Idaho Medicaid

Participant Guide to Mental Health Parity

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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Idaho Medicaid – Participant Guide to Mental Health Parity

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How to Use this Parity Guide

The federal parity regulations, as they apply to Medicaid managed care, private insurance, and health insurance plans purchased through the state health insurance marketplace, are fundamentally very similar; however, this guide focuses exclusively on the application of federal law through federal Medicaid regulations enforced by the Centers for Medicare and Medicaid Services (CMS).

On the other hand, this guide does **not** focus on regulations pertaining to private health insurers that are enforced by the Idaho Department of Insurance and, if necessary, at the federal level by the U.S. Department of Labor. The two bodies of regulatory law affecting state Medicaid agencies and private health insurers differ in several respects, and the processes for filing complaints, grievances, and appeals are certainly different as well.

The most comprehensive source of information on parity is the Employer Benefits Services Administration (EBSA) of the U.S. Department of Labor. EBSA offers a wealth of resources for pursuing parity-related actions against carriers of private health insurance plans, including a large staff of Benefits Advisors and investigators. The EBSA has more than a hundred Benefits Advisors nationwide, and if necessary, these advisors can refer parity-related complaints to EBSA investigators for formal investigation and enforcement action.

Where to Call for Help on Parity

If you suspect that an individual or employer private health insurance plan may be violating parity laws…

- Call the Idaho Department of Insurance at 800-721-3272, or
- Call the Employer Benefits Services Administration (EBSA) of the U.S. Department of Labor at 866-444-3272.

If you have parity concerns involving Medicaid's Idaho Behavioral Health Plan (IBHP)…

- Call Optum Idaho at 855-202-0973.

If you are an Idaho Medicaid enrollee and have general questions about parity…

- Email the Idaho Medicaid parity team at mentalhealthparity@dhw.idaho.gov.

Introduction/Summary of New Parity Regulations

Historically, mental health and substance use disorder treatments were subject to more restrictive limits than medical and surgical services, resulting in frequent service denials and other adverse limitations on access to care. Prior to 2008, when a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA) was passed, inequitable medical management practices that discriminated against mentally ill or addicted persons were legal in many states, barring these participants from using the appeals process to file complaints to resolve issues of unequal coverages. Now that federal parity laws are in force across the nation, insurers must treat behavioral health benefits the same as physical health benefits, and consumers can use the law's increased protections to increase access to care.

MHPAEA now requires benefits for mental health and substance use treatment to be at least as generous as the coverages for medical treatment, such as surgical services, hospital services, and doctor visits. As far as comparability is concerned, treatment limits or financial requirements for addiction or mental health care services don't have to be exactly the same as medical services, but they can't be more restrictive than the requirements that apply to two-thirds of medical services in the same category. These service classifications are: 1) inpatient, in network; 2) inpatient, out of network; 3) outpatient, in network; 4) outpatient, out of network; 5) emergency services; and 6) prescription drugs.

To give a concrete example, under MHPAEA, if your health plan allows unlimited doctor visits for a chronic condition such as diabetes, it must also allow unlimited doctor visits for a mental health condition such as schizophrenia.

If your plan does not place annual or lifetime dollar limits on medical and surgical (M/S) benefits, it cannot impose such limits on mental health or substance use disorder benefits. Your plan also cannot contain separate treatment limitations (e.g., maximum number of annual visits allowed, frequency of treatments, etc.) that apply only to mental health or substance use disorder benefits. MHPAEA also eliminates separate financial requirements, such as separate deductibles, for mental health and substance use disorder (MH/SUD) benefits. Instead, the plan must have a single deductible amount, which applies to all benefits offered by the plan. The explanations above describe only some of the provisions and impacts of MHPAEA. Others will be explored in the section of this guide entitled Red Flags Indicating Possible Parity Violations.

It is important to note that federal parity laws do not compel an insurer to offer MH/SUD services in a given health plan; however, if a plan offers any specific MH/SUD services, they must be comparable in scope to the M/S benefits offered.

The Importance of Parity

Here's why parity is so important:

- According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately one in five American adults will experience a diagnosable mental health condition in any given year, and more than half of all Americans know someone in recovery from a substance use condition.
- In 2014, according to SAMHSA, 43.6 million American adults had a mental illness; however, fewer than half received mental health care. As many as 22 million people have some kind of substance use disorder, but only one in 10 has been to a treatment center.

Successful and longstanding efforts on the part of insurers to restrict access to and contain the costs for behavioral health care have been recognized as being among the reasons why so many Americans suffering from mental health and substance use disorders were not seeking and/or receiving treatment for these conditions.

Applicability: Which Types of Plans Need to Comply with Parity?

Parity laws do not apply to every kind of health plan available in America today. Below are some types of plans subject to federal parity laws:

- Employer-funded plans with 51 or more insured employees
- Most group health plans for employers with 50 or fewer employees
- Medicaid managed-care plans; e.g., the Idaho Behavioral Health Plan
- CHIP (Children's Health Insurance Program)
- Health plans purchased through the Health Insurance Marketplaces
- Most individual and group health plans purchased outside the Health Insurance Marketplaces

Plans not subject to federal parity laws include the following:

- Medicare plans
- Traditional fee-for-service Medicaid coverage
- Small employer plans (50 or fewer employees) that were created before March 23, 2010, with no significant changes since that date

Disclosure Requirements

Federal parity regulations require insurers and Medicaid managed care organizations (MCOs) to reply in a timely manner to requests for information on their parity compliance, including information on medical necessity determinations, reasons for denials of service or reimbursement, and the plan's processes, strategies, evidentiary standards and other factors used to apply treatment limitations to mental health or substance use disorder benefits. The Code of Federal Regulations, which was amended at 42 CFR 438.915 in the MHPAEA Final Rule, puts it this way:

§ 438.915 Availability of information.

(a) ***Criteria for medical necessity determinations.*** The criteria for medical necessity determinations, made by a MCO or by a PIHP or PAHP providing services to an MCO enrollee, for mental health or substance use disorder benefits must be made available by the MCO, PIHP, or PAHP administrator to any enrollee, potential enrollee, or contracting provider upon request. MCOs, PIHPs, and PAHPs operating in compliance with § 438.236(c) will be deemed compliant with the requirements in this paragraph (a).

(b) ***Reason for any denial.*** The reason for any denial by a MCO, PIHP, or PAHP of reimbursement or payment for services for mental health or substance use disorder benefits in the case of any enrollee must be made available by the MCO, PIHP, or PAHP administrator to the enrollee.

In accordance with 42 CFR 438.236, managed care organizations must also adopt practice guidelines and disseminate these guidelines to all affected providers, as well as to enrollees and potential enrollees upon request.

Idaho Department of Health and Welfare (IDHW) Parity Compliance Efforts

The compliance date for the relevant sections of the MHPAEA Final Rule is October 2, 2017. As state Medicaid agencies amend their administrative rules, managed care contracts and Medicaid State Plans, states are expected to include amendments that will serve to eliminate existing provisions that are contrary to the objectives and language of MHPAEA.

As part of its compliance efforts, Idaho Medicaid has drafted proposed rule changes for IDAPA 16.03.09, Medicaid Basic Plan Benefits, and IDAPA 16.03.10, Medicaid Enhanced Plan Benefits. The changes proposed would eliminate most of the previous limitations in rule on behavioral health and substance use disorder benefits. Likewise, on the federal level, the Medicaid Policy Team has been working with the Centers for Medicare and Medicaid Services (CMS) to remove those same benefit limits from the the Idaho Medicaid State Plan.

Idaho Medicaid proposed the following specific rule changes related to parity, and requested an effective date of July 1, 2018:

1. Allowing inpatient psychiatric stays for as long as they are medically necessary, and make them subject to the same reviews as general hospital stays.
2. Aligning participant eligibility criteria for inpatient psychiatric stays with CFR restrictions.
3. Changing general hospital procedural guidelines for alignment purposes.
4. Amending general hospital inpatient provisions to match current Medicaid practice and comply with federal requirements.
5. Removing limitations for psychiatric evaluations and psychotherapy contained in the physician services sub-area of IDAPA Chapter 09.

These proposed changes to Idaho Administrative Rules must be approved by the Idaho State Legislature before they become effective and final.

Red Flags Indicating Possible Parity Violations

Parity violations can come in all shapes and sizes, and can also be well-disguised and hard to spot. Some violations, such as an unequal limitation on the number of annual visits, are spelled out in health plan documentation for all to see. In other cases, such as when parity enforcement investigators discover that denial rates for mental health/substance use disorder services are significantly higher than for medical/surgical services, a considerable investigation effort may be required before it becomes clear what is really going on.

This section presents examples of what constitutes a parity violation. Some are from actual cases where the federal government took action to find, document, and remedy parity violations on the part of major health insurance carriers. These are some of the most common red flags to look for that may indicate a possible parity violation.

Financial Requirements

Financial requirements encompass plan provisions such as deductibles, copayments, and coinsurance. Those terms are defined below.

Deductibles are the total amounts you must pay before your health plan will begin paying all or a portion of your medical expenses. A practice that federal parity laws prohibit is using "separate but equal" deductibles. To comply with the law, deductibles for MH/SUD and medical/surgical benefits must accumulate together towards a single, combined total.

In addition, your health plan may impose higher copayments or coinsurance requirements for MH/SUD treatment. If a copayment (what you must pay at the time of service) or coinsurance (the percentage that you must pay after the deductible is met) for MH/SUD services seems higher than the financial requirements applied to M/S services, that violates parity.

Coverage Exclusions

One of the primary drivers for the MHPAEA bill was the fact that, prior to its enactment, it was common for plans to offer a full range of medical/surgical benefits, but to offer only a limited selection of MH/SUD benefits. Federal parity laws cannot force a plan to include both M/S and MH/SUD benefits; however, if a given plan includes any MH/SUD benefits, they must be comparable to those offered on the M/S side.

The Employer Benefits Services Administration (EBSA) of the U.S. Department of Labor reports that a fully insured plan In California excluded treatment of "chronic behavior disorders" lasting

more than 6 months, without applying a comparable exclusion for chronic medical conditions. The EBSA responded by initiating enforcement action against the insurer.

Another example involves exclusions that apparently apply only to MH/SUD services. Some plans exclude addiction treatment when it is related to illegal activities or ordered by the court, or exclude SUD treatment services that can be shown to be involuntary. All of the circumstances described in this paragraph are almost exclusively MH/SUD in nature, so plans that exclude these services are more than likely violating parity laws.

Relapsing is part of the disorder for most addicts, but some plans still attempt to deny coverage for SUD treatment if a participant leaves a treatment program against medical advice. Similar exclusions in your plan might also violate parity.

Below are some additional red flags to watch for involving coverage exclusions:

- Coverage denied for medication-assisted treatment for addiction (using medications such as naltrexone, methadone, buprenorphine, etc.). Federal law prohibits coverage exclusions for prescription drugs based on whether a drug is generally prescribed for MH/SUD conditions.
- Coverage denied for preventative screenings and services for MH/SUD when such services are covered for other medical/surgical conditions.
- Coverage denied for inpatient SUD treatment taking place anywhere other than a hospital, when the plan offers coverage of non-hospital-based treatment for medical/surgical conditions (such as treatment in a skilled nursing facility).

Authorization Standards

Prior authorization and notification requirements are very common utilization management tactics that insurers use to restrict patients' access to covered mental health/substance use disorder benefits. For example, the Department of Labor discovered a plan that required pre-notification for non-scheduled MH/SUD admissions and reduced the dollar amount covered by 50% if the plan administrator was not notified in advance.

Prior authorization is routinely required to obtain covered benefits on both the M/S and MH/SUD sides, and the result is authorization of a predetermined number of days in a hospital or treatment facility. Parity problems arise when greater durations are authorized for M/S stays than for MH/SUD stays, or when the attending physician is given fewer days to submit a MH/SUD treatment plan for approval than are allowed for submission of a M/S treatment plan.

Provider Networks

Federal parity laws prohibit restriction of MH/SUD treatments to a certain location, facility type, or provider specialty—unless, of course, comparable restrictions are imposed on M/S benefits. If a plan allows out-of-state providers to treat medical conditions, it cannot require participants to use only in-state providers for MH/SUD treatments.

Below are some additional red flags to watch for involving plans' provider networks:

- Plans that exclude certain provider types or types of MH/SUD facilities while covering a much broader range of medical/surgical facilities and provider types.
- Plans that state that a particular service, such as outpatient SUD treatment, is covered, but its network does not include any providers who are qualified to deliver that service.
- Plans that have an adequate number of qualified MH/SUD providers in the network, but none of these in-network providers is currently accepting new patients.
- Plans that require MH/SUD facilities or providers to be state-licensed or certified at a certain level, but do not impose comparably high licensure requirements on M/S facilities and providers.

Provider Reimbursement

Provider reimbursement rates that are lower for MH/SUD services than for M/S services are prohibited, since lower rates can restrict access to care for patients with these conditions. Guidance from federal regulators indicates that provider payment rates can be based on an array of factors—from service type, geographic market, demand for services, supply of providers, and provider practice size to the training, experience and licensure of providers—these factors cannot be applied more stringently to MH/SUD providers than to M/S providers.

A 2013 study by the federal Department of Health and Human Services included the following research finding:

> *Reimbursement rates for MH/SUD services were based on lower percentages of usual, customary and reasonable standards than medical/surgical services.*

This kind of rate-setting practice not only violates parity laws, it also creates incentives for providers to bill incorrectly; i.e., coding invoices using M/S service rate codes instead of lower-paying MH/SUD rate codes.

Care or Stay Reviews

As a cost-containing measure, plan administrators conduct reviews of claims for valid medical necessity and proper coding of services. These reviews may occur prior to treatment (prior authorizations), during a facility stay (known as concurrent reviews), and after completion of treatment (retrospective reviews).

In 2016 guidance, the Department of Labor described a situation where, prior to authorizing admission to an inpatient mental health facility, a plan required that a plan representative conduct an in-person examination to determine medical necessity; by contrast, authorizations of inpatient M/S admissions were handled over the phone. The DOL guidance stated that this practice was not permissible, because "the plan is imposing a prior authorization NQTL [non-quantitative treatment limitation] more stringently with respect to inpatient mental health benefits than to inpatient medical/surgical benefits."

Below are some additional red flags to watch for involving care or stay reviews:

- Plans that routinely perform retrospective reviews for MH/SUD services, while reviews of medical/surgical services are much less common.
- Plans that require concurrent care reviews at 10-day intervals for MH/SUD stays, but either do not require any concurrent reviews for M/S services, or require them much less frequently.
- Plans that allow attending physicians to conduct reviews for M/S services, but require that reviews of MH/SUD services be performed by healthcare professionals employed or paid by the plan.

Fail-First Requirements

As an example of a fail-first requirement, an insurance company refused coverage for intensive outpatient treatment of alcoholism because it wanted the patient to go to AA first.

Another scenario reported to DOL investigators involved a plan that required individuals to try an intensive outpatient program for substance use treatment first, before the plan would cover inpatient treatment. Since the plan had a similar requirement for medical/surgical coverage, the insurer appeared to be compliant with parity laws. However, no intensive outpatient SUD treatment facilities that would meet the plan's requirement were available in the patient's geographical area, whereas they were available in the medical/surgical context.

This plan's "fail-first" protocol was not permissible, according to the DOL, HHS, and Treasury departments, because it "includes a condition that an individual cannot reasonably satisfy," and the lack of access applies only to MH/SUD benefits. As a result, "the fail-first requirement is, in

operation, applied more stringently with respect to MH/SUD benefits than medical/surgical benefits."

Progress or Improvement Requirements

Below are examples of progress requirements and improvement requirements.

Progress Requirements: For coverage of intensive outpatient treatment for MH/SUD, the plan/insurer required that a patient demonstrate a lack of progress with non-intensive outpatient treatment of a lesser frequency.

Likelihood of Improvement: Before covering residential treatment of MH/SUD, the plan requires that a licensed practitioner attest to the fact that inpatient treatment is likely to result in improvement. In some cases, practitioners employed by the plan will make the determination that the patient is not going to improve with treatment and deny coverage; when such an authorization practice is only applied to behavioral health services, the parity violation is all the more obvious.

Improvement requirements are sometimes applied to benefits that are subject to retrospective reviews; i.e., reviews conducted after the enrollee has already begun treatment. For example, a plan might only cover services that result in measurable and substantial improvement in mental health status within 90 days. If the retrospective review finds that this requirement has not been met, the plan will deny reimbursement to the provider for services that the patient has already received.

Planning Requirements

Planning requirements can violate parity in very overt ways, such as when a plan requires written treatment plans in order to access care, but this requirement only applies for access to mental health services.

In some cases, plans may also require—only for MH/SUD services—a course of follow-up treatments, and may also impose a restriction that the written plan must include only those conditions that, in the opinion of practitioners working for the insurer, can be significantly improved by the services specified in the treatment plan.

Links to Parity Resources

Idaho Medicaid

Main Website	http://healthandwelfare.idaho.gov/Default.aspx?TabId=123
Mental Health Parity	http://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/MedicaidFeeSchedule/tabid/268/Default.aspx
Idaho Behavioral Health Plan (IBHP)	http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicaidBehavioralHealthManagedCare/tabid/1861/Default.aspx
IBHP 1915(b)(4) Waiver	http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/IBHPWaiver.pdf

Optum Idaho (Idaho Behavioral Health Plan–IBHP)

Main Website	https://www.optumidaho.com/
Member Rights and Responsibilities	https://www.optumidaho.com/content/ops-optidaho/idaho/en/members/rights---responsibilities.html

Centers for Medicare and Medicaid Services (CMS)

Main Website	https://www.medicaid.gov
CMS Policy Guidance	https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html
State Medicaid Manual	https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html
List of All Idaho Medicaid State Plan Amendments	https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html?filterBy=Idaho
Final Rule: MHPAEA	https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf

IDAPA: The Idaho Administrative Procedure Act

• Index	***Index to IDAPA Chapter 16: Administrative Rules for IDHW***
• 16.03.01	***Eligibility for Health Care Assistance for Families and Children***
• 16.03.09	***Medicaid Basic Plan Benefits***
• 16.03.10	***Medicaid Enhanced Plan Benefits***
• 16.05.03	***Rules Governing Contested Case Proceedings and Declaratory Rulings***
• 16.07.17	***Substance Use Disorders Services***

Federal and State Resources to Investigate Possible Parity Violations

U.S. Department of Labor (EBSA)	https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity
Idaho Department of Insurance (DOI)	http://doi.idaho.gov/

Federal Government Research on Mental Health Coverage and Parity Issues

U.S. Department of Labor: *FY 2016 MHPAEA Enforcement Fact Sheet*	https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2016.pdf
U.S. Department of Labor: *Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs)*	https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf
Substance Abuse and Mental Health Services Administration (SAMHSA): *Receipt of Services for Behavioral Health Problems* (2014)	https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.htm
ASPE Research Brief: *Substantial Improvements to Mental Health and Substance Use Disorder Coverage* (2013)	https://aspe.hhs.gov/system/files/pdf/117356/mhsudRB_0.pdf