VERMONT

DEPARTMENT OF FINANCIAL REGULATION

Insurance Parity in Residential Care for Children and Youth

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Submitted by

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Introduction.

Section 8 of Act 137 of 2022, *an act relating to miscellaneous provisions affecting health insurance regulation*, created the Insurance Parity in Residential Care for Children and Youth Working Group (the Working Group) to increase access to appropriate residential treatment for children and youth who are enrolled in commercial health insurance. The Working Group consisted of members representing the Department of Financial Regulation (DFR), the Department of Mental Health (DMH), the Department for Children and Families (DCF), the Agency of Education (AOE), the Department of Vermont Health Access (DVHA), Howard Center, Brattleboro Retreat, New England School for Girls, Blue Cross Blue Shield of Vermont (BCBSVT), MVP Health Care, and the Office of the Health Care Advocate (HCA).

The Legislature directed the Working Group to: 1) examine the barriers that make it difficult for children and youth to access medically necessary residential treatment; 2) identify the reasons that Vermont residential treatment programs are resistant to becoming approved providers for private insurance; 3) propose solutions to overcome the barriers and reasons identified above, including the possibility of creating a common set of quality and utilization management criteria and processes for private insurance and Medicaid-funded residential treatment; and 4) explore solutions to streamline funding options for State-placed private pay students by considering the provisions of 16 V.S.A. §§ 11 and 2950.

The Working Group met four times over the course of 2022, on July 20, August 23, November 15, and December 19. Each meeting was focused on a specific barrier identified by DFR and DMH making it difficult for children and youth with commercial insurance coverage to access medically necessary residential treatment:

- Educational Funding.
- Provider Accreditation.
- Utilization Review and Reimbursement; and
- Coordination of Benefits.

This report will describe each barrier in turn, summarize the Working Group's discussion of that barrier, and propose solutions to overcome it. In general, the barriers discussed by the Working Group represent procedural and administrative shortcomings that can be readily addressed by improving communication and processes.

Educational Funding.

Intensive residential mental health treatment for children in Vermont is provided by a handful of facilities: the Vermont School for Girls, Brattleboro Retreat, Abigail Rockwell Center for Children (ARCC), Brookhaven, Community House, Howard Center (HC) Park Street, NFI Group Home, and the NFI Allenbrook Program. Allowable costs for these facilities are assigned to three distinct service categories: treatment; room and board; and education. For patients who are eligible for Vermont Medicaid, treatment is paid directly by Medicaid, room and board is paid out of general fund money appropriated to the Agency of Human Services (AHS) through the placing departments (DMH, DCF and Department of Disabilities, Aging and Independent Living (DAIL)), and education is paid by AOE, but only for only the children placed by a State Department listed above. For patients with commercial insurance, however, the educational

component of residential mental health treatment represents a significant barrier to access because commercial health insurance does not cover educational programming, including anything designed principally to improve academic performance, reading or writing skills.[1] Therefore, families placing a child with commercial insurance into residential mental health treatment often must pay for the educational component out-of-pocket, even though a facility is in-network with the insurer and the treatment services are otherwise covered.

The Working Group discussed two potential solutions to this issue: 1) extending Agency of Education funding for educational expenses to patients with commercial insurance who meet medical necessity criteria, and 2) liaising with individualized education program (IEP) teams around the state to recommend residential mental health treatment where educationally and medically appropriate. These solutions were based on the different funding mechanisms available for students who require alternative educational placements. Students who are placed in a residential setting funded by DCF, DMH or DAIL are considered "state-placed" and have their educational expenses paid through AOE under 16 V.S.A. § 1075(c). Students who are referred to a residential educational setting as part of an IEP have their educational expenses paid by their local school district (with a portion paid by AOE, based on a funding formula).

State-placed students are referred to residential mental health treatment through the Case Review Committee (CRC)—a body created by the State Interagency Team (SIT)[2] to serve children and adolescents with severe behavioral health needs in the least restrictive setting appropriate to their needs. The CRC thoroughly reviews all requests for residential placements made by the DCF, DMH, and DAIL and recommends placement only to pre-approved facilities. CRC is comprised of representatives from DCF, DMH, DAIL, AOE and a representative of a family advocacy organization. According to statistics compiled by the Agency of Human Services, 346 children and youth were in residential care through the CRC process in FY 2022, a majority of whom were referred to residential care by DCF. A majority of placements are in-state, and 51% of stays are for 12 months or less.[3] AHS departments are currently involved with between 5-15 cases per year of children and youth with Medicaid and private health insurance or only private health insurance coverage who have struggled to access appropriate care. These youth typically have extended or multiple stays in inpatient settings because appropriate care is not easily available.

When discussing the possibility of extending AOE funding for educational expenses to patients with commercial insurance, AOE expressed concern that without state review of some kind, a family placing their child in residential mental health treatment would represent a "unilateral

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[1] *See, i.e.,* Blue Cross Blue Shield of Vermont, 2021 Health Care Benefits, Platinum, Gold, Silver, and Bronze Plans Certificate of Coverage, at 30 (Jan. 2021), *available at* https://www.bluecrossvt.org/documents/2021-platinum-gold-silver-and-bronze-plans-certificate-coverage. Other commercial health insurers have similar exclusions for educational services.

[2] The State Interagency Team (SIT) is comprised of representatives from the Agency of Education, Agency of Human Services, Department for Children and Families, Department of Mental Health, Department of Disabilities, Aging and Independent Living, Vermont Federation of Families for Children's Mental Health, and other groups such as the Department of Health's Division of Alcohol and Drug Abuse Prevention, Vocational Rehabilitation, and the Department of Corrections as appropriate.

[3] Agency Of Human Services Residential Turn the Curve Advisory Committee, Regional and State Residential Data FY2023 Quarter 1, at 37 (2022).

placement" for which public funding is typically unavailable. AOE also expressed concern about the possibility of an insurer approving placement at a facility that had not been approved and contracted with by a state department as a qualified treatment provider. With respect to the idea of liaising with IEP teams to access local district funding, the Working Group was skeptical that commercial insurers could effectively coordinate with school districts around the state about alternative placements, which would effectively require parents to involve their health insurer in IEP conferences if they thought their child would need residential mental health placement. Additionally, because school districts can only use this funding mechanism for children with an IEP, it would be impossible for a school to fund residential treatment for a child/youth without an IEP.

To address the above concerns raised with respect to AOE funding the for educational expenses Working Group discussed the possibility of creating a state process for assessing medical necessity and utilizing CRC's recommendation process to identify possible residential programs for students with commercial insurance. AOE noted that under the Supplemental Rules Pertinent to Special Education and Section 504 of the Rehabilitation Act, local school districts not AOE, are required to fund "instruction for no less than an average of six hours per week" for students who are "unable to attend school for a period of ten consecutive school days or more because of pregnancy or a medical disability[,]" which AOE reads to include mental illness.[4] AOE advised that while the rule is typically invoked to provide educational services for students who are, for instance, hospitalized long-term for cancer treatment, it would also apply in the context of residential mental health treatment.

The Working Group therefore proposes formalizing a process through which AOE can communicate with DFR, DMH, and local school districts to ensure that students with commercial insurance in residential mental health treatment have the educational resources to which they are entitled under AOE's supplemental rules. The working group also encourages AOE, DMH, and DFR to continue working towards creating a framework for students with private insurance, led by DMH, and utilizing CRC, that could recommend that AOE or local school districts fund educational expenses at residential mental health facilities approved by a State Department.

Provider Accreditation.

Under DFR Rule H-2009-03, health insurers are required to ensure that in-network providers are accredited by the National Committee for Quality Assurance (NCQA) or other national independent accreditation organization approved by DFR. As of August 2022, only two Vermont residential mental health providers have such external accreditation: Brattleboro Retreat and the Vermont School for Girls. Providers advised the Working Group that the cost of accreditation, which could run into the thousands of dollars, as well as the staff time required to complete the accreditation process, made external accreditation impractical for providers with limited resources. Because very few Vermont providers have the external accreditation

[4] *See* Agency of Education, Supplemental Rules Pertinent to Special Education, Sec. 1252, *available at* https://education.vermont.gov/sites/aoe/files/documents/edu-vermont-supplemental-rules.pdf.

necessary to join commercial insurance networks,[5] patients with commercial insurance are often directed to in-network, out-of-state providers. If a patient wants or needs to use a provider that is out-of-network with their insurer, in some cases, families did not know whether the services would be covered until 24 hours before intake. This is particularly impractical when residential placements are so in-demand due to recently reduced capacity on a national level, and sometimes take weeks, if not months, to find.

Vermont Medicaid relies on the DCF licensure process for in-state residential mental health providers rather than external accreditation. The DCF licensure process[6], while comprehensive, is far less expensive and administratively burdensome than external accreditation. All residential treatment providers in Vermont are licensed by DCF and almost all accept Vermont Medicaid beneficiaries. The practical result of this is that there is one set of Vermont-based residential mental health providers favored by Vermont Medicaid, and another set of out-of-state residential mental health providers favored by health insurers because they are in-network.

To address this problem, the Working Group discussed whether it would be feasible to amend Rule H-2009-03 to require health insurers to accept DCF licensure as an alternative to external accreditation for residential mental health providers when provided with the licensure report. Providers uniformly agreed that such an amendment would greatly ease the process of going in-network with health insurers. Both MVP and BCBSVT expressed openness to relying on DCF licensure in lieu of accreditation if they could review a copy of the residential treatment program licensing report, as well as confirm malpractice insurance coverage and participation agreements with the Centers for Medicare and Medicaid Services (CMS) as with other network providers.

The Working Group accordingly proposes amending Rule H-2009-03 to require health insurers to accept DCF licensure as an alternative to external accreditation for residential mental health providers to ease the process of contracting with health insurers.

Utilization Review and Reimbursement.

Even for residential mental health providers who are in-network with commercial health insurers, insurers' utilization review and reimbursement practices can represent a significant barrier to access.

Utilization Review.

Providers in the Working Group noted that utilization review can "end up in a bind," wherein a given level of care may only be authorized for two weeks, but it takes at least 30 days to fully evaluate a patient, including psychological tests and other evaluations. Providers also expressed concern that insurers' utilization review processes did not align with the discharge process for patients in residential treatment, which can be "vastly more complicated" than discharge from a physical health facility because of the need to arrange outpatient and community supports prior

[5] BCBSVT noted to the Working Group that health insurers can assess the quality of unaccredited facilities by using internal criteria or obtaining a copy of a review completed by the state or the federal Centers for Medicare and Medicaid Services (CMS).

[6] DCF's licensure regulations for residential treatment programs in Vermont are available online at: https://outside.vermont.gov/dept/DCF/Shared%20Documents/FSD/Publications/RTP-Regs.pdf.

to discharge, as well as address family dynamics and functioning that may have impacted the child's presenting treatment needs. Finally, providers reported issues with some of the terminology used by health insurers to describe contractual exclusions from coverage, specifically the term "custodial care," which is meant to describe services designed to help in daily living activities such as dressing but has sometimes been misapplied to residential mental health treatment.

As DFR has previously reported, health insurers have discretion within the limits set under 8 V.S.A. § 9418b and DFR Rule H-2009-03 to determine its own prior authorization procedures, including deciding when prior authorization is necessary, and the criteria used to adjudicate prior authorization requests.[7]

- BCBSVT requires prior authorization for residential mental health services using admission criteria from MCG Health.[8] If the patient meets criteria for residential care, BCBSVT will approve care for a period of time based on statistical benchmarks provided by MCG Health. If the patient requires additional days beyond what was initially approved, BCBSVT approves additional days unless the patient has met the clinical criteria for discharge.
- MVP does not require prior authorization for residential mental health services. As with inpatient hospital stays, MVP only requires that providers notify it with basic information about a member going into treatment within two days. After fourteen days, MVP asks providers to provide a status update for the patient. If the patient is the subject of an order requiring residential treatment or otherwise has a complex case, MVP will follow up with the provider more often. Utilization review does not begin until 60 days post-admission and is focused on ensuring that symptoms are addressed as a core component of the treatment plan. Discharge is managed by the residential treatment provider in recognition of the challenges involved in setting up outpatient and community supports.

Despite the complexities inherent in residential mental health placements and discharge, neither BCBSVT nor MVP routinely assign case managers, who assist in care coordination, to patients who require that level of care. In contrast, DMH's procedural guidelines for prior authorization of out-of-home treatment specifically require regular communication between the residential provider, a DMH care manager, and the local Designated Agency.[9] The guidelines also call for regular treatment team meetings between "the child when appropriate, family, local treatment providers, local education, residential clinical, case management and education, and at times,

[7] Department of Financial Regulation, Report, Opportunities to Increase the Use of Real-Time Decision Support Tools Embedded in Electronic Health Records to Complete Prior Authorization Requests for Imaging and Pharmacy Services, at 2 (Jan. 15, 2022), *available at* https://dfr.vermont.gov/sites/finreg/files/doc_library/dfr-legislative-report-act140-electronic-prior-authorization.pdf.

[8] MCG Health provides proprietary clinical care guidelines for use by hospitals and health insurers. *See* https://www.mcg.com/care-guidelines/behavioral-healthcare/.

[9] The Designated Agencies are private nonprofit agencies that work with DMH to provide mental-health care in each geographic region of the state. *See* https://mentalhealth.vermont.gov/about-us/designated-providers.

the State placing entity."[10] The process works to ensure both that patients who need residential care cannot receive the care they need in the community and that patients who no longer require that level of care can reintegrate into their communities with a plan for appropriate supports.

The Working Group discussed the need for insurer utilization review processes to emphasize coordination between the insurer, the residential provider and local service providers who provide continuing support after discharge. Since the goal for children and youth placed in residential treatment is to return to their families and communities, it is critical to have the insurer meaningfully participate in discussions about outpatient supports and services. The Working Group proposes that insurers provide case managers to all members who require residential mental health care to participate in these discussions. The Working Group also recommends that insurers eliminate prior authorization requirements for children and youth residential mental health placements and limit subsequent utilization review to ease the administrative burden of placement and allow sufficient time for a full clinical evaluation to take place upon intake.[11]

Additionally, the Working Group strongly encourages regular and open communication between insurers, Designated Agencies, DMH, the residential treatment provider, the HCA and families before, during, and after a residential placement. To facilitate this communication, the Working Group proposes that stakeholders work to create a shared lexicon for the purposes of minimizing misunderstandings caused by differences in terminology between insurers and providers, especially when those misunderstandings can lead to a denial of coverage.

Reimbursement.

Vermont Medicaid reimburses each residential treatment provider a program-specific per diem rate set by the Division of Rate Setting within AHS.[12] Similarly, health insurers do not have a single residential treatment rate, nor do they have one rate that is paid to all providers. Rates are negotiated with providers/facilities on a provider-by-provider basis. Because sharing specific rates paid to providers could lead to horizontal antitrust collusion and price fixing, the Working Group only discussed reimbursement in general terms. Providers expressed dissatisfaction with both the rates set by the Division of Rate Setting and rates paid by

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[10] Department of Mental Health, Child, Adolescent and Family Unit, Procedural Guidelines for Prior Authorization of Out-of-Home Treatment for Children and Families with Intensive Mental Health Needs, at 8-9 (Feb. 1, 2018), *available at* https://mentalhealth.vermont.gov/sites/mentalhealth/files/doc_library/Out_of_Home_Placement_Procedural_Guidelines.pdf.

[11] This recommendation does not extend to Vermont Medicaid, which covers children and youth in DCF custody and delegates the authority to determine whether residential mental health treatment is medically necessary to DMH, which in turn requires patients to have a recent history of active participation in treatment with a local Designated Agency and has strict eligibility criteria to ensure that residential placement is not primarily a result of unmanageability within the home or community.

[12] *See* Agency of Human Services, Division of Rate Setting, Vermont Private Nonmedical Institutions Rules (Sep. 2015), *available at* https://dvha.vermont.gov/sites/dvha/files/doc_library/Adopted%20V.P.N.M.I.R.%20Effective%209.8.15.pdf. As noted above, the per diem rate is split into different components paid by separate agencies within state government.

commercial insurance. Providers added, however, that the process of getting reimbursed from health insurers, in terms of navigating different billing platforms, submitting claims, and responding to insurer audits presented more of a barrier to access the amount since it often requires additional administrative staff.

Although the Working Group was unable to come to a consensus on any proposals to address issues related to reimbursement and claims processing, DFR can work with providers and insurers on specific problems that arise during claims submission and processing using its authority under 18 V.S.A. Ch. 221, Subch. 2.

Coordination of Benefits.

The Working Group's last meeting focused on coordination of benefits for individuals who have Vermont Medicaid as well as commercial insurance coverage. Under state and federal law, Medicaid is the payer of last resort to any insurer that contracts to pay health care costs for a beneficiary, meaning that Medicaid cannot pay claims that are covered by another insurer.[13] For these dual-eligible individuals, DMH advised the Working Group that it and the families it works with struggle to ascertain what is authorized and covered by insurance, and how long those services will be covered. DMH further noted that the process of determining coverage extends timeframes for getting a child or youth in need into treatment because the family must coordinate between their child's providers, Medicaid, and their health insurer—an extremely onerous process for families that are already struggling with a child in need of residential mental health treatment.

To address this problem, the Working Group discussed expanding and formalizing the HCA's role as a bridge between families, payers, and providers. In previous complex cases involving coordination of benefits, DVHA, DFR, and BCBSVT have been able to successfully communicate and coordinate with families through the HCA. The HCA advised the Working Group that the HCA Helpline is available to assist families to determine what their health insurance covers, and advocates can help families that are having trouble accessing a particular benefit, such as medically necessary residential mental health care for a child, either with advice or through direct assistance. The HCA can also assist with problems related to coordination of benefits but cannot require individual providers to participate in Vermont Medicaid or a health insurance plan. Because there is currently little awareness within DMH or among the Designated Agencies about the resources and services the HCA provides, the Working Group proposes that DFR arrange focused outreach between the HCA, DMH, and Designated Agencies. The Working Group also recommends that DMH, DVHA, and Designated Agencies direct families facing coordination of benefits issues to the HCA for assistance as a matter of routine.

Conclusions and Summary.

DFR and DMH would like to extend their gratitude to all the stakeholders who participated in the Working Group, especially to the providers who took time out of busy schedules to offer their insights. The Working Group brought all of the stakeholders together on a human level,

[13] Under 33 V.S.A. § 1908 and 42 C.F.R. § 433.139, Vermont Medicaid must "claw back" payments made to providers when it identifies another liable third party, such as a health insurer. The provider must then seek reimbursement from that third party.

and those connections have already worked to support youth in need of residential mental health care.

The issues the Working Group discussed are not dependent on action by the federal government or driven by national market forces that are outside of the state's control. Virtually all of the problems discussed above can be addressed merely by improving processes and communication between state agencies, insurers, and providers. To that end, the Working Group's proposals are summarized below:

- Creating a process, through which AOE can communicate with DFR, DMH, and local school districts to ensure that students with commercial insurance in residential mental health treatment have the educational resources to which they are entitled under AOE's supplemental rules.
- Amending DFR Rule H-2009-03 to require health insurers to accept DCF licensure as an alternative to external accreditation for residential mental health providers.
- Assigning case managers to all members of health insurance plans who require residential mental health care.
- Creating a shared lexicon to minimize misunderstandings caused by differences in terminology between insurers and providers; and
- Raising awareness among providers and DMH about services the HCA can provide to patients' families with respect to coordination of benefits.

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