Washington State Health Care Authority

Washington State Parity Analysis

As required by:

Mental Health Parity and Addiction Act (MHPAEA) Regulations

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Washington State Parity Analysis

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Introduction

Overview and Purpose

On March 30, 2016, the Center for Medicare and Medicaid Services (CMS) issued the Mental Health Parity and Addiction Equity Act (MHPAEA). The act requires states to analyze financial requirements (FR), Quantitative Treatment Limitations (QTL) and Non-Quantitative Treatment Limitations (NQTL) applied to behavioral health (BH) [1] services, in order to ensure that those limitations are no more restrictive than those under medical/surgical (M/S) benefits. States must also ensure that certain availability of information requirements are met. The original parity report was completed in October 2017 and the updated parity analysis is due by January 1, 2020. This updated report is meant to demonstrate the continued compliance with the analysis and reporting requirements of MHPAEA.

The original parity analysis was a joint effort between the Department of Social and Health Service's (DSHS) Division of Behavioral Health Resources (DBHR) and the Health Care Authority (HCA). The structure and content of this report is based on information from the Medicaid and Children's Health Insurance Program (CHIP) Parity Policy Academy, the Mental Health Parity Toolkit, coaching calls from our CMS assigned coach, and SAMHSA Parity Policy Academies Medicaid/CHIP Learning Network Documentation and Hot Topic Webinars. The report covers requirements of the parity rule and an overview of our state's system, including:

1. The process used to determine our benefit packages.
2. How mental health (MH) and substance use disorder (SUD) conditions and benefits are defined and mapped.
3. Analysis of financial requirements, quantitative treatment limitations, aggregate lifetime and annual dollar limits.
4. The process for identifying and analyzing non-quantitative treatment limitations.
5. Analysis of the current system and work that will need to be done to bring the state into full compliance.
6. The plan for community outreach and education.
7. How the state will meet availability of information requirements.

We have attempted to replicate the process used in the original parity report for this updated report as closely as possible to ensure we are consistent in our review and analysis process. However it is important to note that there have been some significant changes that have occurred in the purchasing and delivery of behavioral health services in our state, most notably the legislatively driven (SB 6312) integration of our physical and behavioral health system, as well as the moving of DBHR from DSHS to HCA (ESHB 1388).

[1] BH services include both MH and SUD services.

Design of the Washington State Behavioral Health System

As Washington State's Medicaid authority, HCA is responsible for all Medicaid funded services in the state. While HCA retains direct oversight of all M/S services, it historically had delegated responsibility for most SUD and some higher level MH services. Behavioral health (BH) services for this population are provided using a two tiered system. The top tier, managed by DBHR, provided SUD services and more intensive MH services to an acute and/or chronic population. DBHR contracted with Behavioral Health Organizations (BHOs) to administer these services. A recipient who did not meet the threshold for this higher level of care could access lower tiered mental health services. HCA oversaw the lower tiered MH services through contracts with Managed Care Organizations (MCOs) and the fee-for-service (FFS) system.

In 2014, the state passed a new law (SB 6312) that required all regions of the state to adopt a new integrated approach to physical and behavioral health services. SB 6312 outlined a six-year system transformation process that:

- Changed how the State purchased mental health and substance use disorder services in the Medicaid program.
- Directed the State to fully integrate the financing and delivery of physical health, mental health and substance use disorder services in the Medicaid program via managed care by 2020.
- Directed HCA and DSHS to jointly establish common Regional Service Areas for behavioral and physical health care purchasing.

As of January 2020, all regions of the state will have integrated care for physical and behavioral health. In these fully integrated regions, HCA contracts with MCOs for the full scope of Medicaid M/S, MH, and SUD services. This parity analysis includes an in-depth review of BH services in our state.

Benefit Packages

Managed Care

Washington State has multiple Medicaid funded benefit packages with a behavioral health benefit. Figure 1 includes a summary of the various benefit packages. Despite the variety of benefits available, the state relies upon the same managed care entities to administer services across all benefit packages.

Benefits for individuals enrolled in the Children's Health Insurance Program (CHIP) or the Alternative Benefits Program (ABP) are managed by the same MCOs as other Medicaid enrollees. ABP behavioral health benefits are the same as those in the traditional Medicaid program.

Additionally, HCA changed the Washington Apple Health (Medicaid) program that serves the foster care population by shifting to integrated foster care (IFC). This program is designed to fundamentally improve health outcomes and care for individuals in foster care, foster care alumni and individuals in adoption support. On January 1, 2019, Coordinated Care of Washington (CCW),

began delivering the integrated foster care benefit statewide. This benefit provides health care coordination across a full continuum of services and is inclusive of the same benefit package as the integrated managed care benefit. Therefore, it is included in this analysis.

Fee For Service

BH benefits are available on a FFS basis for American Indian/Alaska Native (AI/AN) and dual eligible individuals. FFS behavioral health benefits meet parity requirements, as there are no quantitative/non-quantitative treatment limits, financial requirements, or aggregate lifetime limits.

Approach to Parity Analysis

Identifying Behavioral Health and Medical Surgical Benefits

The parity analysis process requires states to define which benefits fall under the M/S and BH categories. Benefits are categorized based on the diagnoses they are meant to treat. States choose a method for assigning benefits to categories based on generally recognized independent standards of current medical practice. Following guidance provided by the CMS Parity Toolkit and subsequent technical assistance, Washington State used the ICD-10-CM as a guide to determine diagnostic benefit categories.

For the purpose of the parity review, the state defines BH conditions as those conditions listed in ICD-10-CM, Chapter 5, "Mental, Behavioral Health and Neurodevelopmental Disorders." The conditions listed in Chapter 5: subchapter 1, "Mental Disorders due to known physiological conditions" and subchapter 8, "Pervasive and Specific Developmental Disorders" were excluded because the etiology of these conditions is a medical condition, and treatment would address medical concerns first. M/S conditions definitions are consistent with the M/S conditions listed in ICD-10-CM, Chapters 1-4, Chapter 5-subchapter 1, and Chapters 6-20.

Placement of Services in Benefit Categories

The parity analysis requires a comparison of BH and M/S benefits within defined categories. For example, BH inpatient benefits are analyzed for parity against M/S inpatient benefits. For the purposes of the parity analysis, the four benefit categories are: outpatient, inpatient, emergency, and pharmacy.

Federal parity regulations allow states some latitude in placement of benefits within each of these categories. Washington State developed a preliminary list of benefits in each category based on current state plan services. The state then consulted with MCOs to ensure the list was accurate and complete. Before sending out parity questionnaires, the state created a list of services covered under each category. This helped ensure consistency among MCOs when answering questions about each benefit category.

The definitions for each category are:

- Outpatient: Routine services that occur in an outpatient setting and are not included in the emergency category.
- Inpatient: Any non-emergency service that involves the individual staying overnight at a facility. This includes inpatient MH and SUD treatment and crisis stabilization services occurring in a facility.
- Emergency: Services or items delivered in an emergency department (ED) setting or emergency/crisis stabilization services, not requiring an overnight stay, which are not delivered in an inpatient setting.
- Pharmacy: Covered medications, drugs and associated supplies requiring a prescription.

Appendix Figure 2: Service Categories for FIMC Regions and "Lower Level" MH Benefits lists, by procedure code, all services covered by these systems.

Appendix Figure 3: Medical Surgical Services lists benefits by category.

Information Gathering Process

In 2017, the state implemented a two-step process for determining parity between the BH and M/S benefits. A questionnaire was sent to all five MCOs asking them to identify any treatment limitations related to BH services. MCOs in the fully integrated region were asked to address the full range of MH and SUD services. The MCOs were asked to provide detailed responses regarding the policies and practices involved in each area addressed on the questionnaire. They were also required to submit policies or written procedures documenting the practices described.

Once obtained, the state analyzed the responses to determine which BH benefits include treatment limitations. The state compared BH treatment limitations against those in the same category for the M/S benefit. Information about M/S NQTLs was obtained through HCA and MCO policy documents.

The analysis of the pharmacy benefit followed a similar approach, but was undertaken on a separate timeline. The pharmacy benefit is managed by the five MCOs.

In 2019, the state followed the same two-step process in completing our updated parity analysis. This allowed us to use a process that had been vetted through CMS and our parity coach in 2017, as well as consistency in our review.

Quantitative Treatment Limits, Financial Requirements, and Aggregate Lifetime/Annual Dollar Limits

The state reviewed mental health and substance use disorder services contracted through the MCOs to evaluate the BH benefits. The state did not find any financial requirements, quantitative treatment limits, or aggregate lifetime limits.

Outpatient Benefit Analysis

The only NQTL identified for outpatient BH services was the prior authorization requirement applied to some MCO services. Outpatient NQTL requirements are described below.

MCO Managed Outpatient Benefits

Description of MCO Outpatient NQTLs

The MCOs do not require prior authorization for most services. Exceptions include psychological and neuropsychological testing and applied behavioral analysis.

Criteria Development: MCO Outpatient NQTLs

The criteria the MCOs use to determine which services require authorization differs based on the type of service. The authorization process might include a clinical review of the client's record or in some cases, application of a standardized tool, such as the InterQual Level of Care Guidelines for psychological testing.

Frequency and Stringency of MCO Outpatient NQTLs

If an individual does not meet the prior authorization requirements for an MCO managed MH benefit, the individual does not receive the service.

M/S Outpatient Benefits

Description of M/S Benefit Outpatient NQTLs

Prior authorization is generally required when a service is or has the potential for overutilization (i.e. large variation among practices, used more than the evidence supports), high cost and is therefore important to ensure that is being utilized for the appropriate conditions, newer service that may be appropriate for a few patients but is investigational/experimental for most, service with a history of abuse and/or fraud around the service.

Generally, if outpatient and inpatient authorization rates (i.e. approvals) trend over 90%, the prior authorization requirement may be removed. Also in cases where care has become a community standard of care and is supported by evidence, a prior authorization requirement may be removed.

Criteria Development: M/S Outpatient NQTLs

Medical necessity is defined in rule (WAC 182-500-0070) and further delineated in rule (WAC 182-501-0165). Criteria for determining medical necessity based on best available evidence, evidence reviews and in comparison to alternatives is in rule (WAC 182-501-0165) to guide determinations.

Frequency and Stringency of M/S Outpatient NQTLs

Denial of authorization means a covered service will not be paid for by the State. Upon denial, a provider may seek peer-to-peer consultation to discuss the denial.

The State authorizes covered services when determined to be medically necessary according to program rules previously noted. A client has a hearing right if a covered service is requested and not authorized (chapter 182-526 WAC). Additionally, a non-covered service may be requested as an

exception to rule (WAC 182-501-0160), but there is no hearing right for decisions pertaining to authorization of a non-covered service.

Inpatient Benefit Analysis

As in the outpatient analysis, the only NQTL identified for inpatient BH was the requirement that providers obtain prior authorization for planned admissions and/or stays at a Residential Treatment Facility before services begin. NQTLs are described below.

MCO Managed Inpatient BH Benefits

Description of FIMC Region Inpatient NQTLs

There are five MCOs that manage inpatient BH benefits. No authorization is required for urgent or emergent admissions; ongoing or planned inpatient admissions and care do require authorization.

Criteria Development: FIMC Region Inpatient NQTLs

The five MCOs use the inpatient billing guide and a clinical approach to determine authorization, with a focus on client safety and ensuring that inpatient treatment is the appropriate and least restrictive option.

The MCOs follow ASAM guidelines for authorization of inpatient SUD services.

Frequency and Stringency of FIMC Region Inpatient NQTLs

The state requires MCOs to follow a standardized appeals process.

M/S Inpatient Benefits

Description of M/S Benefit Inpatient NQTLs

Prior authorization is generally required when a service is, or has the potential for: overutilization (i.e. large variation among practices, used more than the evidence supports; is high cost and is therefore important to ensure that is being utilized for the appropriate conditions; is a newer service that may be appropriate for a few patients but is investigational/experimental for most; or is a service with a history of abuse and/or fraud.

Generally, if outpatient and inpatient authorization rates (i.e. approvals) trend over 90% the prior authorization requirement may be removed. Also, in cases where care has become a community standard of care and is supported by evidence, a prior authorization requirement may be removed.

Criteria Development: M/S Inpatient NQTLs

Medical necessity is defined in rule (WAC 182-500-0070) and further delineated in rule (WAC 182-501-0165). Criteria for determining medical necessity based on best available evidence, evidence reviews and in comparison to alternatives is in rule (WAC 182-501-0165) to guide determinations.

Frequency and Stringency of M/S Inpatient NQTLs

Denial of authorization means a covered service will not be paid for by the State. Upon denial, a provider may seek peer-to-peer consultation to discuss the denial.

The State authorizes covered services when determined to be medically necessary according to program rules previously noted. A client has a hearing right if a covered service is requested and not authorized (chapter 182-526 WAC). Additionally, a non-covered service may be requested as an exception to rule (WAC 182-501-0160), but there is no hearing right for decisions pertaining to authorization of a non-covered service.

Emergency Benefit Analysis

Emergency BH services are managed by the MCOs. The MCOs were asked to identify NQTLs related to emergency services, including services provided by local crisis teams. No NQTLs were identified. Emergency services are available to all individuals without authorization.

Pharmacy Benefit Analysis

Assessing MH Parity – NQTLs for Covered Outpatient Drugs

HCA is in the process of implementing a single preferred drug list (PDL) that applies to all MCOs and FFS programs. This means that all MCOs and FFS will have the same coverage status and authorization criteria for covered outpatient drugs. The integration of physical and behavioral health does not change access or authorization criteria for covered outpatient drugs.

Washington State's designated single state agency for the administration of Medicaid (Health Care Authority or HCA) delivers a Covered Outpatient Drug benefit to Fee-for-Service (FFS) and MCO enrollees according to the provisions of Sec. 1927 of the Social Security Act (SSA 1927) [42 U.S.C. 1396r–8] and the Apple Health Managed Care (AHMC) contracts (inclusive of Foster Care and Fully Integrated versions of those contracts). SSA 1927 requires states to cover all drugs produced by drug manufacturers who have signed a rebate agreement with CMS. SSA 1927 also establishes the parameters that can be used in establishing coverage, determining prior authorization criteria, making authorization decisions, and performing other types of Drug Utilization Review (DUR). The rules for state coverage of Covered Outpatient Drugs are universal across all drugs, making no distinction between physical, mental, or BH medications.

Washington Apple Health has no copays, deductibles, lifetime limits, or any other out-of-pocket forms of financial participation. Therefore, there are no financially based quantitative limits for Covered Outpatient Drugs. For the purpose of medical necessity determinations, the provisions of SSA 1927 require that all drugs be available with an authorization process, effectively eliminating any possibility of utilization based quantitative limits. Within the Covered Outpatient Drug benefit, we will be assessing only non-quantitative treatment limitations, as no quantitative limits apply.

The single PDL will ensure the same utilization management criteria for non-quantitative treatment limitations for all Apple Health clients in an MCO or FFS program. The utilization management process applies to all drugs, and HCA reviews them on safety, effectiveness, cost, and any other relevant factors to determine appropriate and optimal management through NQTLs. The Washington State Drug Utilization Review (DUR) Board and Washington State Pharmacy and Therapeutic (P&T) committee, made up of licensed healthcare professionals, consider available data in the context of medically appropriate use, and determine whether a drug should have additional utilization controls in place, and if so, what those controls should be. These utilization

management requirements are NQTLs that can take a variety of forms including, but not limited to, prior authorization requirements, diagnosis requirements, soft quantity limits, step therapy protocols, and provider specialty requirements.

Medicaid enrollees encounter these NQTLs in the form of prior authorization requirements which represent a barrier to unfettered utilization. The order of the steps in the prior authorization process, and who initiates requests can vary from MCO to MCO, but generally align with the following steps:

1. Claims are rejected at the point-of-sale when a retail pharmacy attempts to bill for a medication that has not been authorized.
2. A healthcare provider must supply information regarding the medical necessity of the drug in question for that particular client.
3. Submitted information is reviewed according to criteria set forth in SSA 1927 and as determined by the aforementioned DUR Board or P&T committee.
4. If a client receives a denial of service or other adverse benefit determination, they have the option of requesting re-review with additional information, and/or pursuing a hearing process.
5. If approved, the claim for reimbursement from the pharmacy will now process without stops.

Assessing Parity for Mental and BH Drugs

To determine whether there was any variance in the treatment of physical, mental, or BH drugs, HCA first identified those drugs as MH or BH drugs. This was done by cross referencing mental and BH diagnoses (as described in Section III above) with the FDA indication for which a drug is most often prescribed. For example, antipsychotic medications all share a primary FDA indication for the treatment of either bipolar disorder or schizophrenia, and are therefore a clear inclusion under the MH category. Some medications with potential psychotropic uses were NOT included as MH drugs, because their primary use was in the treatment of a physical health condition. For this reason, many drugs which can act as mood-stabilizers were not included because the same products' primary uses were as anticonvulsants. Please see Attachment 5 for a list of drugs included for assessment as mental or BH products.

Next, HCA developed a set of questions specific to pharmacy utilization which were designed to examine whether there were instances where mental and behavioral drugs may be subject to processes or criteria at variance with physical health counterparts. These questions were sent out to all 5 MCOs and the FFS program to provide detailed descriptions on a drug by drug basis of the processes for applying criteria, criteria development, and determining when clients did or did not meet criteria. The questions were as follows:

1. **Quantitative or Non-quantitative limit:** Describe any and all limitations on the product or products, such as step therapy, quantity limits, tried and failed criteria, generics first policies, full prior authorization, conditional/situational prior authorization. Describe any thresholds which trigger authorization or limitations to coverage.
2. **Medical Necessity/Initial Authorization:** What are the written and operating processes, strategies, evidentiary standards, and other factors applied during an initial medical necessity/ appropriateness review? Are there any exceptions and if so how are they

applied? (i.e.; What are the authorization criteria and processes for INITIAL approval when a limitation applies)

   a. **Consequences:** What happens if requirements are not met/ authorization is not approved? What alternatives are available? Are there exceptions or alternate approval processes?
   b. **Reason for requiring authorization/ limitation:** What was the source of the decision to restrict the product or class of products? Please be specific for each limitation described (e.g.; "Age/dose limits required by HCA; Step Therapy requirement per class review by P&T due to overutilization of high cost brands; Fills per Month limit per PBM administrative policy.")
   c. **Source of requirements/ authorization criteria:** Who established criteria, and what was the source of information used? Identify the factors (e.g.; cost of treatment, high cost growth, variability in cost and quality, elasticity of demand, provider discretion in determining diagnosis, type or length of treatment, clinical efficacy of treatment or service, licensing and accreditation of providers, fraud potential) that determine the services selected for concurrent review. What evidentiary standards support their use?

3. **Medical Necessity/Concurrent Review:** Questions 1 – 1c repeated in the context of ongoing review/ subsequent approvals.
4. **Prescriber / pharmacy restrictions:** Indicate whether there are restrictions on the specialty of the prescriber, or whether the product is limited to distribution through a specific source (i.e.; specialty pharmacy, medical benefit only, mail order for maintenance fills)
5. **Other restrictions:** Describe any other requirements or procedural restrictions not otherwise addressed.
6. **Example of physical health medication with similar types of restrictions:** Please provide an example of a non-MH/ non-SUD treatment drug with similar types of restrictions and requirements. Please attach or provide a link to related policies if available.

These questions were answered for each drug categorized as mental or BH by each of the five MCOs and the FFS program. All responses were consistent with the general structure of pharmacy benefit management as described above. All plans provided similar information indicating:

- NQTLs were established based on standard reasons such as high risk to the patient, high utilization when a more appropriate therapy existed, or high cost.
- Authorization criteria are established based on FDA labeling and /or as determined based on evidence-based literature review by a P&T or DUR Board.
- All requests are reviewed based on individual determinations of medical necessity.
- If there is an adverse benefit determination made, clients have the option of requesting some form of re-review, as well as having a hearing process available to them.
- In most instances, another drug with substantially similar criteria could be found in the physical health benefit.

All MCOs and FFS responses established that NQTLs and processes for management of drugs were consistent and made no distinction between the type of condition being treated, with the exception of limitations based on the Children's MH program that all MCOs are required by HCA to participate in.

Children's Mental Health

Since 2005 HCA has developed, maintained, and expanded a set of requirements around safeguarding children from inappropriate over-medication, including high doses of drugs, duplicative therapies, and polypharmacy. HCA periodically convenes a Children's MH Workgroup where prescribers, foster care advocates, MH advocates, drug manufacturers, and the public at large all have an opportunity to discuss and provide input to HCA designated pediatric MH specialists. Through these discussions, expert prescribing experience, and nationally recognized prescribing guidelines, the Workgroup recommends thresholds for the prescribing of MH drugs which should not be exceeded without requiring review by a physician specializing in pediatric psychiatry. Although these recommendations are developed in a different manner than other NQTLs, and tend to be less related to specific FDA indications, they are still subject to final review and approval by the same DUR Board through which all physical, mental, and BH drug criteria are developed and finalized.

When authorization is required for HCA to cover a prescription which has been written outside of these guidelines (primarily related to age based dosing limits and elimination of unnecessary polypharmacy), a prior authorization review is conducted in a manner similar to the processes around any authorization for any type of medication. The single difference lies in the requirement for the prescriber to participate one-on-one in the review process, rather than simply submitting paperwork, as authorizations are not approved until the child's entire MH treatment plans and needs are assessed by an agency designated pediatric psychiatrist. This represents slightly more stringent NQTLs in that there is an additional administrative burden on the prescribing practitioner, and slightly longer turnaround times for the authorization process, taking longer for the client to receive medications if they are ultimately approved.

This program was originally developed in response to national concerns regarding the high rate of psychotropic medication prescribing for foster care children. Multiple studies conducted between 2005 and 2011 have shown that children in foster care were being medicated at a much higher rate than non-foster children. The higher rates do not necessarily indicate inappropriate prescribing practices, and could be due in part to foster children's greater MH needs, greater exposure to traumatic experiences, and the challenges of coordinating their medical care. However, even when appropriate, they still represent higher risks to the patient.

Studies consistently demonstrated prescribing practices in the Foster Care population which represented significant health risks, such as very high doses of medications, children receiving multiple duplicative therapies, and concurrent prescriptions for five or more medications. Washington State determined that it was necessary to take extra steps to safeguard foster children and monitor the prescribing of MH drugs. In developing a program to address these concerns, the State determined that it was of equal importance to safeguard ALL children from inappropriate prescribing. Although these high risk prescribing practices were seen at greater rates in the foster population, they were also seen in the non-foster population, and were of equal concern no matter what the child's living arrangement or adoptive status may be.

As a utilization problem which represents the highest risk to the most vulnerable population, HCA has determined that additional administrative burden and delay in filling of prescriptions is warranted for the sake of ensuring children have access to treatment recommendations of a physician specializing in the condition being treated. The unique degree of risk for this population warrants a unique level of scrutiny. Although this situation is unique to coverage of MH medications for children, it does not represent a lack of compliance with MH parity requirements, because the application of this standard is not related to the type of service being provided, but to severity of risk for the affected population. If a class of physical health medications was found to consistently be prescribed at high rates in a manner which potentially jeopardized client safety for an extremely vulnerable population best managed by specialist care, similar programs would be put into place.

At this point in time, only children's MH prescribing has risen to this level of need to mitigate risk, but the fact that it happens to apply to a MH service is coincidental and does not represent a lack of compliance with parity.

Summary of Pharmacy Parity Analysis

HCA is compliant with MH parity requirements for Pharmacy services. All MCOs and the FFS program apply all processes and criteria equally regardless of the category a medication may fall into. Any variance in the degree of NQTL is directly proportional to the risks being addressed rather than the condition, and are consistent with the way any drug class would be treated.

Provider Contracting

The MCOs were asked to describe their provider contracting requirements to ensure there is no disparity in contracting practices between the BH and M/S benefits. The MCOs were asked to describe provider selection, geographic limitations, out of network limitations, and excluded providers.

Inpatient Provider Contracting and Geographic Limitations

The MCOs pay for inpatient MH and SUD treatment from licensed SUD and MH inpatient facilities within the state. Per statewide inpatient billing instructions, the MCOs only pay for out-of-state hospital admissions (excluding certain specified out-of-state border communities) when the admission is an "emergency." This excludes voluntary psychiatric admissions. They do pay for out-of-state involuntary admissions

M/S Benefit Provider Contracting and Geographic Limitations

For outpatient M/S services, MCOs contract with providers licensed in Washington State (or providers in border communities) who bill for services within their scope of practice. Inpatient services are paid for following the same inpatient billing guide process described above.

Out of Network Benefits

As with the M/S benefit, if a contracted provider is not identified, the MCO will contract with an out-of-network provider to ensure the individual receives medically necessary services.

Excluded Providers

In both the BH and M/S systems, providers excluded from participating in government programs are considered ineligible for participation. No additional limitations were identified.

Availability of Information Requirements

In addition to the parity requirements described above, states were required to demonstrate compliance with certain availability of information requirements by October 2, 2017. Washington State was in compliance with these requirements prior to the parity analysis and continues to be in compliance. Compliance with each requirement is described below.

Reason for Denial of Payment

States must ensure that managed care entities inform Medicaid enrollees the reason for any denial of payment. The parity toolkit states that, if an MCO or PIHP provides a notice of adverse benefit determination to enrollees for any denial nor reimbursement or payment, the requirements in 438.915(b) are met. The state requires the MCOs to provide a notice of adverse benefit determination to enrollees, consistent with 42 CFR 438.404 for any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Criteria for Medical Necessity

The criteria used to make medical necessity determinations must be available to Medicaid enrollees. The state requires, by contract, that the MCOs include in each notice of adverse benefit determination the medical necessity criteria used and any processes, strategies, or standards used in setting coverage limits.

Practice Guidelines

States should ensure that managed care entities disseminate practice guidelines to providers and, upon request, to enrollees as required by 42 CFR 438.236. This requirement is included in the MCO Medicaid contracts.

Summary of Parity Analysis

The state was pleased to find that in almost all areas addressed by this analysis, there was little disparity between the BH and M/S benefits. There are no QTLs or other financial restrictions on any

BH benefits. No disparity exists between the M/S and BH emergency and inpatient benefits. There are no significant differences in provider contracting between the two benefits.

Ongoing Monitoring Activities

The state has continued to review and ensure parity compliance on a regular basis to determine whether BH benefits continue to meet parity requirements. Any changes to the state plan or waivers that affect BH services will be reviewed for compliance. Additionally, a high volume of specific complaints about parity issues may trigger a parity analysis.

In light of integration now being completed across the state a workgroup has been formed to evaluate our current parity review practices. This workgroup will utilize identified best practices and make modifications and changes as needed to ensure compliance with federal parity requirements.

Plans for Community Outreach and Education

In an effort to support parity efforts in Washington State, HCA and DSHS had partnered with our colleagues at the Office of the Insurance Commissioner (OIC) to strategically coordinate our outreach and education efforts. Both short term and long-term strategies were identified to raise awareness of the importance of behavioral health parity and to help identify potential parity concerns.

During initial work, we focused on consumers, providers, advocates, and managed care organizations. We believe that partnering with consumers and providers is key to improving our efforts to ensure that the BH parity laws are followed. Consumers and providers interact with health plans on a daily basis and can help us spot potential behavioral health parity compliance issues. Both the HCA and the OIC have continued to engage in joint public education efforts, such as presenting at NAMI and establishing a behavioral health parity advisory committee to further parity efforts. The committee continues to advise and act as a "focus group" as we develop our outreach and education plan and materials.

Appendices

Figure 1: Medicaid State Plan Benefit Packages (WAC 182-501-0060)

1. The letter "Y" means a service category is included for that program.
2. The letter "N" means a service category is not included for that program.
3. Refer to WAC 182-501-0065 for a description of each service category and for the specific program rules containing the limitations and restrictions to services.

Service Categories	ABP 20-	ABP 21+	CN1 20-	CN 21+	MN 20-	MN 21+
Ambulance (ground and air)	Y		Y	Y	Y	Y
Applied behavior analysis (ABA)	Y	N	Y	N	Y	N
Behavioral health services	Y	Y	Y	Y	Y	Y
Blood/blood products/related services	Y	Y	Y	Y	Y	Y
Dental services	Y	Y	Y	Y	Y	Y
Diagnostic services (lab and X-ray)	Y	Y	Y	Y	Y	Y
Early and periodic screening, diagnosis, and treatment (EPSDT) services	Y	N	Y	N	Y	N
Enteral nutrition program	Y	Y	Y	Y	Y	Y
Habilitative services	Y	Y	N	N	N	N
Health care professional services	Y	Y	Y	Y	Y	Y
Health homes	Y	Y	Y	Y	N	N
Hearing evaluations	Y	Y	Y	Y	Y	Y
Hearing aids	Y	Y	Y	Y	Y	Y
Home health services	Y	Y	Y	Y	Y	Y
Home infusion therapy/parenteral nutrition program	Y	Y	Y	Y	Y	Y
Hospice services	Y	Y	Y	Y	Y	Y
Hospital services Inpatient/outpatient	Y	Y	Y	Y	Y	Y
Intermediate care facility/services for persons with intellectual disabilities	Y	Y	Y	Y	Y	Y
Maternity care and delivery services	Y	Y	Y	Y	Y	Y
Medical equipment, supplies, and appliances	Y	Y	Y	Y	Y	Y
Medical nutrition therapy	Y	N	Y	N	Y	N
Nursing facility services	Y	Y	Y	Y	Y	Y
Organ transplants	Y	Y	Y	Y	Y	Y
Orthodontic services	Y	N	Y	N	Y	N

Out-of-state services	Y	Y	Y	Y	Y	Y
Outpatient rehabilitation services (OT, PT, ST)	Y	Y	Y	Y	Y	N
Personal care services	Y	Y	Y	Y	N	N
Prescription drugs	Y	Y	Y	Y	Y	Y
Private duty nursing	Y	Y	Y	Y	Y	Y
Prosthetic/orthotic devices	Y	Y	Y	Y	Y	Y
Reproductive health services	Y	Y	Y	Y	Y	Y
Respiratory care (oxygen)	Y	Y	Y	Y	Y	Y
School-based medical services	Y	N	Y	N	Y	N
Vision care Exams, refractions, and fittings	Y	Y	Y	Y	Y	Y
Vision hardware Frames and lenses	Y	N	Y	N	Y	N

Figure 2: Service Categories

Service	Service Category
SUD SERVICES	
Level 1 WM Ambulatory withdrawal management without extended onsite monitoring.	Outpatient
Level 2 WM Ambulatory withdrawal management with extended onsite monitoring.	Outpatient
Level 3.1 Clinically Managed, Low Intensity Residential Services	Inpatient
Level 3.2 WM Clinically managed Residential Withdrawal Management.	Inpatient
Level 3.3 Clinically Managed, Population Specific, High Intensity, Residential Services.	Inpatient
Level 3.5 Clinically Managed, Medium Intensity Residential Services	Inpatient
Level 3.7 WM Medically monitored inpatient withdrawal management.	Inpatient
Alcohol/Drug Screening and Brief Intervention	Outpatient
Case Management Services	Outpatient
Laboratory Services	Outpatient
Level 1 Outpatient Services	Outpatient

Level 2.1 Intensive Outpatient Services	Outpatient
MENTAL HEALTH SERVICES	
Crisis Services	Emergency
Freestanding Evaluation and Treatment	Inpatient
Psychiatric Inpatient Services	Inpatient
Brief Intervention Treatment.	Outpatient
Day Support	Outpatient
Family Treatment	Outpatient
Group Treatment Services	Outpatient
High Intensity Treatment	Outpatient
Individual Treatment Services	Outpatient
Intake Evaluation	Outpatient
Medication Management	Outpatient
Medication Monitoring	Outpatient
Mental Health Services provided in Residential Settings	Outpatient
Peer Support	Outpatient
Psychological Assessment	Outpatient
Rehabilitation Case Management	Outpatient
Special Population Evaluation	Outpatient
Stabilization Services	Outpatient
Therapeutic Psychoeducation	Outpatient
Crisis Triage	Inpatient
Crisis Stabilization (Inpatient)	Inpatient
Crisis Stabilization (Outpatient)	Outpatient

Figure 3: Service Categories for Mental Health Benefits

BH Service Codes				
CPT® Code	**Short Description**	**IP/OP/PH/C***	**HCA**	**HCA Limits/EPA/PA**
90785	Psytx complex inter-active	IP/OP	HCA	
90791	Psych diagnostic evaluation	IP/OP	HCA	One per client, per provider, per calendar year
90792	Psych diag eval w/med srvcs	IP/OP	HCA	One per client, per provider, per calendar year
90832	Psytx pt&/family 30 minutes	IP/OP	HCA	
90833	Psytx pt&/fam w/e&m 30 min	IP/OP	HCA	
90834	Psytx pt&/family 45 minutes	IP/OP	HCA	
90836	Psytx pt&/fam w/e&m 45 min	IP/OP	HCA	
90837	Psytx pt&/family 60 minutes	IP/OP	HCA	
90838	Psytx pt&/fam w/e&m 60 min	IP/OP	HCA	
90845	Psychoanalysis	IP/OP	HCA	
90846	Family psytx w/o patient	IP/OP	HCA	
90847	Family psytx w/patient	IP/OP	HCA	
90849	Multiple family group psytx	IP/OP	HCA	
90853	Group psychotherapy	IP/OP	HCA	
96130	Psycho testing by psych/phys	IP/OP	HCA	Limit of two for lifetime. EPA for COE evaluation
96110	Developmental screen	IP/OP	HCA	

96116	Neurobehavioral status exam	OP	HCA	PA
96132	Neuropsych test by psych/phys	OP	HCA	EPA, PA if EPA does not apply
96138	Neuropsych testing by tech	OP	HCA	EPA, PA if EPA does not apply