Prior Authorize Outpatient Psychotherapy > 24 Visits per Calendar Year

(See page 113 DVHA budget book)

Summary of issue; Budget language proposal:

DVHA states it will save $2,200,000 by requiring preauthorization of outpatient psychotherapy after 24 visits and asserts this change is intended to **"keep provider payments and methodologies on par with the private insurance community."** The private insurance community in Vermont discontinued the use of all prior authorizations for mental health visits after the new federal regulations were enacted in 2014 barring the practice as a violation of parity law.

Vermont parity law bans the state from establishing visit limits that place a greater burden for access to treatment for a mental condition than for access to treatment for other health conditions. Prior authorizations place burdens on access to treatment.

Federal parity law regulations specifically interprets the use of prior authorization as a barrier to access that is not permitted unless it is applied across a majority of other services as well.

This proposed DVHA budget language would achieve a best practice aimed at the same issue, thus presumes the same projected savings but without violating state and federal parity law:

Sec. Y. OUTPATIENT PSYCHOTHERAPY; UTILIZATION REVIEW

Following a Medicaid beneficiary's twentieth outpatient psychotherapy visit in the same calendar year, the Department of Vermont Health Access shall review the individual's case to determine whether he or she may benefit from enhanced case management services in order to ensure that the individual is receiving appropriate, high-quality, coordinated care that is tailored to the individual's specific health care needs.

Technical Rate Adjustments to Align with Best Practices . . . . . $(7,820,882)

$(3,572,579) state

DVHA has committed to making changes that will keep provider payments and methodologies on par with the private insurance community. These changes include:

- **Prior Authorize Outpatient Psychotherapy > 24 Visits per Calendar Year** ~ ($2,200,000) gross: The Clinical Utilization Review Board (CURB) reviewed utilization of the outpatient psychotherapy services for adults and children. The number of outpatient psychotherapy services per person has been increasing. After reviewing the utilization data, on July 15, 2015 the CURB voted unanimously in favor of requiring outpatient psychotherapy providers. Recommendation from CURB: Require Prior Authorization for outpatient psychotherapy visits one standard deviation beyond median. This equates to after 24 visits per calendar year, a prior authorization is needed for additional visits.

8 VSA § 4089b. Health insurance coverage, mental health, and substance abuse
(emphasis added)

(b) As used in this section:
(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402. **Health insurance plan includes any health benefit plan offered or administered by the State**, or any subdivision or instrumentality of the State.

(2) "Mental condition" means any condition or disorder involving psychiatric disabilities or alcohol or substance use that falls under any of the diagnostic categories listed in the mental disorders section of the International Classification of Diseases, as periodically revised.

(3) **"Rate, term, or condition" means** any lifetime or annual payment limits, deductibles, copayments, coinsurance, and any other cost-sharing requirements, out-of-pocket limits, **visit limits**, and any other financial component of health insurance coverage that affects the insured.

(c) A health insurance plan shall provide coverage for treatment of a mental condition and shall:

(1**) not establish 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 than the co-payment applicable to care or services provided by a primary care provider under an insured's policy and no greater co-payment for specialty mental health care or services than the co-payment applicable to care or services provided by a specialist provider under an insured's policy;