Washington State Health Care Authority

Washington State Parity Analysis

October 2, 2017

As required by:

Mental Health Parity and Addiction Act (MHPAEA) Regulations

Washington State Parity Analysis

Medicaid Program Operations and Integrity
P. O. Box 45530
Olympia, WA 98504
Phone: (360) 725-2053
Fax: (360) 586-9551
www.hca.wa.gov

Behavioral Health Administration
P.O. Box 45330
Olympia, WA 98504-5330
Phone: (360) 725-1400
Fax: (360) 725-2280
www.dshs.wa.gov/bha/division-behavioral-health-and-recovery

Table of Contents

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 and treatment limitations 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 initial parity analysis is due by October 2, 2017. This report is meant to meet the analysis and reporting requirements of MHPAEA.

The 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.

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 does delegate 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, provides SUD services and more intensive MH services to an acute and/or chronic population. DBHR contracts with Behavioral Health Organizations (BHOs) to administer these services. A recipient who does not meet the threshold for this higher level of care can access lower tiered mental health services. HCA oversees lower tiered MH services through contracts with Managed Care Organizations (MCOs) and the fee-for-service (FFS) system.

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

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 outlines a six-year system transformation process that will:

- Move provision of SUD services to BHOs.
- Require managed care contracts to ensure integrated service delivery between primary care and behavioral health settings.
- Direct HCA and DSHS to jointly establish common Regional Service Areas for behavioral and physical health care purchasing.

The Southwest Regional Service Area chose to adopt the fully integrated model in April of 2016. The North Central region is expected to move to full integration in January 2018. SB 6312 requires all remaining regions to adopt this approach by January 2020. In these fully integrated regions, HCA contracts with MCOs for the full scope of Medicaid M/S, MH, and SUD services.

The parity analysis includes an in-depth review of both the lower and higher levels of BH services in our state. To ensure inclusiveness in our analysis, DBHR and HCA partnered with, and elicited participation and feedback from allied systems and providers. This included presenting and soliciting feedback at statewide BHO Administrator meetings and scheduling regular technical assistance calls with MCOs.

Benefit Packages

Managed Care

Washington State has multiple Medicaid funded benefit packages with a behavioral health benefit. Attachment 1 includes a summary of the various benefit packages. Despite the variety of benefits available, the state relies upon the same managed care entities (MCOs and BHOs) 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 and BHOs as other Medicaid enrollees. ABP behavioral health benefits are the same as those in the traditional Medicaid program. Because CHIP and ABP are managed by the MCOs and BHOs, these benefit packages are included in the analysis.

Benefits are managed as described below:

- M/S Benefits: Managed by five MCOs across the state.
- Lower Level (Less Intense) MH Benefits: Managed by five MCOs.
- Higher Level (More Intense) MH Benefits: Managed by the BHOs in nine regions across the state. In the Fully Integrated Managed Care (FIMC) region, two MCOs manage this benefit.
- SUD Benefits: Managed by the BHOs in nine regions across the state. In the FIMC region, two MCOs manage this benefit.

Because the MCOs and BHOs oversee all managed care benefits, the state obtained the necessary information for the managed care portion of the parity analysis from these entities, simplifying the information gathering process. The analysis compared treatment limitations between the following managed care entities:

- MCO M/S limitations to BHO BH limitations.
- MCO M/S limitations to MCO BH limitations.

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 analysis, 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.

This approach approximates the state’s management of M/S and BH benefits. In most of the state, BHOs oversee most of the higher-intensity MH and all the SUD benefits, including the majority of the diagnoses listed in Chapter 5 of the ICD-10-CM. MCOs manage the M/S benefits and the remaining covered diagnoses in other sections of the ICD-10-CM. When a disorder affects both M/S and BH, the MCO system covers the M/S benefit, while the BH system addresses the MH or SUD treatment. In the fully integrated region, the MCOs cover all benefits.

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 and BHOs 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 and BHOs 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 1: Service Categories for BHO Regions lists, by benefit category, all MH and SUD state plan services covered by the BHO system.

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

The state implemented a two-step process for determining parity between the BH and M/S benefits. A questionnaire was sent to all BHOs and MCOs asking them to identify any treatment limitations related to BH services. For BHOs this included higher level MH benefits and all statewide SUD benefits. The MCOs were asked to describe any limitations related to the lower level MH benefits they manage. The two MCOs in the fully integrated region were asked to address the full range of MH and SUD services. The BHOs and 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.

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

The state reviewed low acuity services contracted through the MCOs and higher level services contracted through the BHOs in non-integrated regions to evaluate 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 and all BHO services. Outpatient NQTL requirements are described below.

BHO Managed Outpatient Benefits

Description of BHO Outpatient NQTLs

All BHOs require prior authorization for all outpatient benefits. There was variation in the justification for this approach, but all BHO agreed that the state contract requires prior authorization for all services. Additionally, some BHOs stated that prior authorization for outpatient services is necessary to prioritize limited and more expensive intensive outpatient services that are partially supplemented by state funding, such as the Program for Assertive Community Treatment (PACT).

Criteria Development and Justification: BHO Outpatient NQTLs

All BHOs utilize the state developed Access to Care Standards (ACS). These standards are incorporated into the state's 1915b Waiver and were developed as a means of determining whether individuals receive MH services in the BHO system (higher levels of care) or the MCO system.

In addition to the ACS, many BHOs use a multi-tiered treatment approach for outpatient MH services. Once it has been determined an individual meets ACS criteria, the individual is assigned to a level of care based on the individual's treatment needs. Each level has specific treatment expectations, including frequency and intensity of treatment. Several BHOs use the Level of Care

Utilization System (CA/LOCUS) to determine placement. The LOCUS is a nationally accepted, standard approach to level of care placement. Other BHOs utilize regionally developed level of care guidelines.

SUD treatment is based on the American Society for Addiction Medicine (ASAM) criteria. The ASAM criteria is widely accepted and used nationally as a means for determining levels of care for SUD treatment.

Frequency and Stringency of BHO Outpatient NQTLs

Both initial treatment and ongoing care require authorization. While the frequency of authorization varies across BHOs, re-authorization is required every six months in most cases.

If the individual does not meet authorization requirements, they will not receive BHO-funded outpatient services, and are referred to treatment elsewhere. This could include treatment through the lower-level MH benefit managed by the MCOs.

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.

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.

FIMC Region Outpatient Benefits

In the FIMC region, the two MCOs manage all BH benefits. The two MCOs in this region use the same approach described in the MCO section above. Most BH outpatient benefits do not require prior authorization.

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 service will not be reimbursed/covered. Upon denial a provider may seek a peer-to-peer consultation to discuss denial. A client may request a hearing. The state covers all services deemed medically necessary unless they are in non-covered. Medical-necessity is determined and informed by rule (WAC 182-501-0165).

Summary of Outpatient Benefits Analysis

The BHO system requires authorization for all outpatient services. This is due to state requirements and a need to manage limited, higher cost services. The M/S system also requires authorization for higher cost services, but not for other outpatient services. This disparity will be addressed in the "Summary of Parity Analysis and Planned Changes" section, below.

Inpatient Benefit Analysis

As in the outpatient analysis, the only NQTL identified for inpatient BH was the requirement that providers obtain prior authorization before services begin. NQTLs are described below, categorized by which organization manages the benefit.

BHO Managed Inpatient BH Benefits

Description of BHO Inpatient NQTLs

The BHOs manage the inpatient BH benefit in all but one region of the state. BHOs require prior authorization for all inpatient services. The prior authorization process involves calling a 24/7 number to request voluntary inpatient authorization.

Criteria Development and Justification: BHO Inpatient NQTLs

The statewide inpatient billing guide developed by HCA is used in all regions. The guide includes a standard approach for authorizing and billing inpatient services for both MH and M/S. The guide includes a definition of medical necessity. BHOs and MCOs utilize a clinical information gathering approach to determine medical necessity. This approach determines if the individual is in need of voluntary inpatient MH treatment and focuses on determining safety and whether there are less restrictive treatment options available.

Inpatient treatment is the most intensive and costly BH benefit. The state and the BHOs have developed less restrictive alternatives to inpatient treatment, including crisis stabilization and triage centers. The authorization process includes making sure lower levels of care are not more appropriate.

Criteria for inpatient SUD treatment is based on the American Society for Addiction Medicine (ASAM) criteria statewide. ASAM is a widely accepted, national standard for determining which level of SUD treatment an individual needs.

Frequency and Stringency of BHO Inpatient NQTLs

The number of inpatient days authorized depends on the individual's clinical presentation. If an individual does not meet criteria, the facility is not paid for the treatment provided. The state requires BHOs to follow a standardized appeals process.

MCO Managed Inpatient BH Benefits

MCOs, except those in the FIMC region do not manage inpatient BH benefits.

FIMC Region Inpatient BH Benefits

Description of FIMC Region Inpatient NQTLs

The two MCOs in the FIMC region manage inpatient BH benefits. No authorization is required for admission; ongoing inpatient care does require authorization.

Criteria Development: FIMC Region Inpatient NQTLs

Like the BHOs, the two MCOs in the FIMC region 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

Like the BHOs, the number of inpatient days authorized depends on the individual's clinical presentation. If an individual does not meet criteria, the facility is not paid for the treatment provided. 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), 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 PA 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 service will not be reimbursed/covered. Upon denial a provider may seek a peer-to-peer consultation to discuss denial. A client may request a hearing. We cover all services deemed medically necessary unless they are in non-covered. Medical-necessity is determined and informed by rule (WAC 182-501-0165).

M/S Benefits: The MCOs require prior authorization for all non-emergent inpatient benefits. Inpatient services are more expensive and authorization is a means to ensure medical necessity criteria are met.

Summary of Inpatient Benefit Analysis

The state determined that parity exists for inpatient NQTLs, as both the BH and M/S systems require authorization for all inpatient services.

Emergency Benefit Analysis

Emergency BH services are managed by the BHOs in the non-integrated regions of the state and by the MCOs in the FIMC region. The BHOs and 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

Unlike other services described in this report, the Covered Outpatient Drug benefit is not affected by the distinctions between MCO and BHO delivered services, as all drugs are provided under MCO and FFS programs (with the exception of methadone provided in a SAMHSA certified opioid treatment program). For this same reason, Covered Outpatient Drugs will be unaffected by future benefit integration.

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. 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.

Pharmacy benefits and the pharmacy industry are generally managed similarly across all types of payers. Apple Health's FFS program and MCOs all reflect this by having substantially similar processes for establishing utilization management policies, which represent the only form of NQTLs in place within the pharmacy benefit. The utilization management process usually begins with the identification of drugs with high risk, high potential for inappropriate use, or high cost. Utilization data is assessed to determine whether there are possible opportunities to promote safety and cost-effectiveness through the use of NQTLs. Drug Utilization Review (DUR) Boards or Pharmacy and Therapeutic (P&T) committees 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.

It is of note that while HCA generally allows MCOs to develop their own formularies and criteria, many MH and BH drugs have specific contract provisions dictating how these products are covered. Parity has been addressed historically as problems were identified, and MCOs are specifically directed how to cover MH drugs in a way that does not allow disparity to develop.

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

BHO/FIMC Outpatient BH Provider Contracting and Geographic Limitations

Because BHOs in the non-integrated region, and MCOs in the FIMC region, are funded to manage BH services within a specified geographical area, they only contract with outpatient service providers within their region. If an individual lives closer to a provider in another county, some BHOs develop cross-county agreements so that individuals can receive services closer to home.

BHOs only contract with licensed MH or SUD agencies, not individual contractors. BHO services are the most intensive level of care available to BH clients, requiring a level of service not available through individual (non-agency) clinicians.

MCO Outpatient BH Contracting and Geographic Limitations

MCOs manage the lower intensity MH benefit, and contract with licensed mental health providers throughout the state, as long as the provider is paneled with the MCO.

BHO/FIMC Inpatient Provider Contracting and Geographic Limitations

BHOs and the two MCOs in the FIMC region pay for inpatient MH and SUD treatment from licensed SUD and MH inpatient facilities within the state. Per statewide inpatient billing instructions, the BHOs and 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 in the BHO/FIMC inpatient section above.

Out of Network Benefits

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

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 in either the BHO or MCO BH systems.

Availability of Information Requirements

In addition to the parity requirements described above, states must 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. 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 BHOs and 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 BHOs and 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 CFR 438.04. This requirement is included in the BHO and MCO Medicaid contracts.

Summary of Parity Analysis and Planned Changes

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.

The one area of concern raised by this analysis is the outpatient BH benefit managed by the BHO system. BHOs require all outpatient services to be prior authorized, while very few outpatient services in the M/S benefit require prior authorization.

A disparity exists, not because the BHOs require prior authorization on some benefits, but because all BHO outpatient benefits require prior authorization, while very few M/S outpatient benefits have the same requirement. Because the M/S system requires prior authorization for some of the most intensive or costly outpatient benefits, this leaves open the option for BHOs to do the same.

In order to address this disparity, the state met with the BHO administrators to discuss removing the prior authorization requirement from outpatient services. While the administrators accepted the need to remove prior authorization for most outpatient services, there were concerns about the effect this would have on other aspects of their system. For example, data from the current outpatient authorization process is used by the state for various quality and performance measurement activities.

In order to rectify the discrepancy between the outpatient BH and M/S benefits, the state will remove the language in BHO contracts that requires initial authorization for all outpatient services. The contract language will allow authorization of some of the highest intensity services, such as the Program for Assertive Community Treatment (PACT). Allowing the BHOs to require prior authorization for some, but not all, of their outpatient benefit brings that system in alignment with the outpatient M/S benefit.

The state will incorporate these changes into the January 2018 BHO contracts. This allows time for contract negotiation, execution, and submission to CMS. In the coming weeks, the state will meet with BHOs to better define which high-intensity outpatient services may require additional authorization (e.g. PACT) and to identify data and operational changes.

The state does not anticipate a need to change the state plan to accommodate this new approach. The BH section of the state plan makes no mention of an authorization process for outpatient BH services.

Timeline for Changes Due to Washington State's Parity Analysis

- September 2017: Begin meeting with BHOs to identify operational issues related to removal of outpatient BH authorization process for some services.

- October 2017: Begin working on contract updates related to outpatient authorization changes.
- November/December 2017: Conclude meetings with BHOs regarding operational changes related to outpatient authorization.
- January 2018: Effective date for new contracts implementing outpatient authorization changes.

Ongoing Monitoring Activities

The state will review the parity analysis on an annual 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.

Plans for Community Outreach and Education

In an effort to support and sustain parity efforts in Washington State, HCA and DSHS have partnered with our colleagues at the Office of the Insurance Commissioner (OIC) to strategically coordinate our outreach and education efforts.

We have identified both short term and long term strategies to raise awareness of the importance of behavioral health parity and to help identify potential parity concerns. Our target groups include 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. A few of the specific efforts for outreach and education are listed below.

Short Term

In the short term we have identified key entities that we are partnering with to provide parity presentations to, such as:

- Washington State Behavioral Health Advisory Council: This council includes consumers, providers, advocates, government representatives, and other private and public entities. The membership represents the state's population with respect to race, ethnicity, disability, and age, urban and rural. The focus of this council is with the need, planning, operation, funding and use of services for mental health, substance use and gambling disorders.
- National Alliance on Mental Illness (NAMI)-Washington: We will be hosting a panel presentation at the 2017 annual conference to raise awareness of compliance efforts and to solicit input on future plans. We believe an ongoing partnership with NAMI will be key in ensuring an effective parity future for Washington.

Long Term

Learning from best practices presented from other states at the Parity Policy Academy, we are in the developmental stage of establishing a behavioral health parity advisory committee. The committee will review behavioral health parity issues across Medicaid, CHIP and commercial health insurance plans. The committee will advise us and act as a “focus group” as we develop our outreach and education plan and materials.

Appendix

Figure 1: Medicaid State Plan Benefit Packages

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						
• Mental health (MH) inpatient care	Y	Y	Y	Y	Y	Y
• MH outpatient community care	Y	Y	Y	Y	Y	Y
• MH psychiatric visits	Y	Y	Y	Y	Y	Y
• MH medication management	Y	Y	Y	Y	Y	Y
• Substance use disorder (SUD) detoxification	Y	Y	Y	Y	Y	Y
• SUD diagnostic assessment	Y	Y	Y	Y	Y	Y
• SUD residential treatment	Y	Y	Y	Y	Y	Y
• SUD outpatient treatment	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

Service Categories	ABP 20-	ABP 21+	CN1 20-	CN 21+	MN 20-	MN 21+
Early and periodic screening, diagnosis, and treatment (EPSDT) services	Y	N	Y	N	Y	N
Habilitative services	Y	Y	N	N	N	N
Health care professional services	Y	Y	Y	Y	Y	Y
Hearing evaluations	Y	Y	Y	Y	Y	Y
Hearing aids	Y	N	Y	N	Y	N
Home health services	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, durable (DME)	Y	Y	Y	Y	Y	Y
Medical equipment, nondurable (MSE)	Y	Y	Y	Y	Y	Y
Medical nutrition services	Y	Y	Y	Y	Y	Y
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

Service Categories	ABP 20-	ABP 21+	CN1 20-	CN 21+	MN 20-	MN 21+
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 for BHO Regions

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 FIMC Regions and "Lower Level" Mental Health Benefits

BH Service Codes Jan 1/2017				
CPT® Code	**Short Description**	**IP/OP/PH/C***	**HCA/BHA**	**HCA Limits/EPA/PA**
90785	Psytx complex inter-active	IP/OP	HCA/BHA	
90791	Psych diagnostic evaluation	IP/OP	HCA/BHA	One per client, per provider, per calendar year
90792	Psych diag eval w/med srvcs	IP/OP	HCA/BHA	One per client, per provider, per calendar year
90832	Psytx pt&/family 30 minutes	IP/OP	HCA/BHA	
90833	Psytx pt&/fam w/e&m 30 min	IP/OP	HCA/BHA	
90834	Psytx pt&/family 45 minutes	IP/OP	HCA/BHA	
90836	Psytx pt&/fam w/e&m 45 min	IP/OP	HCA/BHA	
90837	Psytx pt&/family 60 minutes	IP/OP	HCA/BHA	
90838	Psytx pt&/fam w/e&m 60 min	IP/OP	HCA/BHA	
90845	Psychoanalysis	IP/OP	HCA	

90846	Family psytx w/o patient	IP/OP	HCA/BHA	
90847	Family psytx w/patient	IP/OP	HCA/BHA	
90849	Multiple family group psytx	IP/OP	HCA/BHA	
90853	Group psychotherapy	IP/OP	HCA/BHA	
90865	Narcosynthesis	IP/OP	HCA	
90867	Tcrania magn stim tx plan	IP/OP	HCA	One per client, per year
90868	Tcranial magn stim tx deli	IP/OP	HCA	30 visits in 7-week period followed by 6 taper treatments
90869	Tcran magn stim redetermine	IP/OP	HCA	One per client, per year
90870	Electroconvulsive therapy	IP/OP	HCA	
96101	Psycho testing by psych/phys	IP/OP	HCA/BHA	Limit of two for lifetime. EPA for COE evaluation
96110	Developmental screen	IP/OP	HCA/BHA	
96111	Developmental test extend	OP	HCA/BHA	One per client, per provider, per year
96116	Neurobehavioral status exam	OP	HCA/BHA	PA
96118	Neuropsych tst by psych/phys	OP	HCA/BHA	EPA, PA if EPA does not apply
96119	Neuropsych testing by tech	OP	HCA/BHA	EPA, PA if EPA does not apply