Mental Health Parity Analysis and Non-Quantitative Treatment Limitations

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DFR Grant-Funded Research

- In 2021, DFR received $663,538 from the Centers for Medicare and Medicaid Services under the State Flexibility to Stabilize the Market Grant Program.
- The program is meant to *"help States assess the health insurance needs of consumers and support the development of innovative measures, as well as to ensure access to affordable health coverage…"*

Grant Funded Projects

- Project 1: Development of a new Essential Health Benefits Benchmark Plan.
  - Status: Completed. Information available online at: https://dfr.vermont.gov/vermont-essential-health-benefits-benchmark.
- Project 2: Health Insurance Form and Formulary Review Processes and Verification Tools.
  - Status: Ongoing.
- Project 3: Medical Nutrition Therapy Utilization Review and Analysis.
  - Status: Ongoing.

Mental Health Parity Analysis

- Reviewing recently submitted policy forms to assess regulatory compliance, including compliance for non-quantitative treatment limitation requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and 8 V.S.A. § 4089b, as well as consistency with NAIC guidance.
- Compile a list of mental health and substance abuse services, identified by procedure codes (CPT/HCPCS) to be deemed "primary" mental health and substance abuse services for the purpose of compliance with 8 V.S.A. § 4089b(c)(1). The common elements underlying the selection of these primary mental health and substance abuse services shall include:
  - The most common or routine mental health and substance abuse services;
  - Outpatient/office mental health and substance abuse services;
  - Services provided to all persons regardless of age or gender.

MHPAEA

- Requires health plans that cover mental health and substance use disorder (MH/SUD) benefits to offer the same level of benefits that they do for medical/surgical (M/S) care.
- Prohibits health plans from imposing a non-quantitative treatment limitation (NQTL) on MH/SUD benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits *are comparable to and applied no more stringently* than factors used in applying the limitation with respect to M/S benefits in the same classification.

NQTL Examples

- Prior Authorization
- Concurrent Review
- Standards for provider accreditation to participate in insurance networks, including reimbursement rates
- Formulary design
- Step therapy protocols

Vermont Mental Health Parity Statute

8 V.S.A. 4089b requires health insurers in Vermont to cover MH/SUD benefits, and prohibits, among other things, the establishment of:

"any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition than for access to treatment for other health conditions," including:

- no greater co-payment for primary mental health care or services
- no greater co-payment for specialty mental health care or services

Preliminary NQTL Analysis & Responses

Focus Areas:

- Prior Authorization
- Concurrent Review
- Formulary Design
- Benefit Exclusions
- Medical Policies
- Provider Reimbursement Rates
- Standards for Provider Accreditation
- Restrictions on Billing Codes

High-Level Preliminary Findings

- The Department and its contractor, Public Consulting Group (PCG), requested NQTL analyses from Blue Cross Blue Shield of Vermont (BCBSVT), MVP Health Care (MVP), and Cigna.
- Overall, BCBSVT provided the most complete analysis
- DFR will request additional information from MVP and Cigna where necessary

Prior Authorization/Concurrent Review/Medical Policies

- Consistent application of NQTL to M/S and MH/SUD benefits across benefit classifications.
- Use of a multidisciplinary clinical committee that relies on medical or scientific evidence to determine coverage criteria and utilization management across all care categories.
- Use of a comparable methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria.

Provider Reimbursement

- Methodology and process for negotiating in-network provider reimbursement is comparable between MH/SUD services and M/S services.
- However, notable differences in how MH/SUD providers are reimbursed:
    - MH/SUD professional service reimbursement is based on provider discipline level while M/S professional reimbursement is not.
    - Reimbursement rates set to reflect "oversupply" of Master's-level clinicians and incentivize participation by psychiatrists.

Provider Accreditation

- DFR has already noted provider accreditation as an issue hindering access to residential mental health care services. *See* https://dfr.vermont.gov/sites/finreg/files/doc_library/Residential-Mental-Health-Report-Advance-Copy.pdf
- Provider enrollment and credentialing requirements apply for any provider wanting to gain admission to insurance networks.

Restrictions on Billing Codes

Claims edits (rules built into claims processing systems that cause services billed by a provider to become ineligible for payment) apply to all provider types, but some edits related to "bundling" or "unbundling" (e.g., requirements that two codes must or must not be reported together) can disproportionately impact MH/SUD providers.

For example, insurers might require MH/SUD providers providing Medication-Assisted Treatment to bill code G2068, which encompasses:

- buprenorphine dispensing and/or administration,
- substance use counseling
- individual and group therapy
- toxicology testing