

**Leads:** Hugh Ewart and Laurie Lippold

### Behavioral Health Parity in Insurance Coverage

Jane Beyer & Barb Jones, *Office of the Insurance Commissioner (OIC)*

*See page 4 for slides.*

#### Highlights

- OIC regulates and reviews the contracts that the carriers enter into, or the Managed Care Organizations (MCO's) enter into with providers.
- Apple Health not covered by state mental health parity laws.
- HCA has more control as a purchaser than OIC has as a regulator.
- Integrated managed care includes behavioral health.
- State parity laws require mental health services to be covered
- OIC has received 2 grant cycles of federal funding to do the work
- Cycle 1 of grant funding included gathering data that is being used to inform the work for cycle 2
- Key takeaway from cycle 1 data is the need for more workforce
- Currently conducting a full review of 4 biggest carriers for compliance with MHPAEA/BH parity.
- Milliman conducting the work in cycle 2.
- OIC largely looks at commercial rates because those are determined by negotiation between the insurer and the provider.
- If consumers feel that they are not receiving parity for BH services, they can cite the WAC or submit a Consumer Parity Disclosure form (from Dept of Labor) to the commercial insurer. If they do not offer the service, they must provide and pay for an out-of-network provider.
- Next day appointment provision applies exclusively to commercial health plans

#### Discussion Q / A

- Any examples of action taken in WA state under MPHEA?
  - We are involved in compliance work. Statute – we cannot share any info about these actions until there is a final resolution.
- Who is participating in the current focus groups, and should we be helping facilitate additional participation from among this group?
  - NAMI, NOLA, other consumer related groups, providers, marriage and family therapists, licensed counselors, psychiatrist, psychologists, and clinical social workers. Milliman is the contact for attendees.
- I hear from friends who are on private insurance panels that they often find barriers in being paid, i.e., multiple refusals requiring additional administrative time, all of which significantly delay provider payment. Wonder if this might be an item you consider reviewing in your grant stages of investigation.
  - If we get complaints from clients or providers, we can reach out and ask/investigate.

#### Chat:

- [RCW title 48](#) is for the commercial insurance market. [RCW 74.09](#) is for Medicaid/Apple Health
- [OIC complaints & appeals](#) – or call 1-800-562-6900
- [WAC 284-170-200\(5\)](#): (5) In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility within reasonable proximity

of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. An issuer must satisfy this obligation even if an alternate access delivery request has been submitted and is pending commissioner approval.

<https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MHPAEA-Disclosure-Template-1.pdf>

This is also a helpful webinar about how a provider can structure a letter as part of an appeal: <https://www.lac.org/resource/sample-forms-for-challenging-denied-mh-sud-claims>

## Review workforce possible strategies

*See page 43 for list and page 45 for meeting poll results.*

## Identify and discuss additional items

- Concerned about re-procurement process: adding additional MCOs within each region increases overhead/administrative burden for community health providers. Additional audits, etc.
- Supervision rate: keep on the list without action. HCA has a report coming out and the Ballmer-funded pilot is beginning.

## Updates

### Apprenticeship Programs

*Laura Hopkins & Sheryl Schwatz*

- The first apprenticeship program starts August 15<sup>th</sup> and includes behavioral tech and then substance use disorder professionals' program will start in September with peer counselor program starting in October.
- This year's legislative ask is a 4-year apprenticeship program – ability to get BA and clinical experience before they begin their Masters' degree and continue to support/expand virtual learning program.
- Existing programs are 1-2 years, with option to transfer to Olympic or WSU for 3-year degree.

### WA State BH Workforce Development Initiative

*Vaughnetta Barton*

- Goal of increasing the workforce by 400, which is 1915 graduates before 2027.
- Working with the Ballmer Group to administer conditional grant at a maximum of 51,500 based on unmet need and exchange.
- Grant requires 2 years of academic support in exchange for 3 years of employment.
- 20 students graduated this past spring, which was the proof of concept for the Ballmer Group.
- WSBHWDI data collection will be shared and accessible via our website in July 2023.

### Washington Council

*Julia O'Connor*

- Launching Ballmer-funded teaching clinic demonstration sites next month.

### Workforce Board

*Renee Fullerton*

- Starting work sessions.
- Register to participate in [2022 Behavioral Health Workforce Feedback Sessions](#). If you are not able to attend a session that interests you, please email [renee.fullerton@wtb.wa.gov](mailto:renee.fullerton@wtb.wa.gov) and I can help you give asynchronous feedback.

## Chat:

- [Washington State Behavioral Health Workforce Development Initiative](#)
- [The Re-imagining Behavioral Health: Race, Equity, and Social Justice conference](#) (Sept. 29-30)

## Next meeting

- Hugh and Laurie meet to bring more detail to possible workforce strategies and bring back to the group.
- Determine short, medium, and long-term; Legislative item or not; Requires funding or policy-only?
- Next meeting is August 17, 2022, from 10 to 11 a.m.

## Attendees:

Vaughnetta Barton, University of Washington (UW)

Kelsey Beck, Kaiser Permanente

Jane Beyer, Office of the Insurance  
Commissioner (OIC)

Rachel Burke, Health Care Authority (HCA)

James Chaney, Department of Health (DOH)

Devon Connor-Green

Thalia Cronin, Community Health Plan of  
Washington (CHPW)

Rebecca Daughtry, HCA

Hawa Elias, Community Health Network  
of Washington (CHNW)

Hugh Ewart, Seattle Children's

Kiki Fabian, HCA

Renee Fullerton, Workforce Board (WB)

Scarlett Gentry, Community Youth Services

Robert Hilt, Seattle Children's

Marissa Ingalls, Coordinated Care

Avreayl Jacobson, King County Behavioral Health  
And Recovery

Todd Jensen, HCA

Barb Jones, OIC

Laurie Lippold, Partners for Our Children

Julia O'Connor, WB

Steve Perry, HCA

Sheryl Schwartz, UW

Jolene Seda

Susan Skillman, UW

Christian Stark, Office of the Superintendent  
of Public Instruction (OSPI)

Mary Stone-Smith, Catholic Community Services

Ashlen Strong, Washington State Hospital  
Association (WSHA)

Shannon Thompson, Washington Mental Health  
Counselor Association (WMHCA)

Andy Toulon, Legislative staff

Alex Wehinger, Washington State Medical  
Association (WSMA)

Cindi Wiek, HCA



# Access to Behavioral Health Services

*Workforce and Rates Subcommittee/CYBHWG*



OFFICE of the  
**INSURANCE  
COMMISSIONER**  
WASHINGTON STATE

August 3, 2022

# Today....

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- OIC's Behavioral health parity work
- Status Update: Next day appointments (E2SHB 1477)
- Status Update: Behavioral health crisis service coverage (E2SHB 1688)
- Continuing the discussion...

# What health plans does OIC regulate?

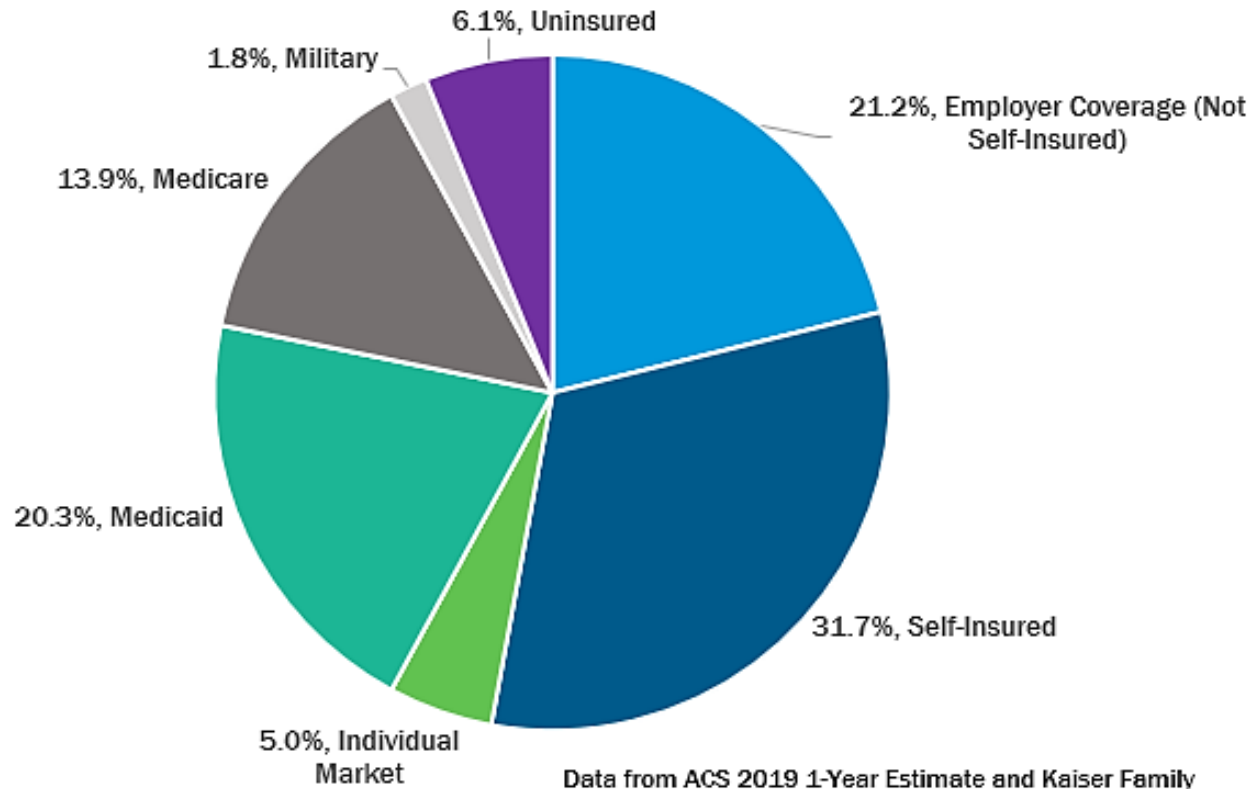
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- OIC regulates commercial health plans issued by health insurance carriers
  - Disability insurers, e.g. Cigna, Aetna
  - Health Care Service Contractors, e.g. Premera, Regence
  - Health Maintenance Organizations, e.g. Kaiser Permanente, Molina
- Individual, small group, large group and association health plan markets
- OIC cannot regulate self-funded group health plans, i.e. employer sponsored coverage in which the employer bears financial risk for their health benefit plan (NOTE: SFGHP's can opt into Balance Billing Protection Act)

# Health Coverage in Washington

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Health Coverage in Washington State, 2019



# BH Services & Private Insurance

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State mandated benefits for mental health and Substance Use Disorder (SUD) treatment services, e.g.

- State mental health parity law (e.g. [RCW 48.44.341](#))
- OUD drugs without prior authorization ([RCW 48.43.760](#))
- Withdrawal management without prior authorization ([RCW 48.43.761](#))

OIC provider network access rules ([Chap. 284-170 WAC](#))

- Network must include sufficient number and type of mental health and substance use disorder treatment providers and facilities
- If there is an insufficient number/type of providers, must cover out-of-network care



# BH Services and Private Insurance

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## Federal Affordable Care Act and Essential Health Benefits requirements

- EHB's must include mental health and SUD treatment services (individual and small group plans)

## Federal Mental Health Parity and Addiction Equity Act (MHPAEA)

- Applies to fully-insured and self-funded health plans

# Behavioral Health Parity Compliance

# What does MHPAEA require?

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- MHPAEA requires health plans and health insurance policies to provide benefits for mental health and substance use disorders that are comparable to the benefits that they provide for medical and surgical expenses.
- Addresses comparability in both quantitative and nonquantitative terms.
  - **Quantitative treatment limitations (QTL's):** cost-sharing (deductibles, copayments, and coinsurance) requirements and limits on the quantity of care (number of visits, treatments, or days of care).
  - **Nonquantitative treatment limitations (NQTL's):** other coverage policies that do not lend themselves easily to numerical analysis.
- Washington state BH parity law also requires that BH services be covered, e.g. [RCW 48.44.341](#).

# MHPAEA and NQTLs

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NQTL's include, but are not limited to:

- Medical necessity/experimental or investigative;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Provider credentialing standards;
- Reimbursement rates;
- Network adequacy standards and policies;
- Step therapy or fail-first policies;
- Exclusions based on failure to complete a course of treatment.

45 CFR §146.136(c)(4)(ii)

# MHPAEA and NQTLs

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MHPAEA standard for evaluation of nonquantitative treatment limitations:

- Any processes, strategies, evidentiary standards, or other factors used in applying an NQTL to mental health or SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits
- Applies both as written and in operation

45 CFR 146.136(c)(4)(i)

# MHPAEA and NQTL's

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An “unequal” quantitative outcome does not, in and of itself, establish a parity violation. It can be a “red flag” or warning sign that a more in-depth examination of the carrier’s policies and processes, as written and in operation, is necessary.

# Consolidated Appropriations Act of 2021

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## Sec. 203, Strengthening Parity in Mental Health and Substance Use Disorder Benefits:

- Enhances enforcement of NQTL compliance, including timeframes within which plans must voluntarily comply, and public disclosure to all plan participants if a plan fails to come into compliance
- Issuers and SFGHP's must perform and document NQTL comparative analyses – using a “five step” NQTL analysis
- DOL guidance:  
<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf>

# Access to Behavioral Health Services Grant

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- Federal grant from CMS/CCIIO to examine access to behavioral health services in commercial fully – insured individual, small group and large group health plans.
- Cycle I Grant: 2018 to 2021
- Cycle II funding: September 2021 to September 2023



# During Cycle I

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- First market scan, with [review by UW consultants](#)
- Second Market Scan
  - Focus: Health insurer policies that have a substantial impact on access to care – both “as written” and “in operation”
- Full BH/medical paid and denied claims dataset; [analysis](#) by OnPoint reutilization of BH services in commercial market

# Second Market Scan Focus

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- NQTL's as written and "in operation", including:
  - Prior authorization for inpatient services
  - Concurrent review for inpatient and outpatient services
  - Provider credentialing for inpatient services
  - Provider directory accuracy
  - Provider payment rates
- Carriers responded for their largest enrollment individual, small group and large group plans in Washington

# Goals/Deliverables for Cycle II

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## Market Conduct Oversight:

Under Washington state law, at [RCW 48.37.080](#), all data and documents obtained by the OIC during market conduct, i.e. compliance and enforcement, actions must remain confidential and are not subject to public disclosure.

## Activities:

- “Market conduct” actions: Based on carriers’ Second Market Scan responses, as well as some new NQTL comparative analyses.
- Revisions to OIC’s MHPAEA/BH parity compliance review tools; and
- OIC Market Conduct staff BH parity training.

# Goals/Deliverables for Cycle II

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## Consumer and Provider Education and Support

- Enhance OIC's behavioral health parity website
  - Content for website completed: October 2022
- Create additional consumer and provider education materials
  - Consumer and provider outreach/focus groups: August 2022
  - Materials completed: October/November 2022
- CAP staff training specific to BH parity, consumers' use of the DOL Consumer Parity Disclosure form, and any other consumer tools
  - November/December 2022

# Next day appointments – E2SHB 1477

# Next day appointment provision

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## Sec. 106:

Health plans issued or renewed on or after January 1, 2023 must make next-day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions to receive covered behavioral health services.

- The appointment may be with a licensed provider other than a licensed behavioral health professional and may be provided through telemedicine.
- Need for urgent, symptomatic care: presentation of behavioral health signs or symptoms that require immediate attention but are not emergent.

# Next day appointment provision – Rules

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New carrier reporting requirements in [WAC 284-170-280](#)

Network reports – Each carrier’s “Access plan”:

- Must address process for ensuring access to next day appointments for urgent, symptomatic behavioral health conditions

WAC 284-170-280(3)(g)(i)(M)

# Next day appointment provision – Rules

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## 988 Crisis Hotline Appointment Form D report

- New form to document compliance with next day appointment access
- Form content to be developed, with input from interested parties
- Reporting must reflect all appointment requests from any source
- Timeline for reporting to be determined annually by OIC
  - Range from weekly to twice yearly
  - Reporting frequency will be posted on OIC website by December 1 each year



# Coverage of BH Crisis Services & Balance Billing Protections – E2SHB 1688

# State BBPA & Federal No Surprises Act

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## Balance Billing Protection Act (2019)

- Effective January 1, 2020
- Comprehensive law – considered a “specified state law” under the federal No Surprises Act (NSA)

## Federal No Surprises Act (2020)

- Effective January 1, 2022

## E2SHB 1688 (Chap. 263, Laws of 2022)

- Aligns the BBPA and NSA, but retains key BBPA consumer protections
- Effective March 31, 2022

# E2SHB 1688 – Applies to...

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Sec. 7, amending RCW 48.49.020:

- State regulated private health plans
  - NSA applies to grandfathered health plans
- PEBB/SEBB plans
- [Self-funded health plans that “opt-in”](#), i.e. agree to comply with balance billing prohibitions, associated consumer protections and BBPA dispute resolution process
  - ESHB 1688 retains opportunity for self-funded group health plans to opt-in to state BBPA. 380 plans as of April 2022.

NSA is baseline for SFGHP’s that do not opt-in to BBPA

# Coverage of Emergency services

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- “Emergency services” must be covered whether provider is in- or out-of-network and without prior authorization requirements.
- Emergency services providers include hospitals and behavioral health emergency services providers.
- Emergency services include screening, stabilization, and post-stabilization, which includes observation or an inpatient and outpatient stay with respect to the visit during which emergency screening and stabilization services were provided.
  - “Prudent layperson” standard applies

Sec. 2, amending RCW 48.43.005 and Sec. 3, amending RCW 48.43.093

# BH Emergency Services Providers

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“Behavioral health emergency services providers” include:

- A crisis stabilization unit as defined in RCW 71.05.020.
- An evaluation and treatment licensed or certified as such by DOH.
- An agency certified by DOH under chapter 71.24 RCW to provide outpatient crisis services.
- A triage facility as defined in RCW 71.05.020.

# BH Emergency Services Providers (cont'd)

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“Behavioral health emergency services providers” also include:

- An agency certified by DOH under chapter 71.24 RCW to provide medically managed or medically monitored withdrawal management services.
- A mobile rapid response crisis team as defined in RCW 71.24.025 that is contracted with a BHASO to provide crisis response services in the behavioral health administrative services organization's service area.

See Sec. 2(48) for additional detail regarding these settings.

# What are “emergency services”?

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Emergency services include the following services provided by a behavioral health emergency services provider:

- Screening: A screening examination that is within the capability of a behavioral health emergency services provider including ancillary services to evaluate the emergency medical condition.
- Stabilization: Examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health emergency services provider to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in §1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)).

# What are “emergency services”? (con’t)

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Emergency services also include the following services provided by a behavioral health emergency services provider:

- Post-stabilization care: Covered behavioral health services provided by staff or facilities of a behavioral health emergency services provider after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished.
- Post-stabilization services relate to mental health or substance use disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.



# Balance billing prohibitions apply to...

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Because behavioral health emergency services providers are “emergency services” under state law, they cannot balance bill consumers enrolled in:

- Fully insured individual and group health plans.
- Washington state public employee and school employee health benefit plans.
- Self-funded group health plans that have opted into the BBPA.

From consumer perspective, it’s as if the service had been provided by an in-network provider.






# Balance Billing – Consumer Protections

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Can consumers be asked to waive their balance billing protections?

- For health plans subject to BBPA, consumers **cannot** be asked to waive their balance billing protections.
- For self-funded group health plans that have not opted into the BBPA, NSA notice and consent provisions apply. Consumers **cannot** be required to waive their protections.

# Consumer Notice of BB Protections

	Providers and Facilities	Carriers
When consumer schedules non-emergency services (BBPA)		
Within 72 hours of a consumer receiving <u>emergency services</u> (BBPA)		
When provider/facility requests payment from a consumer, and if payment is not requested, on the date a claim is submitted for payment (NSA)		
When a carrier authorizes non-emergency services for a consumer (BBPA)		
On a consumer's Explanation of Benefits, i.e. whether service is protected from balance billing (BBPA & NSA)		

# OIC Network Access Standards

# OIC Network Access Standards

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OIC must review a carrier's provider network to determine whether it includes a sufficient number of facility-based providers at a carrier's in-network hospitals and ambulatory surgical facilities.

New provision for emergency behavioral health services providers:

- Beginning January 1, 2023, OIC will require carrier's networks to include a sufficient number of contracted BH emergency services providers.

RCW 48.49.135

# OIC Network Access Standards

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For any service covered by a health plan, OIC may allow a carrier to submit an Alternative Access Delivery Request (AADR) to address a gap in their provider network. Carrier must show:

- No greater cost to enrollees.
- Substantial evidence of good faith efforts to contract.
- No available alternative provider or facility for carrier to contract with.
- For services subject to balance billing prohibition, notice to OON providers and facilities that deliver services referenced in the AADR.
  - Once notice is provided by the carrier, carrier need not reimburse the provider in an amount greater than amount charged at the time notification was provided.

# BBPA & Network Access

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- For services subject to the balance billing prohibition, a carrier cannot treat their payment of out-of-network providers or facilities under the BBPA or NSA to satisfy OIC's network access standards, unless expressly authorized by OIC under Section 18.
- For services subject to balance billing prohibition, a carrier can request to file an amended AADR to allow use of BBPA arbitration process to determine payment rates under the AADR if:
  - Request is submitted at least 3 months after the AADR's effective date.
  - Carrier demonstrates substantial evidence of good faith efforts to contract with the provider or facility.

# BBPA OON Provider Payment & Dispute Resolution

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The out-of-network (nonparticipating) provider is paid a “commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area.”

If the provider and carrier cannot agree on this amount, after a 30-day informal negotiation period, they can proceed to arbitration:

- Initiation of arbitration notice to OIC.
- OIC provides parties with list of arbitrators/arbitration entities.
- Providers can “bundle” claims with same procedural code that occur within 1 month of each other, if same carrier and same provider.
- Each party presents evidence/methodology to support their position.
- Parties can “settle” any time prior to arbitrator issues their decision.
- Arbitrator chooses one party’s “best final offer”. Decision is final and binding.
- Parties split the cost of arbitration; each pays its own attorney’s fees.



# Arbitration under Section 18

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## Section 11(13), amending RCW 48.49.040:

- Issue in arbitration is commercially reasonable payment for services addressed in the AADR.
- “Baseball arbitration”, i.e. arbitrator chooses either the carrier’s or provider’s final offer amount.
- Decision is final and binding on parties, and applies from effective date of amended AADR to either expiration of the AADR or the parties reach an agreement on a contract.
- BBPA arbitration will continue to be used for these disputes, even after state transitions to federal IDR system.
- Pending arbitrator’s decision, carrier’s allowed amount paid to provider is commercially reasonable amount.

# Consumer Advocacy Program

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- Reviews issues/concerns with fully insured insurance plans and associated HCBMs
  - Claims
  - Billing
  - Underwriting
- Provides referrals for further assistance
- Can submit complaint online or via phone or text  
<https://www.insurance.wa.gov>

**List of possible workforce priorities for 2023**

Issue	Individuals/Orgs	Pursue?	Notes
Peer support specialists	Other subcommittees; Rep. Davis; WG support item in 2022		
Issues related to CLIP, e.g. rate for milieu staff, health benefits for families, training opportunities, other	WG support item in 2022		
Path to credential refugees and individuals from other countries	Rep. Thai		
Supervision hours and other supervision issues (e.g. having to pay for supervision)	Professional groups; BHI subcommittee		
Other barriers to licensing/credentialing	Sara S/LMHCs		
Time it takes to issue a license/credential; licensing delays	Legislators; professional groups; YAACC subcommittee		
Conditional grants	WDI		
Loan repayment	WA Council of BH Agencies		
Expand CHW work	Sarah W.		
Explore alternative payment models	Sarah W.		

**List of possible workforce priorities for 2023**

Issue	Individuals/Orgs	Pursue?	Notes
Clinical coaching model	Sarah W.		
Funding for costs associated with being in school, e.g. living expenses	BHI subcommittee		
Professional development/training	Discussed at various subcommittee meetings		
Workplace culture	Discussed at various subcommittee meetings		
Additional rate increase	WA Council; others		
Paperwork Issues	Continues to come up; legacy issue for the WG		
Asks related to the apprenticeships getting underway	TBD		
Asks related to implementation of BHI start-up	TBD		
Asks related to the access survey	TBD		

# Poll results - Possible Recommendations

