Applied Behavioral Analysis

- Failure to Complete a Course of Treatment
  - Example: Substance Use Disorder Programs

- Fail-First
  - Example: Gastric Band (Medical)
  - Rare in Post-parity environment for behavioral

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- Behavioral health interventions
- Health coverage and the justice system
- Collaborative partnerships
- Emergency management roundtable

- **When**: January 21-23, 2015
- **Go to www.naco.org/2015healthjusticeforum** for more information
- **Contact**: Emmanuelle St. Jean, Program Manager at estjean@naco.org or 202.942.4267