HB 3046-4, Behavioral Health Access Parity

Reporting

This section is focused on enshrining the reporting requirements established in 2017's Senate Bill 860, which required commercial insurers to provide data on their behavioral health benefits and plan management tools to demonstrate compliance with Oregon's mental health parity law and applies those requirements to coordinated care organizations (CCOs).

This section creates definitions for:

- Mental health benefits
- Substance use disorder benefits
- Nonquantitative treatment limitation (NQTL)
- Median maximum allowable reimbursement rate (MMARR)

This section aligns Oregon statue with federal reporting laws by requiring the below entities to conduct an annual analysis of the design and application of medical necessity criteria and benefit limitations on mental health and substance use disorder benefits in comparison to medical and surgical benefits and submit those analyses to the relevant agencies.

- **CCOs must submit a report to the Oregon Health Authority by June 1st of each year the following information:**
  - A description of how each CCO developed their medical necessity criterial for mental health and substance use disorder benefits, and medical and surgical benefits.
  - A description of all NQTLs placed on mental health benefits and substance use disorder benefits, and medical and surgical benefits.
  - The number of denials of coverage and the percentages of denials that were appealed, overturned, and upheld.
  - The percentage of claims paid to in-network and out-of-network providers.

- **Commercial Insurers must submit a report to the Department of Business and Consumer Services by March 1st of each year the following information. *Italicized requirements have a 3-year sunset*:**
  - A description of how each carrier developed their medical necessity criterial for mental health and substance use disorder benefits, and medical and surgical benefits.
  - A description of all NQTLs placed on mental health benefits and substance use disorder benefits, and medical and surgical benefits.

- An analysis of the processes/strategies/specific evidentiary standards used to design, determine applicability, and apply NQTLs to mental health and substance use disorder benefits in comparison to medical and surgical benefits, including the factors considered but rejected.
- An analysis that shows that the design and the processes/strategies used for the determination of applicability of the NQTLs for mental health and substance use disorder benefits were applied no more stringently than for medical and surgical benefits.
- *The number of denials of coverage and the percentages of denials that were appealed, overturned, and upheld.*
- *The percentage of claims paid to in-network and out-of-network providers.*
- *The MMARR for each bill code for in-network behavioral health providers (psychiatrist, psychologists, LPCs, LMFTs, LCSWs, PMHNPs, MDs, PAs, and NPs), indicating whether percentage increases in rates for behavioral health providers were equivalent to those for medical and surgical providers.*
- *Reimbursement rate and percentage of Medicare rates an insurance plan reimburses each mental health CPT code for the behavioral health providers listed above.*

- **Oregon Health Authority must:**
  - Report to the relevant interim committees on the data received by October 4th of each year, assessing parity between the Oregon Health Plan's mental health and substance use disorder benefits and medical and surgical benefits.
    - The assessment will include a review of network adequacy, criteria used to determine medical necessity and benefit coverage, and credentialing requirements and utilization management among CCOs.
    - An analysis of the processes/strategies/specific evidentiary standards used to design, determine applicability, and apply NQTLs to mental health and substance use disorder benefits in comparison to medical and surgical benefits, including the factors considered but rejected.
    - An analysis that shows that the design and the processes/strategies used for the determination of applicability of the NQTLs for mental health and substance use disorder benefits were applied no more stringently than for medical and surgical benefits.

- **Department of Business and Consumer Services must:**
  - Report the findings of the carrier's analyses to the relevant interim committees on the data received by September 15th of each year.

<u>Behavioral Health Parity Mandate Improvements</u>

Much of this section is focused on defining parity in line with the ruling from the United States District Court of the Northern District of California in *Wit v. United Behavioral Health, 2019 WL 1033730 (Wit; N.D.CA Mar. 5, 2019).* This decision made clear that behavioral health coverage and benefits must be provided no more restrictively than for medical and surgical coverage.

Critical to the definition of parity is ensuring that patients and families have access to benefits that treat the underlying causes that drive crises. It is also critical that benefit determinations are made using generally accepted standards of care that are specific to behavioral health and that patients and families have access to care that truly meets their need as determined by evidence-based, multidimensional assessments.

This section makes requirements for CCOs and commercial insurers to clarify and strengthen Oregon's mental health parity laws, with the goal of ensuring that Oregonians can access needed behavioral health care similar to how they access physical care. Regardless of geographic location or specialty need or insurance carrier.

- **CCOs must provide the following coverage:**
    - Behavioral health services that include treatment of co-occurring BH disorders or medical conditions in a coordinated manner.
    - Level of care placement that is consistent with a member's score or assessment using the relevant level of care criteria, including treatment at the least intensive and least restrictive level of care appropriate, so long as it is safe, effective, meets the needs of the individual's condition.
    - Include treatment to maintain function/prevent deterioration, for the appropriate duration based on an individual's needs, and culturally and linguistically appropriate treatment, and treatment appropriate to the needs of children/adolescents/seniors/older adults/LGBTQIA individuals.

- **CCOs and Utilization Management:**
    - CCOs may not require prior authorization on a list of behavioral health treatments and services established in OHA rule.
    - CCOs must provide the behavioral health treatment provider with the details of the organization's scoring or assessment if there is a disagreement about the level of care required for a member.

- **Commercial Insurers must provide the following coverage:**
    - Coverage of expenses for behavioral health conditions and generally accepted standards of care at the same level and subject to the same limitations (utilization management, copayments, etc.) as coverage for other medical conditions.
    - Coverage based on the specific needs of the patient to effectively treat underlying behavioral health conditions.
    - Behavioral health services that include treatment of co-occurring BH disorders or medical conditions in a coordinated manner.
    - Include treatment at the least intensive and least restrictive level of care appropriate, so long as it is safe, effective, meets the needs of the individual's condition and is comparable effective as a higher level/service/intensity treatment.
    - Include treatment to maintain function/prevent deterioration, for the appropriate duration based on an individual's needs, and treatment appropriate to the needs of children/adolescents.

- Have a network of providers sufficient to timely deliver behavioral health treatment within the geographic area of enrollees. If that is not possible, carriers must provide coverage of out-of-network services without additional out-of-pocket costs, so long as an out-of-network provider is willing to accept in-network rates.

- **Commercial Insurers and Reimbursement**
  - Must update reimbursement methodology for behavioral health treatment providers at a commensurate frequency to that used for medical and surgical treatment providers, unless otherwise directed by federal regulations.
  - Cannot require providers to bill with specific billing codes or restrict reimbursement to particular codes, unless based on medical necessity. This provision is aimed specifically at the carriers restricting the use of 60 min services by providers.

- **Commercial Insurers and Utilization Management:**
  - Cannot limit coverage for treatment of pervasive or chronic behavioral health conditions to short-term or acute treatment at any level of care.
  - Must base any medical necessity of utilization review for the diagnosis, prevention or treatment of behavioral health conditions, including service intensity, level of placement, continued stay or discharge:
    - Generally accepted standards of care
    - Most recent versions of levels of care placement criteria developed by relevant nonprofit professional associations.
  - Can use criteria and guidelines outside scope of criteria but development in a similar manner or based on advancements in technology and types of care.
  - Must provide the behavioral health treatment provider with the details of the carrier's scoring or assessment if there is a disagreement about the level of care required for the insured.
  - Carriers sponsor a one-time formal education program to educate their staff and make that program available to other stakeholders.
  - Nothing in this bill prohibits a consumer from choosing to access behavioral health treatment out-of-network, nor does it prohibit the consumer and provider to agree upon, and the consumer to pay, a fee amount that is above the out-of-network fee reimbursed by insurance.
  - Nothing in this bill prohibits a carrier from utilizing value-based payment methodologies.

<u>Network Adequacy</u>

This section is focused on ensuring that insurance networks have the adequate number and types of providers to treat the needs of their enrollee population. Currently, Oregonians struggle to access behavioral health providers because panels are too small, they include providers not taking new patients or without the specialties required to treat the enrollee needs.

- **Commercial Insurers must:**

- Have an adequate number and distribution of behavioral health provider types (LPCs, LMFTs, LCSW, psychiatric NP, psychologists and psychiatrists) accepting new patients and able to treat the specific and specialized behavioral health needs of their enrollees.