

# **Parity, Equity and Reforms:** How Macro-Economic Forces Are Changing the Business of Addiction Treatment

**Presented to Members of CADPAAC**

*May 26, 2010*

*Presented by  
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Wellstone-Domenici Mental  
Health Parity and Addiction  
Equity Act of 2008  
(MHPAEA) and  
the Interim Final Rule (IFR)

# Mental Health Parity and Addiction Equity Overview of the Law

- Passed October 3<sup>rd</sup> 2008 – Effective January 1, 2010
- Expected to affect more than 150 million people
- Adds SUD to MHP
- Impacts ERISA plans for the first time
- Impacts Medicaid Managed Care Plans
- Stronger State Laws Protected
- Treasury, Labor and HHS Providing Leadership and released **Interim Final Rule on January 29<sup>th</sup>** (open comment period closed May 3<sup>rd</sup>)

# Overview of the Law

- Health plans that provide mental health or addiction treatment benefits must provide the **same financial terms**, conditions, requirements, and treatment limitations for mental health and addictions as they do in providing coverage for medical and surgical conditions – **Treatment Limitations include** **Non-Quantitative Treatment Limitations:**
  1. Medical management standards
  2. Formulary design
  3. Fail-First and Incomplete Treatment
  4. UCR
  5. Standards for provider admission to network
- **Cost-sharing**, deductibles, co-pays, and other forms of co-insurance as well as annual limits and lifetime limits must be equal to “predominant” coverage for “substantially all” of the covered medical and surgical conditions – **Single Plan = Single Deductible**
- Limitations on the **scope of treatment and treatment frequency and duration** cannot be more restrictive than those limiting other medical conditions

# Overview of the Law

- Plans and issuers are not mandated by MHPAEA to cover MH or SUD but where and when they do, MHPAEA applies. Particularly true for **ERISA and Public Employee Health Plans**
- Where allowed for other conditions, **out-of-network benefits** for mental health and addictions treatment must be provided and must be equal to those provided for other medical and surgical benefits
- Plans can continue to engage in healthcare UM, as well as utilization review and other types of assessments, and determine coverage on a case-by-case basis **in a manner no more stringent for MH or SUD than for medical** (*processes, strategies, and standards*).
- Plans are required to provide members, consumers, and providers with their medical necessity criteria and reasons for benefits/coverage or claims denial upon request

# Overview of the Law

- **The Act exempts individual policies and employers with fewer than 50 employees** and plans whose total premium costs increase more than **two percent** in the first year or one percent in any subsequent year, subject to an annual application and review process
- **Issues Requiring Clarification**
  - Covered Diagnoses (currently defined by plan and State)
  - Covered Providers (currently defined by plan and State)
  - Covered Services (currently defined by plan and State)
  - Clarification on Disclosure requirements and Cost Exemptions
  - Medicaid managed care plans

# More on the IFR...

- IFR takes effect among plans that begin on or after July 1, 2010. Plans and issuers already made good faith effort for plans that began January 1, 2010
- Doesn't preempt State laws that are more stringent but State and Federal laws must be compared and determinations made
- EAP cannot serve as Gatekeeper but can continue to provide all other services and benefits
- Cannot establish separate plans to avoid compliance

# More on the IFR...

- References to ***generally accepted medical standards*** such as DSM, ICD and State guidelines
- Defined “predominant” (50%) financial requirements and “substantially all” (2/3) medical benefits in a given “classification”. Will require significant data analysis annually.
- No distinction between generalists and specialists
- Six Classifications of Benefits
  - Inpatient: in and out-of-network
  - Outpatient: in and out-of-network
  - ER
  - Prescription Drug

# The Private Sector

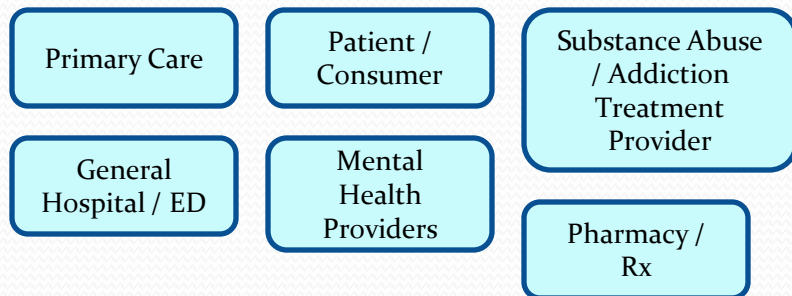
*How the plot thickens and  
where the opportunities are*

# Parity – *A Love Story*

## Set and Stage - Functional Areas



## Sub-Plots and Narrative- Clinical Areas



## Lead Actors - Markets

Self-Insured Employers

Health Plans

Medicaid Managed Care Plans and SCHIP

Third-Party Administrators (TPA)

Preferred Provider Organizations (PPO) and Networks

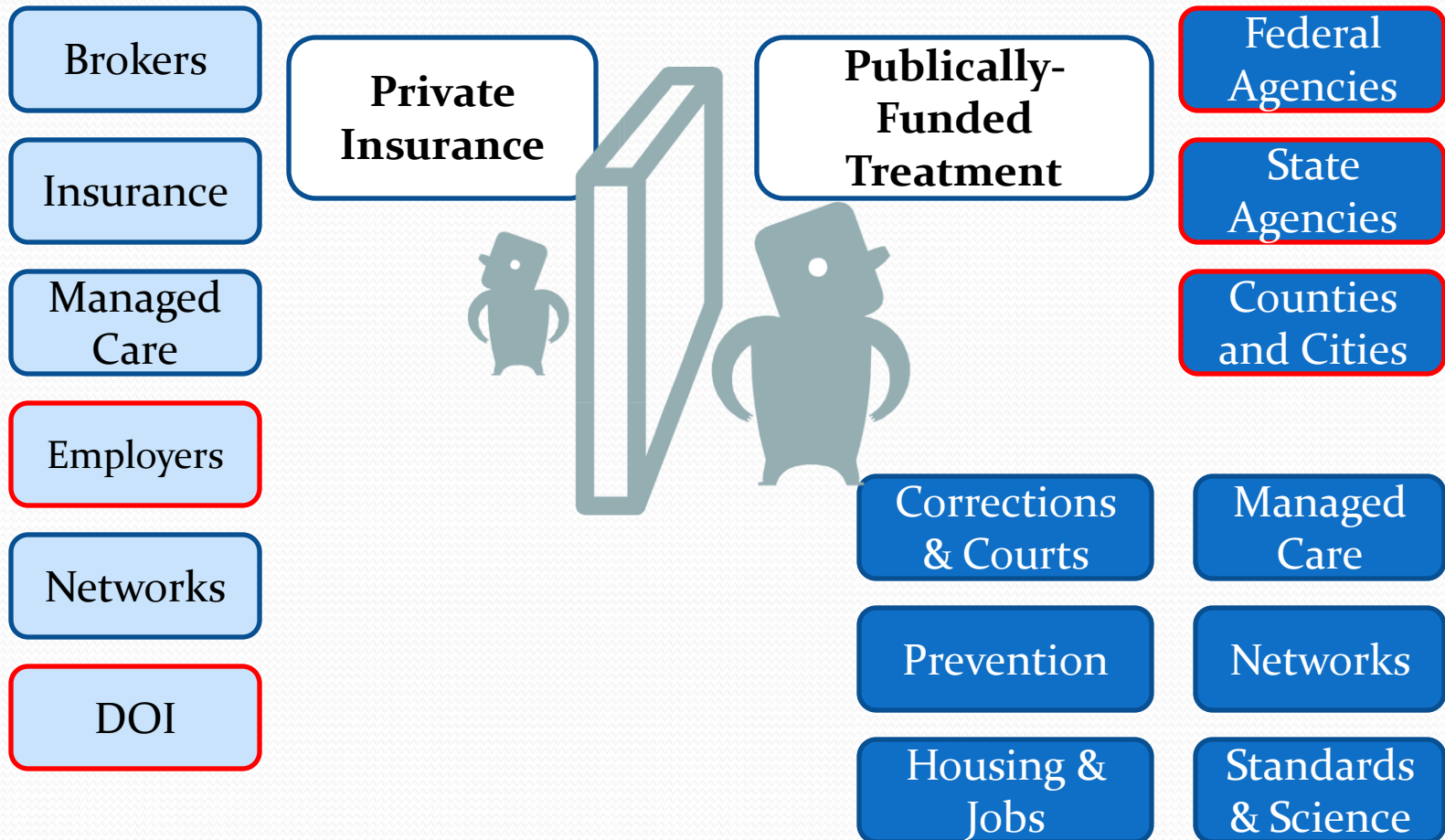
Utilization Mgmt Business Process Outsource

Managed Behavioral Healthcare Organization (MBHO)

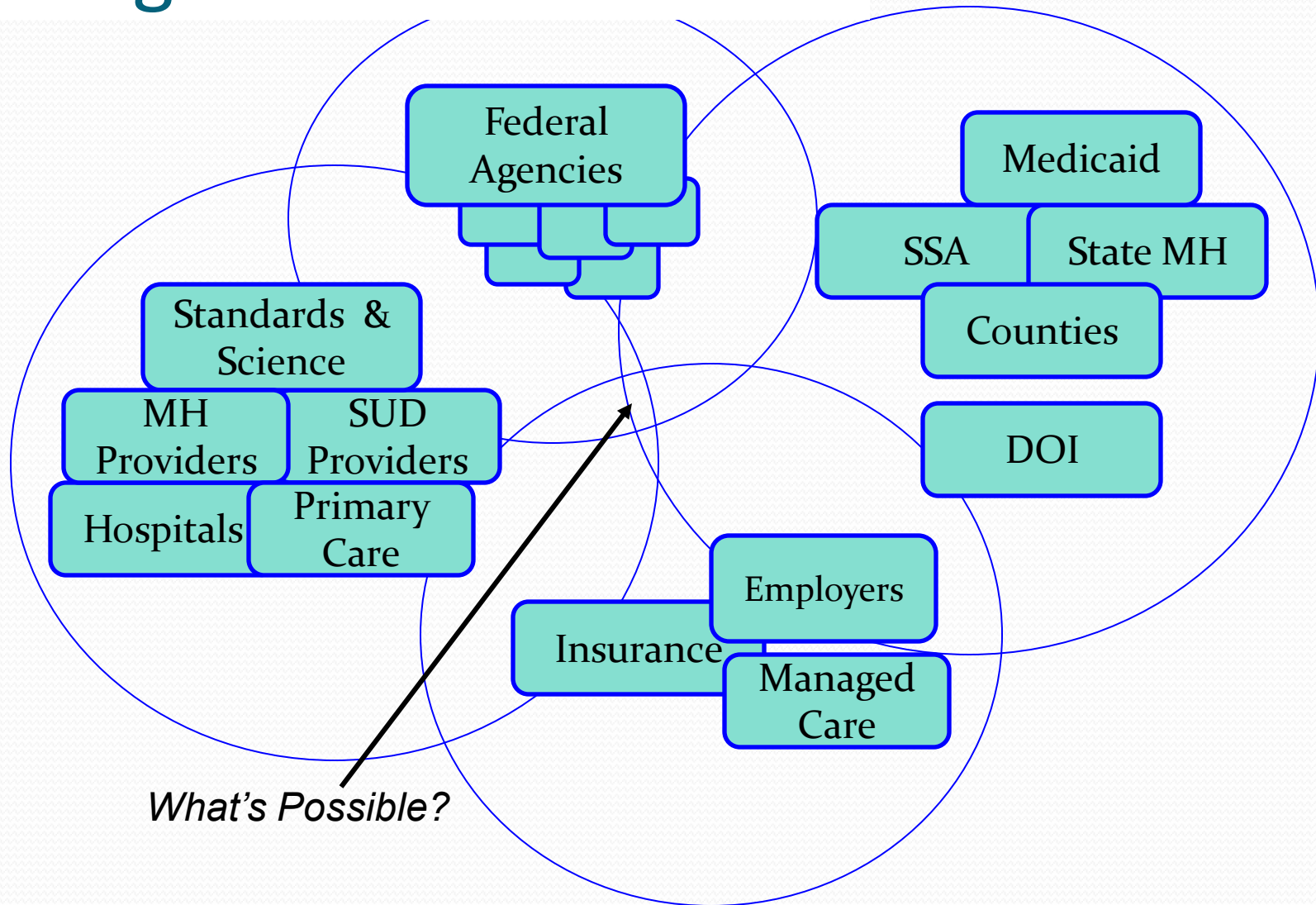
MCOs, HMOs, EPOs, MSOs, Prepaid Inpatient Health Plans

Professional and Facility Providers

# Parity – the Plot? A Tale of Two (58) Systems



# Imagine Addiction Equity Planning Like This...



# Parity Wild Cards

- Significant Issues:
  - Impact of Reform
    - Millions of uninsured moving into Medicaid
    - More people finding affordable coverage in Health Insurance Exchange
    - Elimination of Pre-Existing Condition Clauses enable SUD sufferers to find new coverage
  - Final Parity Regulations
  - MBHO Lawsuit
  - Treating the SMI, SED and Chronically Mentally Ill in a private sector system – usually the domain of the public system
    - 63% of MH and 76% of SUD treatment paid for by public sector
  - What becomes of community-based “wrap-around” recovery support services?
  - Workforce Issues (licensure, shortage, aging, management competencies, etc.)
  - Block Grants?

# Implementation Issues

- Crucial need to educate consumers, families and providers
- Primary Care Physician role and need for integration/bi-directional co-location
- Role of Pharma remains central (and then some)
- SUD coverage expansion
- Prospects for Population Management
- Need to address Special Populations
- “Meshing, Blending and Braiding” Systems of Care

# Impact

- Most consumers likely to see expanded coverage
- However...
  - Employers, health plans and consumers should/must be educated regarding scope of service and best practices
  - Expect more managed care
  - Plans that are out of compliance need to be brought to the attention of CMS, the IRS or the DOL

# Impact on Your Market

- Health Plans will expand utilization management (UM) and other managed care efforts. Expect more rigorous medical management until “generally accepted medical standards” are better defined
- Some health plans have begun carving *IN*
- Medicaid managed care plans should already be compliant with MHPAEA statute
- Providers should be contracting with PPOs, TPAs, MCOs, HMOs and MBHOs

# Opportunities

## Conduct Local/Regional Market Research

- Health plans
- Managed care
- Employers

## Profile Your Market

- Benefit plan designs
- Provider network administrator(s)' willingness to meet and negotiate
- Medical network access standards and contracting requirements
- Features of their fee schedule in light of UCR
- Reputation for contracting, medical management and claims processing
- Mix of MH and SUD providers currently in-network
- Advantage of OON status

# Opportunities

- ✓ Join PPO networks
- ✓ Consider joining Accountable Care Organizations and integrated systems of care
- ✓ Join Patient-Centered Medical Home initiatives
- ✓ Lead or participate in early screening and engagement initiatives (SBIRT)
- ✓ Conduct Comprehensive Strategic Planning with respect to ALL data management and reporting
- ✓ FQHC?

# Things you can do...

- ❑ Learn/teach to negotiate Usual, Customary and Reasonable (UCR) reimbursement (understanding DRG and RBRVS)
- ❑ Assess and evaluate business processes, workflow, forms, information systems and staff capabilities in this area
- ❑ Assess and modify care management capabilities in order to comply with new plan/payer medical management standards and guidelines including the ability to document and communicate diagnosis, treatment plans, referrals and care coordination, progress notes and discharge plans
- ❑ Assess and modify billing procedures and systems to optimize electronic billing
- ❑ Conduct strategic IT planning with providers and consider practice management systems that - at a minimum - are HIPAA EDI capable and compliant

# Pros and Cons of Expanding Business Operations into the Commercial and Managed Care Sectors

Pros	Cons
<ol style="list-style-type: none"><li>1. Adaptive response to creation of new markets representing millions of potential customers</li><li>2. Opportunity to engage people earlier and to keep them employed and in their homes</li><li>3. Opportunity to build new alliances and partnerships in the interest of integration</li><li>4. Many new sources of funding and revenues that help diversify business portfolio and risk</li><li>5. Opportunities for innovation in treatment (<i>behavioral medicine</i>)</li><li>6. Opportunities for innovation in reimbursement</li><li>7. Opportunity to impart fresh ideas and stimulate change</li><li>8. Increased revenues</li></ol>	<ol style="list-style-type: none"><li>1. Distraction from current book of business and – in some cases – your mission</li><li>2. Difficult challenge of marketing, promotion, and protracted contract negotiations with multiple business partners</li><li>3. Difficulties associated with managed care obligations like having to prove medical necessity and the additional oversight of care managers and their protocols (frequency of review)</li><li>4. Additional scrutiny of documentation and new requirements around standards and benefit administration</li><li>5. Implementation of new processes and the technology that enables them – especially EDI-compliant billing systems - complicated by number of payers you contract with</li><li>6. Likely need for additional staff</li><li>7. Competition</li><li>8. Credentials and accreditation requirements</li></ol>

# Take a Stand on Scope of Service

- 1. Covered Conditions**
- 2. Medical Necessity Guidelines**
- 3. Covered Services**
- 4. Covered Providers**

# Where to take it

- Health plans
- MCOs
- MBHOs
- Employers
- PPOs and HMOs
- Dept of Insurance
- Medicaid
- Attorney General
- Governor
- Legislators

# *The Short and Long View* for the Field in the Commercial Sectors

1. Prevention (SBIRT)
2. Comparative Effectiveness Research (CER)
3. Integration (PCMH)
4. Behavioral Medicine (Obesity)
5. Accountable Care Organizations and Value-Based Insurance/Benefit Design
6. Pay-for-Performance, Recovery Outcomes, Quality, Value
7. Competition
8. Mergers and Acquisitions

# Difficulty, Dedication, Focus, Cooperation

1. National/State/County Situation Analysis
2. Comparing and contrasting State and Federal laws and regulations
3. Disseminating guidance to insurance commissioners, health plans and ERISA groups (self-insured employers)
4. Clarifying scope of service questions
5. State Plans and Waivers
6. Standardize and normalize
7. Aligning incentives
8. Financing the sweeping technology transformation required to change
9. Sacrifice, unison, joint agreements, prioritization, action planning and
10. Action.

# Implications for Policy-Makers

1. We are on a 3-year timeline for reform of our system in its entirety. Start with assumption of “clean slate”
2. We must eliminate waste and redundancies
3. We must coordinate and collaborate “on all cylinders” from system design to policy to financing to infrastructure and info management
4. We must be willing to trade-off and sacrifice
5. We must tap into competencies and capacity we don't have, pooling resources every chance we get

# Implications for Policy-Makers

- We must engage legislators
- We must identify a lead agency that will provide a center of gravity during reforms (remembering that reforms are not unlike renovations)
- We need vision and a tactical strategic plan
- We need to allocate and reallocate resources
- Communicate (almost) excessively
- Stay resilient and flexible. It's going to be a wild ride!

# Simply & Finally

1. Policy & Financing Reform
2. Standardization, integration, and coordination of clinical practices and professionals
3. Accountability (pay-for-performance, performance-based contracting, outcomes, and the creation of value)
4. Information systems architecture, infrastructure and the interoperability of data (encounter, claims, quality, etc)

# Questions and Contact

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