Cover Montana Monthly Webinar

Understanding Behavioral Health Access and Coverage

June 2022

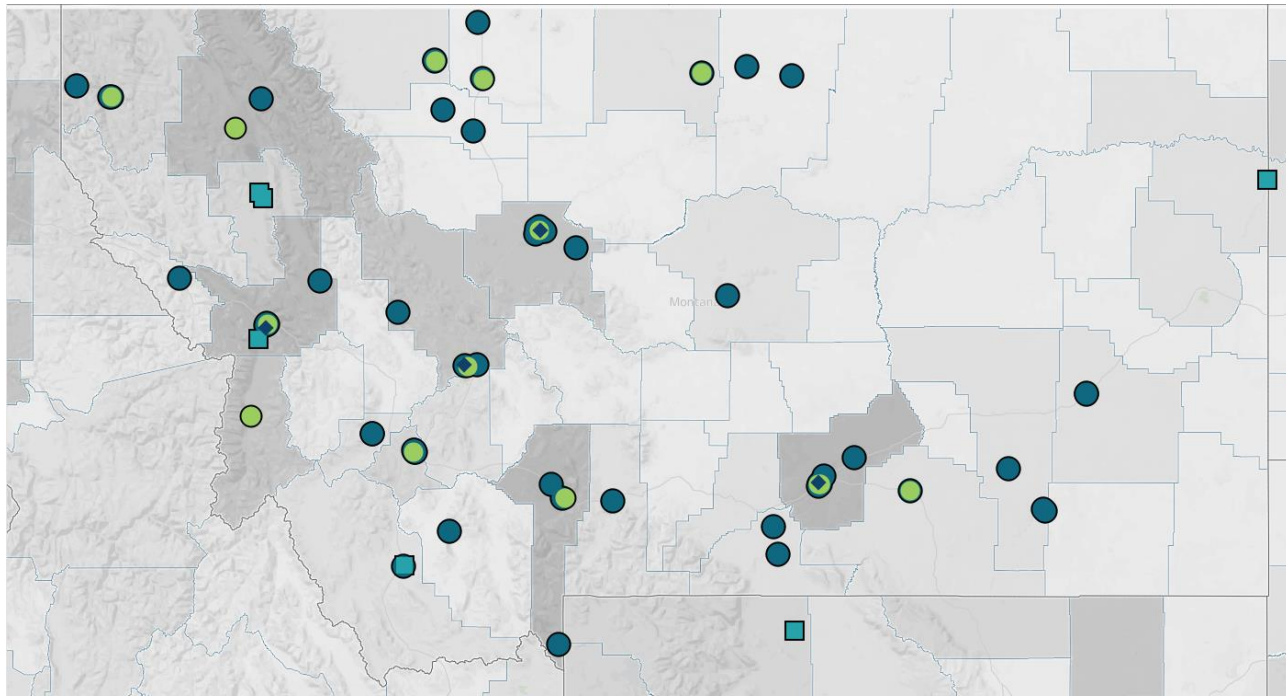
MPCA & Cover Montana

The **Mission** of the Montana Primary Care Association is to promote integrated primary healthcare to achieve health and well-being for Montana's most vulnerable populations.

The **Vision** of MPCA is health equity for all Montanans.

The Montana Primary Care Association supports Montana's 14 Community Health Centers and four Urban Indian Health Centers. MPCA's members serve ~125,000 patients across Montana.

Cover Montana is MPCA's program focused on connecting Montanans to health insurance coverage options.



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Agenda

Welcome

Please tell us who you are in the chat! Name, role, and org.

Brief Updates

Understanding Behavioral Health Access and Coverage - Christina Goe, JD

Breakout discussion

The PHE Continues!

When might the PHE end?
The Administration has committed to giving states 60 days advance notice of the PHE ending so states can prepare. If the US Dept. of Health and Human Services plans to end the PHE on October 13th, we should hear by August 14th. Again, we don't expect to know more about the end of the PHE until August 14th.

What does this mean for enrollees?
Montanans who are enroll in Medicaid or HMK are covered! When the PHE eventually ends, Montana Medicaid will start the process of eligibility redeterminations for everyone enrolled in the program, but that process won't start until the PHE ends. In the meantime, enrollees should update their contact information to make sure the Montana Office of Public Assistance can reach them.

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Keep your contact info up to date.

Do you get your health insurance through Montana Medicaid or Healthy Montana Kids?

Have you moved in the past three years?

Update your contact info.

COVER MONTANA

CONNECTING YOU TO HEALTH INSURANCE COVERAGE

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Toolkit is live and available at covermt.org and soon, MTPCA.org

COVER MONTANA

CONNECTING YOU TO HEALTH INSURANCE COVERAGE

Medicaid & HMK Continuous Coverage Unwinding: Communications Toolkit

Overview

What is the Public Health Emergency and how does it impact Montana Medicaid? During the COVID-19 public health emergency, Montana Medicaid wasn't processing redeterminations. Throughout the pandemic, individuals on Medicaid and Healthy Montana Kids didn't have to worry about providing updated information to DPHHS in order to keep their health care coverage.

Now that the pandemic emergency is ending, they are starting to process redeterminations. This is often referred to as the "end of the Public Health Emergency (PHE)" or the "PHE unwind." The Montana Office of Public Assistance will soon be reaching out to Medicaid and Healthy Montana Kids enrollees, but they need up-to-date addresses in order to reach people! There are currently more than 270,000 Montanans who are covered by Montana Medicaid and Healthy Montana kids and all of them will be redetermined over the next 12 months.

What do people need to do? Starting now, everyone who gets their health insurance through Montana Medicaid or Health Montana Kids should update their contact information and make sure to open their mail or they risk losing coverage. For those Medicaid enrollees who lose coverage, there may be affordable insurance options on the Health Insurance Marketplace.

When is the timeline? The redetermination process will begin in June 2022, but will happen over a number of months. Not all Montanans will be redetermined at the same time and communication and reminders must happen continuously throughout the redetermination period.

Who can help if my patients, or clients have questions? In addition to local Office of Public Assistance and the Montana Public Assistance Help Line, Cover Montana is a resource for Montanans who need help making sense of changes. Cover Montana is a project of the Montana Primary Care Association and connects Montanans to health insurance coverage. Cover Montana provides free, confidential enrollment help with Medicaid, Healthy Montana Kids, and the Health Insurance Marketplace. Cover Montana provides virtual, phone, and in-person enrollment help. Call our toll-free help line at **(844) 682-6837 or** find local in-person enrollment help at www.covermt.org/help.

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Medicaid Change of Address Form

Have you moved in the past three years? Has your address or contact information changed? Please make sure Medicaid/Healthy Montana Kids has your current mobile phone number, email, and mailing address so our records are up to date. It's important to make sure we can reach you with information about changes to your Medicaid/Healthy Montana Kids health insurance.

Update your contact information using the form below. You can also call us at 1-888-706-1535, or create an online account to update your information. Creating an online account will also allow you to get notices right away, renew your benefits online and report changes. Go to apply.mt.gov to create your account.

Last Name *

First Name *

Date of Birth *

MM-DD-YYYY

Case Number

Please list all all additional household members

Last Name

First Name

+ Add another household member

Old Mailing Address *

Address Line 1

Address Line 2

City

Zip

Old Phone Number

(999) 999-9999

New Mailing Address *

Address Line 1

Address Line 2

City

Zip

New Phone Number

(999) 999-9999

Email Address

email@example.com

Save and Exit

Submit

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Mental Health Parity Federal and Montana Law

What Can Consumers and Providers Do Ensure that the Law Achieves Its Full Effectiveness?

Christina Lechner Goe, JD

June 9, 2022

Great need for complete and fair coverage of Mental Health/Substance Use Disorder (MH/SUD) Treatment

One in five adults in the U.S. had a mental illness in 2017.

One in fourteen people age 12 or older had a substance use disorder in 2018.

The pandemic has increased this need.

WHAT IS PARITY?

- In the simplest terms, **parity means equal.**
- The basic concept is that people with mental health and substance use disorders (MH/SUD) are entitled to **comprehensive and effective medical treatment**, the same as people with other “physical” health conditions like heart disease or diabetes.
- Many MH/SUD conditions are chronic, the same as certain physical health conditions and should be eligible for regular, effective treatment.

Historically, most health plans excluded or limited MH/SUD coverage.

What is the Mental Health Parity and Addiction Equity Act (MHPAEA)?

This federal law was enacted in 2008, and since then there has been many clarifications issued through regulations, compliance tools and FAQs.

In simple terms,

MHPAEA requires health plans that cover mental health benefits to cover MH/SUD in "parity" with physical health benefits.

- Meaning, cost-sharing, visit limits, prior authorization and medical necessity determinations—cannot be more restrictive than other medical benefits.

**MHPAEA DOES NOT REQUIRE HEALTH PLANS TO COVER MH/SUD CONDITIONS, BUT IF IT DOES, THE COVERAGE CANNOT BE MORE RESTRICTIVE THAT OTHER PHYSICAL MEDICAL/SURGICAL (MED/SURG) CONDITIONS.

The ACA expanded MH/SUD coverage

MHPAEA applied only to large employer group health plans and only IF mental health benefits were included in the plan.

The ACA included MH/SUD benefits as “essential health benefits,” so that coverage was required in all individual and small employer group health plans.

Also under the ACA, large group health plans are required to offer “minimum value” coverage with an actuarial value of at least 60 % or be possibly subject to a penalty. If MH/SUD benefits are excluded, it is difficult to meet minimum value.

MHPAEA Applies to Some Public Health Plans

- MHPAEA applies to **Medicaid**.
- MHPAEA does not apply to **Medicare**.
  - However, Part B (outpatient coverage) does cover MH/SUD services in parity with other medical services to the extent that the same cost sharing applies.
  - Part A (hospitalization) does not comply with MHPAEA. For instance, inpatient psychiatric hospitalization is limited to 190 days in a LIFETIME.
- MHPAEA also does not apply to TRICARE, but TRICARE currently does cover MH/SUD in parity with MED/SURG benefits.

The Basic Structure of MHPAEA

MHPAEA requires parity in three ways:		
1. **Financial requirements** (Copays, coinsurance and deductibles.)	2. **Quantitative treatment limits** (The number of days in facility or the number of visits.)	3. **Non-quantitative treatment limitations** (Prior authorization and other medical management.)

It is the responsibility of the health plan or insurer to complete the analysis. It is up to the regulators to determine compliance.

The three types of parity analyses must be applied separately to six different classifications of benefits

SIX SPECIFIC CLASSIFICATIONS OF Benefits

1. Outpatient services provided by an in-network provider;
2. Outpatient services provided by an out-of-network provider;
3. Inpatient services provided by an in-network provider;
4. Inpatient services provider by an out-of-network provider;
5. Emergency care;
6. Prescription drugs.

The plan can choose to split outpatient classification into two subclasses: office visits and other than office visits (for example, labs.)

CLASSIFICATIONS, CONT.

- Classification is important because ALL MHPAEA comparisons must be done within each classification, NOT as an overall comparison. EACH OF THE THREE TYPES OF PARITY MUST BE ANALYZED FOR EACH OF THE SIX CLASSIFICATIONS.
- Also, comparisons cannot be done on a one-to-one basis. For example:
  - Diabetes and depression may both be chronic conditions, but the parity analysis cannot be based solely on comparison of those two diagnoses.
  - All specialist visits can have a higher co-pay, but a plan cannot designate all behavioral health providers as specialists.

Financial Requirements

Under MHPAEA, financial requirements must comply with the ***"substantially all/predominantly all" test.***

1. First determine the type of cost-sharing (i.e., copay, coinsurance, deductible) that applies to "substantially all" (defined as at least two-thirds) of MED/SURG benefits in a specific classification (inpatient vs. out-patient.)
2. Once the type is determined, then the analysis must consider the amount— the level of the financial contribution from the member. The "predominant" level (i.e., $30 copay or 50 % coinsurance) that applies is defined as the level that is applied to at least one-half of the MED/SURG benefits.

Example: If a $30 copayment is being applied to at least 2/3 of the med/surg outpatient in-network visits, then the same copayment should be applied to MH/SUD benefits.

Quantitative Treatment Limitations (QTLs)

The rule for QTLs uses the same substantially all/predominantly all test that is applied to financial requirements.

1. A QTL cannot be applied to MH/SUD benefits in a classification unless it is being applied to at least 2/3 of the MED/SURG benefits in the same classification.
2. The level of QTL applied to MH/SUD benefits cannot be lower than the predominant level of the QTL that is applied to at least ½ of the MED/SURG benefits subject to the QTL in that classification.

EXAMPLE: The most common level of QTL applied to at least 2/3 of MED/SURG inpatient hospitalization is 10 days, then the day limits for the same category of MH/SUD services cannot be lower than 10 days.

Non-Quantitative Treatment Limitations (NQTLs)

- NQTLs are non-numerical limitations that may be used to restrict a provider's recommended treatment. These include, but are NOT limited to, medical management techniques, such as prior-authorization, fail first/step therapy rules, formulary design and network tiers.
- MHPAEA requires plans to comply with NQTLs restrictions "**as written AND in operation**"---not just how they are defined in written documents, but also how they are actually implemented.

Key Terms Related to NQTLs

Utilization Management: includes prior authorization, concurrent review, retrospective review of claims, which are mechanisms that health plans and insurers use to make their own determinations for the appropriateness, quality and medical necessity of the care or care setting. These determinations should be based on evidence-based criteria and guidelines.

Medical Necessity (MT Definition): "Medical necessity" means health care services that a health care provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating, curing, or relieving a health condition, illness, injury, or disease or its symptoms and that are:

a) in accordance with generally accepted standards of practice;

b) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and

c) not primarily for the convenience of the patient or health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease.

NQTLs are the most Difficult to Identify and Enforce

- NQTLs are often the biggest barrier preventing covered individuals from getting MH/SUD treatment.
- NQTLs cannot be quantified like cost-sharing or visit limits.
- The rule is described as follows:

  To measure parity of NQTLs, plans must show that these rules and requirements (medical and cost management techniques) are applied equally “as written and in operation.”
- NQTLs include the standards for participation in the provider network.

MHPAEA Transparency Requirements

In 2021, Congress passed a new law (part of Consolidated Appropriations Act 2021) that enhances MHPAEA's transparency requirements.

- It requires health plans to conduct and document an analysis that compares the NQTLs applicable to benefits for MH/SUD to the NQTLs for MED/SURG benefits.
- The analysis must examine the factors and sources of information that form the basis of the NQTLs, as well as an evaluation of how they compare to the similar limitations for MED/SURG benefits.
- The analysis must be in-depth, specific, and well-documented. The analysis is must be made available to any covered person upon request and is subject to government audit. This requirement is in effect NOW.

Transparency Requirements, Cont.

The guidance identifies four specific NQTLs that will receive particular scrutiny in the required analysis:

1. Prior authorization requirements;
2. Concurrent review requirements;
3. Standards for provider admission to participate in a network, including reimbursement rates; and
4. Out-of-network reimbursement rates.

But the analysis is not limited to just these four. NQTLs must be analyzed for each of the 6 categories.

Transparency, Cont.

- A health plan must disclose its medical necessity standards for MH/SUD benefits to its members, beneficiaries, providers and prospective members, upon request.
- Plans must provide detailed reasons for claim denials, upon request, including the basis for the application of any NQTLs, if relied upon.
- These transparency rules do not apply government or public sector employee plans.
  - Transparency requirements for private sector employer plans are broader.

Enforcement of MHPAEA

Enforcement of MHPAEA is divided among several federal and state agencies:

- The USDOL enforces for all private employer plans, both self-funded and fully insured.
- CMS enforces for all state government employer plans and fully insured plans in states that have declined to enforce the minimum federal requirements.
- State Insurance Departments enforce with respect to health insurance companies selling fully insured plans to individuals and employers.

Regulators use a tool that performs calculations for the substantially all/predominantly all test for financial requirements and QTLs. In Montana, and many state DOIs, this can be done during the form review process. Therefore, these kinds of violations are no longer as common as they once were.

NQTLs are the Most Difficult to Enforce and Detect

Regulators have analytical tools to determine whether a plan is compliant with MHPAEA in its application of NQTLs.

But that analysis cannot be triggered until there is a

- (1) a complaint or inquiry from a covered individual or a provider OR
- (2) a market conduct examination that targets MHPAEA compliance.

IT IS CRITICAL THAT PROVIDERS AND CONSUMERS UNDERSTAND THEIR BASIC RIGHTS UNDER MHPAEA SO THAT THEY CAN REPORT POTENTIAL VIOLATIONS TO THE APROPRIATE REGULATOR.

Many state DOIs and sometimes the USDOL conduct market examinations targeting MHPAEA, but it is time consuming, retrospective and costly. However, it is necessary in order to detect NQTLs that violate MHPAEA.

Red Flags that Should Trigger an Inquiry/Complaint to Regulator

The health plan:

- ❑ Has copays, coinsurance and deductibles that are higher for MH/SUD services than for most MED/SURG services.
- ❑ Requires prior authorization for most MH/SUD services, but not for most MED/SURG services.
- ❑ Requires out-patient treatment for MH/SUD diagnoses before it will cover inpatient or residential treatment but does not usually do the same for MED/SURG diagnoses.
- ❑ Covers buprenorphine for pain treatment, but not for treatment of SUD conditions.
- ❑ Requires evidence or information regarding medical necessity for most/all MH/SUD treatment but does not usually do the same for MED/SURG treatment.

RED FLAGS, CONT.

- The covered individual must wait longer or travel further to see an in-network MH/SUD provider than for in-network MED/SURG providers.
- A Network tier design disadvantages access to MH/SUD providers.
- Standards for provider admission for network participation, including reimbursement rates, are more restrictive/inadequate than MED/SURG providers.
  - Formulary design for prescription drugs limits access to MH/SUD drugs more than MED/SURG drugs.
  - Step therapy is applied to MH/SUD drugs more often than for MED/SURG drugs.
  - Exclusions based on failure to complete a course of treatment that are applied to MH/SUD treatments but not to MED/SURG treatments.

Everything that Appears to be Unfair May Not Always be a Violation….

MHPAEA is a complicated law.

There are complex formulas and analysis that must be completed by experts and sometimes lawyers. Detailed data is usually required.

However, without feedback and complaints from providers and consumers, regulators cannot do their job.

The fact that many people are still not aware of their rights under the law or are frustrated with its complexity has hindered enforcement, and therefore the law is still not as effective at leveling the playing field as it should be.

Montana Mental Health Parity Act (2017)

- The purpose of the Act is to ensure that "Montana law applies the same level of parity between mental health and physical health benefits as existed in federal law on January 1, 2017."

  (Previously this Act included limitations which violated both MHPAEA and the ACA.)
- It applies to all individual and group health insurance and group health plans issued to Montana residents by any health insurance issuer.
- There are definitions, which deserve close attention.

  (For instance, autism remains in the list of "severe mental illness" disorders.)
- The Commissioner has rulemaking authority but has not exercised it.
- The state law is important because it allows the CSI to use it power over licensing and its fining authority to enforce mental health parity as to health insurance plans issued in this state.

2022 MHPAEA REPORT TO CONGRESS

- Beginning in 2021, the CAA requires health plans to make available a comparative analysis of their NQTLs as applied to MED/SURG and MH/SUD claims.
- The EBSA and CMS issued 171 letters to plans requesting this analysis for 216 unique NQTLs.
- NONE of the comparative analyses reviewed contained sufficient information upon initial receipt.
- EBSA has “so far” issued 30 initial determination letters finding 48 NQTLs imposed on MH/SUD benefits lacking parity with MED/SURG benefits.
- CMS issued 15 initial determination letters to plans finding 16 NQTLs out of parity with MED/SURG benefits.

Breakout discussions

We'll break into small groups. Please select a group scribe who will take notes and possibly report back to the full group.

Please discuss the following:

- Questions that came up today?

- We have some draft handouts to help explain mental health parity. Please take a look and tell us what you think. Would they be helpful to you and your patients/clients? Is there anything else you would like to see added?

We will have time for a brief report back but want to hear all of your feedback. Please email any additional feedback from your groups to Olivia: oriutta@mtpca.org.

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Thank you for joining us!

Slides and a recording will be posted to
the MPCA website very soon!