California Advocacy Update for Autism Service Providers

Insurance Regulation, Laws, and MHPAEA: What providers need to know

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The Council of Autism Service Providers

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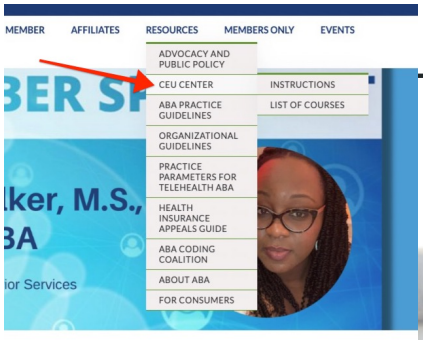

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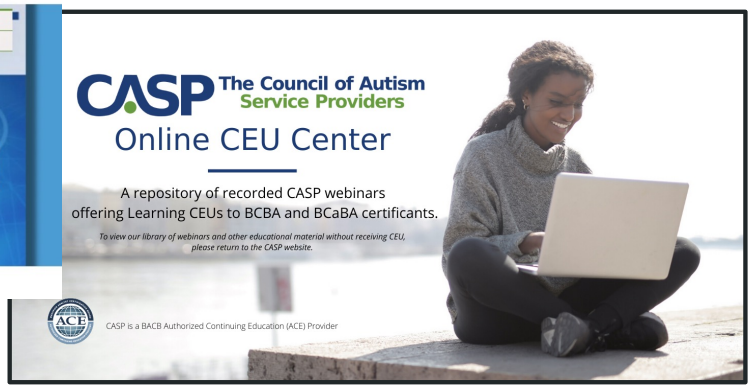

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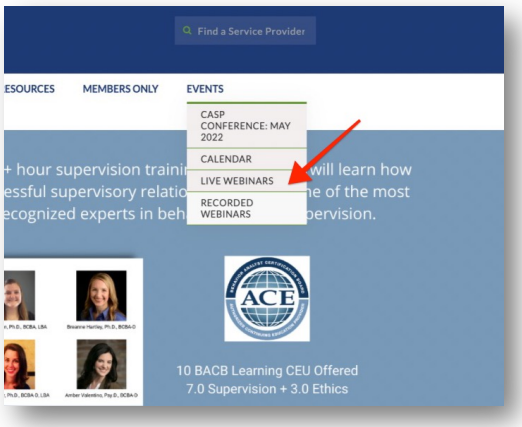


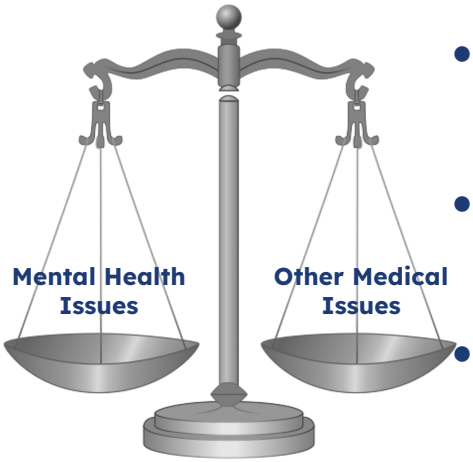
Housekeeping

Please submit your questions and monitor for responses in the **Q&A box**

Please limit use of the **chat box** for comments

There are 1.5 Learning CEUs for this webinar

Mental Health Parity and Addiction Equity Act (MHPAEA)



- Wellstone Domenici Mental Health Parity and Addiction Equity Act (MHPAEA)
- Coverage of mental health conditions "on par" with coverage of medical/surgical conditions
- "Parity" ensures mental health issues are taken as seriously as other medical issues

(Mental Health Parity and Addiction Equity Act, [MHPAEA], 2008)

Prohibits limits *not on par* with other medical conditions…

- Prohibits **quantitative** treatment limits if not applied to coverage for medical/surgical benefits
- Prohibits **non-quantitative** treatment limits unless they are comparable to standards with respect to medical/surgical benefits

(Mental Health Parity and Addiction Equity Act, [MHPAEA], 2008)

Types of Limits

Quantitative Treatment Limits (QTLs)	Non-Quantitative Treatment Limitations (NQTLs)
Limit of number visits per year	Medical management/**medical necessity criteria**
Maximum dollar value on benefit	Provider admission standards, reimbursement formulas
Limit of treatment hours	Treatment plan requirements
Age caps	Caregiver participation requirements
Formulas	Conditioning coverage on likelihood of improvement within set time period
	Review procedures
	Treatment setting limits (schools)

(Mental Health Parity and Addiction Equity Act, [MHPAEA], 2008)

Importance of MHPAEA

- Medical Necessity
- Treatment Plan
- Treatment Evaluation

Medical Necessity

- AMA definition of medical necessity
  - In accordance with **generally accepted standards** of care
  - Clinically appropriate
  - **Not primarily for the economic benefit or convenience**
  - Physicians are able to use their expertise and exercise discretion, consistent with good medical care

AAP Policy Statement of Medical Necessity

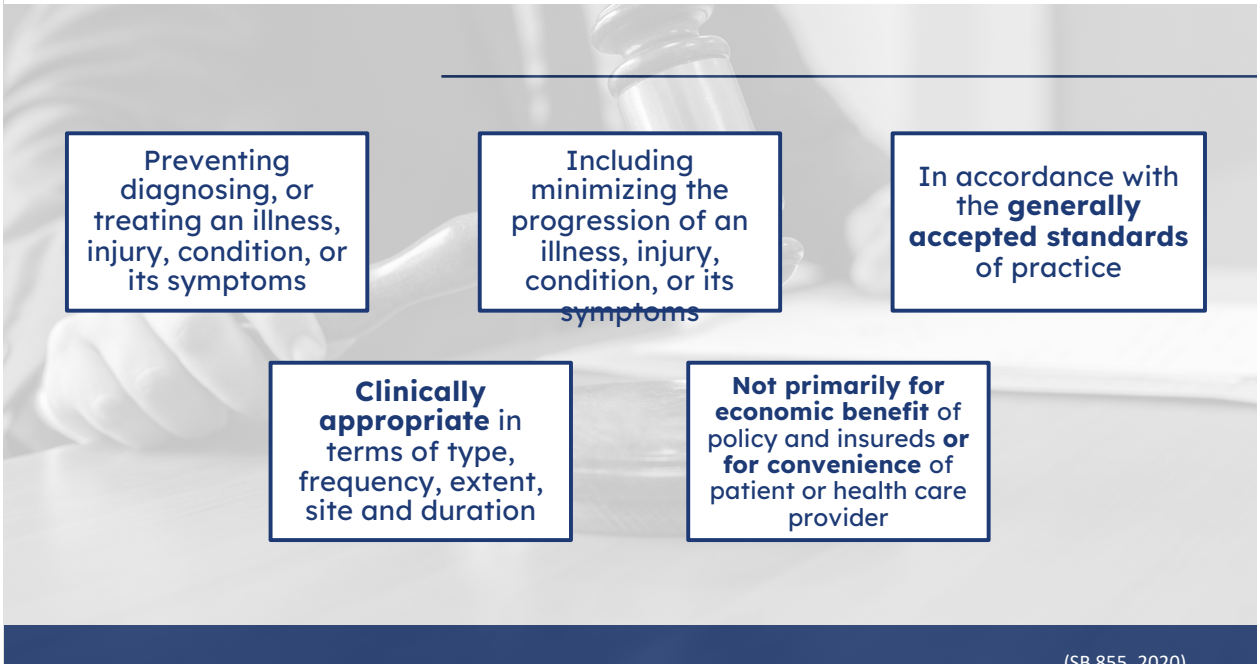
Scope of Health Problems

Evidence of Effectiveness

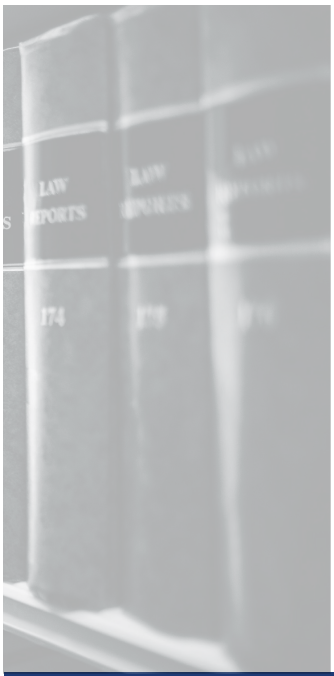
Values

(American Academy of Pediatrics [AAP], 2005).

California's SB 855 - 2020



(SB 855, 2020)



California's SB 855 - 2020

Medical necessity determination or utilization review criteria:

- Current **generally accepted standards** of mental health care
- Expands state mental health parity act to **all DSM conditions**
- Not limit services on basis that those services should/could be covered by a public entitlement program

(SB 855, 2020)

CA SB 855: Generally Accepted Standards

- Treats underlying conditions
- Safe
- Meets needs of the condition
- Maintains functioning or prevent deterioration
- Accounts for unique needs of children and adolescents
- Duration based on patient need

(SB 855, 2020)

CA SB 855: Take Away

Requires health care service plan/entity acting on plans behalf to…

- apply current **generally accepted standards** of mental health disorders…
- when determining medical necessity and utilization review criteria…
- under same terms and conditions applied to other medical conditions…
- California Mental Health Parity Act includes broader definition of mental health conditions, including and applicable to autism

(SB 855, 2020)

Adaptive Skills and Medical Necessity

- Build adaptive behaviors & enhance health, safety, and overall functioning and/or prevent deterioration or regression
- Aligns with ABA Coding Coalition's Model Coverage Policy
- Reflects and encompasses definitions from CMS and Medicaid EPSDT mandate
- Consistent with its inclusion within AMA and AAP's medical necessity definitions
- Clearly described within SB 855 mental health parity law
- **However…**

Payers Definitions of Medical Necessity

- Have their own definitions; defined in various ways
- Many limit to treatment of core symptoms; goals required to be directly tied to core symptoms
- Often contradicts generally accepted definitions and the CPT code definitions
- Providers must comply with their contract with payers and need to get paid
- **But…**

Our Responsibility

1. Educate payers
2. Advocate opportunity for optimal services
3. Avoid acceptance of restrictive payer policies without question
4. Avoid a force-fit of all client goals into narrow definition
5. Share information with state regulators

Legislation and Regulation

- Medical necessity →
- Preventing deterioration/further disability
- Maintenance of functioning
- Restoration to best possible functional level
- Decreasing current/potential risk
- Improving quality of life

Generally Accepted Standards of Care

California Department of Insurance is developing **regulations** specific to SB 855.

Regs state that "*clinical criteria developed by the following **nonprofit professional associations**, and any other nonprofit professional associations that are not specified in this subdivision, **shall be used exclusively** to make utilization review coverage determinations that are within the scope of the criteria …..*
*- **Council of Autism Service Providers**"*

Generally Accepted Standards of Care

All Plan Letter - January 2021

Plans must "Affirm all new nonprofit professional association clinical criteria have been fully implemented into MH/SUD utilization review.
*• Affirm how the plan will comply/has complied with section 1374.721(e), education and training materials. **The plan should affirm it has engaged with each of the nonprofit associations to sponsor a formal education program, provide timelines for implementation, and what plan staff is taking or will take the training.** Affirm education and training materials will be made available to other stakeholders including providers and enrollees."*

Generally Accepted Standards of Care

CASP provided public comment at the Pre-Notice Public Hearing hosted by the Department of Insurance on November 8, 2022

Next step is Proposed Action on Rulemaking, where opportunity for official public comment will be given

Enforcement of Laws and Regulation

- Department of Insurance,

  CA Code of Insurance
- Department of Managed Health Care

  Knox Keene Health Care Service Plan Act of 1975
- When a new law or section is added to either law, regulations typically follow
- It's up to us to complain

Who Regulates Who?: Ask for Plan Manual

Department of Managed Health Care:

- Regulates most (~95%) CA plans
- Initially just HMOs, then non-profit PPOs (blue plans)
- Shares oversight of Managed Care Medi-Cal Plans with Department of Health Care Services

Department of Insurance:

- Regulates most “Life and Health” Insurance Plans, most non Blue PPOs

CALPERS:

- Regulates non HMO state health plans

Who Regulates Who?: Non CA Plans

Department of Labor (Employment Benefits Security Administration):
Regulates Self-Funded non-government Plans

Office of Personnel Management

- Regulates Federal plans

HHS-CCIIO

- Regulates other self-funded government plans

CHAMPUS and TriCare

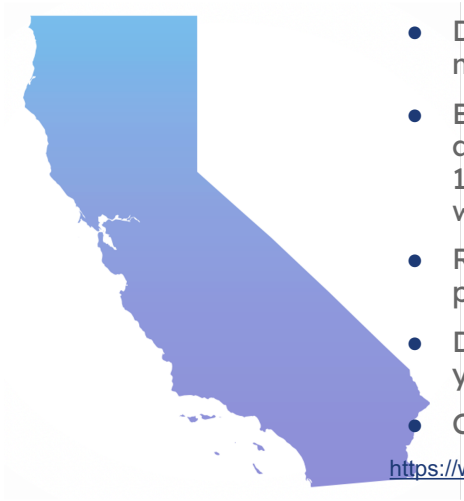
- Military

CA AB 1324: Authorization of Claims

- A health insurer shall not rescind or modify an authorization after the provider renders the health care service **in good faith** and pursuant to the authorization **for any reason**
- This could be used in situations where there is an audit being conducted

(California's DOI)

CA Network Adequacy Laws



- DOI states "mental health providers within 30 minutes or 15 miles of home."
- Both departments require non urgent appointments for mental health providers within 10 days of request, follow up appointments within 10 days of prior visit (new law, SB 221)
- Reasonable access to sufficient number of providers and hospitals
- Do not take take on clients for assessments if you do not have a regular spot for ongoing care
- Continuity of Care – Up to One Year

https://www.insurance.ca.gov/01-consumers/110-health/10-basics/pna.cfm

Knox Keene Health Care Service Plan Act: 1371

Prompt Payment of Claims

- Health plan shall reimburse uncontested claims no later than 30 working days (45 days for an HMO) after receipt of claim
- Plan must identify the portion of the claim that is contested and why
- Interest shall accrue at the rate of 15% per annum (year) and be automatically included with payment

Appeals & State Regulation

CA law requires only one level of appeal. Put it in writing!!!

If urgent (e.g. continued care being reduced), can file expedited with both the plan and CA regulator at the same time. If non-urgent, appeal first and wait 30 days.

Get release from client, and file on their behalf, – they have more rights.

What to include in the appeal letter, here are some suggestions: https://www.mhautism.org/wp-content/uploads/2019/11/ABA-Outline-for-Sample-Appeal-Letter.pdf

Also, a team of advocates, ABA providers and others recently developed the Appeals Playbook: https://www.mhautism.org/requesting-treatments-managing-denials/

Regulatory External Appeal Process

If your standard appeal is denied (usually), you want to take it to the regulator. Fill out the form

- DMHC here: https://wpso.dmhc.ca.gov/imrcomplaint/default.aspx?c=1
- CDI here: http://www.insurance.ca.gov/01-consumers/101-help/index.cfm

Upload relevant documents, including the denial letters, appeal, progress reports, past evaluations, letters from specialists, parent statement, and other items mentioned in letter (prior slide). Okay to include your thoughts on the plan's response to your appeal.

Regulator will process (~ 2 weeks) and send out to external review (if medical necessity is dispute). Reviewed by specialist. Response due in 30 days.

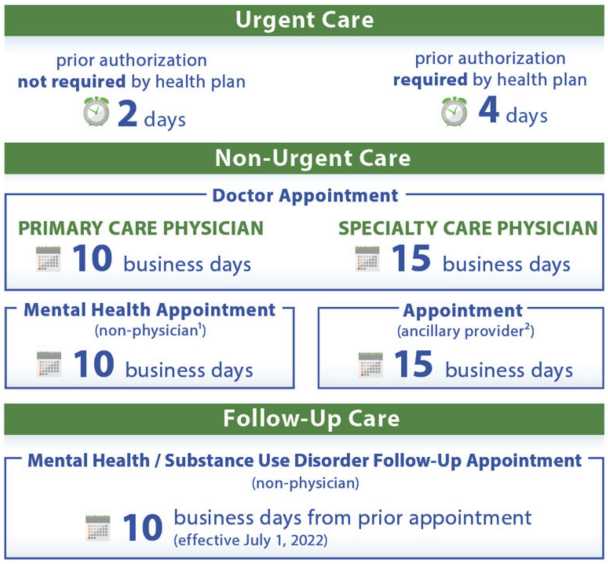
Quick and focussed questions: info@mhautism.org

AB 2581: Credentialing

- Effective January 1, 2023 for contracts issued, amended, or renewed (NOT current contracts)
- Applies to all health plans that provide coverage for mental health and substance use disorders which credential providers
- Assess and verify the qualifications of a healthcare provider **within 60 days** after receiving a completed application

SB 221: Timely Access to Care

Effective July 1, 2022

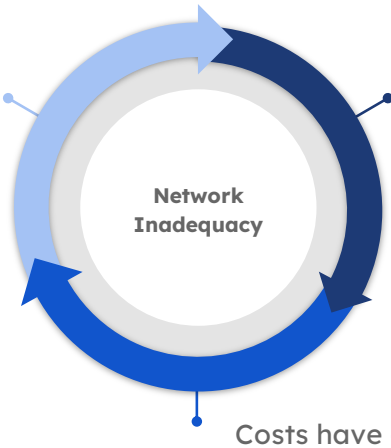


SB 221: A Noble Goal

- Requires health plans, including Medi-Cal, to ensure that an enrollee accessing mental health treatment is able to get a non-urgent initial and follow-up appointment within 10 business days
- Health Plans will expect Providers to abide by these guidelines.
- Providers should document that timely appointments were offered and offered again every 10 business days.
- Section H of the legislation specifies exceptions including **noting in the relevant record** that the longer waiting time will not have a detrimental impact…

SB 221: Reality

Reimbursement rates are largely stagnant resulting in providers not able to provide hourly wages commensurate with current labor market and costs

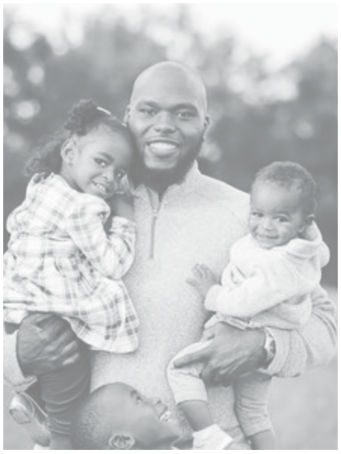


Prevalence of Autism continues to rise resulting in high demand for services

Costs:
Rising minimum wage
Increased PTO
Inflation (gas)
COLA
Increased Compliance
Increased Overhead

Costs have dramatically increased and labor market is still unusually tight

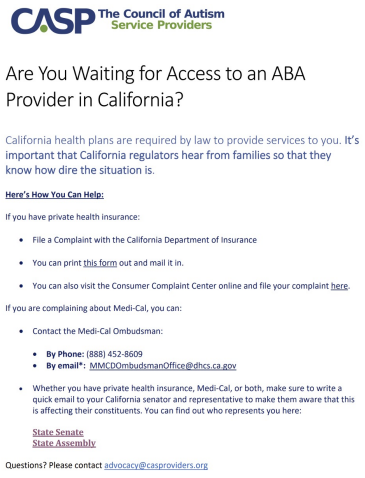
What Can Providers & Families Do?



- Document, document, document!
- Regularly review families not receiving services due to staffing shortages and resignations and offer alternate additional services every 10 days when possible
- Accept intakes and FBAs only when relatively sure you can serve the family
- Single Case Agreements/rate negotiations
- Support families in filing complaints

Change Requires Complaints

- Keep a registry of phone calls by name, date, health plan, plan #, and DOB of clients you cannot serve
- Educate families to file complaints with their plans and regulators when timelines not met
- Awareness of network inadequacy is essential



CASP The Council of Autism Service Providers

Are You Waiting for Access to an ABA Provider in California?

California health plans are required by law to provide services to you. It's important that California regulators hear from families so that they know how dire the situation is.

Here's How You Can Help:

If you have private health insurance:

- File a Complaint with the California Department of Insurance
- You can print this form out and mail it in.
- You can also visit the Consumer Complaint Center online and file your complaint here.

If you are complaining about Medi-Cal, you can:

- Contact the Medi-Cal Ombudsman:
  - **By Phone:** (888) 452-8609
  - **By email*:** MMCDOmbudsmanOffice@dhcs.ca.gov
- Whether you have private health insurance, Medi-Cal, or both, make sure to write a quick email to your California senator and representative to make them aware that this is affecting their constituents. You can find out who represents you here:

  State Senate
  State Assembly

Questions? Please contact advocacy@casproviders.org

Advocacy Collaboration CalABA and CASP

CalABA collecting provider information about

1. Changes in number of employees/patients served
2. Changes in employee wages
3. Changes in authorization utilization
4. Provider capacity and hiring
5. Technician turnover
6. Number of families accepted/turned away

CASP Survey

The Council of Autism Service Providers

Collecting provider information:

- Commercial Insurance Reimbursement Rates
- MediCal Reimbursement Rates

If you are a provider in California, please take **this survey**

Anti-Trust Laws Reminders

The Council of Autism Service Providers (CASP), a 501(c)(6) trade association, strictly complies with federal antitrust laws. CASP does not condone, support, or encourage any actions by its members or staff that violate antitrust laws or regulations. A member's conduct at all CASP-sponsored or CASP-scheduled meetings and events must comply with antitrust laws.

Federal Trade Commission guidelines require that:

- *A third party manages data collection (e.g., a trade association, industry publication, purchaser, government agency, consultant, or academic institution);*
- *The information is more than three months old; and*
- *Disseminated information is sufficiently aggregated—at least five providers report the data; no individual provider's data represent more than 25 percent of the relevant statistic on a weighted basis, and data aggregation is sufficient to prevent a participant from deducing the data provided by any individual competitor.*

Advocacy Next Steps

- Data collected will be aggregated with a subsequent summarized call to action to stakeholders (regulators, payers, Regional Centers, Parent Organizations).
- It is important that caregivers/family members file complaints in order to ensure DHMC/DOI are aware that they are waiting for services. Find the tools needed to do that here.

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CALIFORNIA calABA Association for Behavior Analysis


Q&A