Behavioral Health Is Strong on the Policy Front
Recent Achievements Have an Impact

Where We Are Today

- Many, many years of hard work are paying off right now
- Behavioral health is on the national stage

Recent Achievements

1. Federal mental health parity law (*Fall 2008*)
2. Medicare outpatient parity – copay reduced from 50% to 20% phased in (*2008*)
3. SCHIP reauthorization/mental health parity (*Winter 2009*)
4. Interim final parity regulations: pro-consumer, pro-provider (*February 2010*)

-continued-
Recent Achievements (continued)

5. Healthcare reform, mental health parity through health insurance exchanges adds to mental health parity law (March 2010)

6. IMD/EMTALA Demonstration implemented as part of reform (March 2010). Is first change to IMD since 1972.

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Recent Achievements (continued)

7. Repeal of Medicare 190-day lifetime limit bill introduced
   - S.3028 by Sens. Kerry and Snowe (March 2010)
   - H.R.6143 by Reps. Tonko and Stark (September 2010)

8. Health IT bill introduced to add psych hospitals and mental health/addiction facilities to EHR Medicare and Medicaid incentive payment program under AARA

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Federal Parity Law

“Game – changer”
The Parity Law
• The Paul Wellstone and Pete Domenici Mental Health Parity and Addictio
  n Equity Act signed into law on October 3, 2008
• Basically, became effective January 1, 2010

Key Provisions
• Applies to 113 million employed Americans, including individuals in ERISA plans (self-insured companies)
• Requires equity in financial requirements
• Requires equity in treatment limits

Key Provisions (continued)
• Does not mandate mental health benefits
• Exempts certain businesses
  • With 50 or fewer employees
  • Posting an overall cost increase due to parity requirements (2% in first year; 1% in subsequent years)
  • Exemption only lasts one year; need to reapply the following year (or comply)
Interim Final Regulations

- Department of Health and Human Services
- Treasury Department
- Labor Department

Interim Final Rule

- Goes into effect for health plan years beginning on or after July 1, 2010
- Means that most health plans will not be subject to the regulations until January 1, 2011
- However, in the interim, health plans must make a "good faith" effort to comply with the reasonable interpretation of the law
- But the preamble makes clear that this does not prevent participants or beneficiaries from bringing a private right of action

Parity Regulations

Interim final rule
issued February 2, 2010

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Interim Final Regulations

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Treatment Limitations
- The regulations go further with respect to treatment limitations
- The regulations define treatment limitations as **quantitative** and **non-quantitative**

Definitions
- **Quantitative** limits:
  - Are numerical (e.g., 30 inpatient days).
- **Non-quantitative treatment limitations (NQTL):**
  - Are such things as (NOTE: This list is not exhaustive):
    - Medical management standards, including standards for admission to participate in a network;
    - Determination of usual, customary, and reasonable charges,
    - Requirement for using lower cost therapies before the plan will cover more expensive therapies (also known as fail-first policies or step therapy protocols),
    - Conditioning benefits on the completion of a course of treatment.

Comparison of Med/Surg and Psychiatric Benefits
- Plans are only permitted to compare medical/surgical and mental health benefits for purposes of applying parity requirements using six specified categories:
  1. Inpatient, in-network
  2. Inpatient, out-of-network
  3. Outpatient in-network
  4. Outpatient out of network
  5. Emergency care
  6. Prescription drugs
Key Issues

- Scope of services
- NQTLs/comparable/no more stringent standard
- Recognized clinically appropriate standard of care

Your Role in Parity Implementation
Internally

- **Identify a lead person within your organization** to coordinate parity implementation materials and to track the national discussion.
- **Brief utilization review staff, physicians, and others** on the regulations and the patients' and hospitals' rights under the law:
  - The health plan is obligated to:
    - 1) Provide the reason for any denial to the participant or beneficiary on request.
    - 2) Provide the criteria for medical necessity determination to the potential participant, beneficiary, or contracting provider on request.

With Health Plans

- **Engage in discussions with your target health plans** (particularly those with which you do the most business). Ask them:
  - Their plans – and changes – regarding issues such as treatment limits, deductibles, copayments, precertification, and utilization review.
  - How they will communicate changes to providers and consumers.
  - The kind of outreach input they will have with providers.
  - Who the health plan contact is if providers have concerns/issues.

At Intake/Insurance Verification

- **Put in place procedures as part of the intake/insurance verification process**, such as:
  - Asking the health plan if this patient is subject to parity – or not.
- **Record the fact that you asked such questions** in the record. It may be helpful if an appeal is ever required.
As Part of the Appeals Process

- Put in place procedures to request necessary information from the health plan, such as:
  - Medical necessity criteria for both behavioral and for medical/surgical;
  - Precertification/UR procedures for behavioral and for medical/surgical. See pages 49-51 in the Parity Implementation Coalition Parity Toolkit for a sample letter to appeal concurrent review requirements and the legal justification to do so

Scope of Coverage

- If a patient is denied a level of care (e.g., residential or partial hospitalization) because the health plan does not cover that level of care:
  - Request from the health plan the terms and conditions of coverage for medical/surgical benefits
  - If the health plan provided a continuum of levels of care for medical/surgical conditions, but a much more limited set of benefits for behavioral conditions, make a formal appeal to the health plan
  - Document that you requested this information. See pages 33-36 in the Parity Implementation Coalition Parity Toolkit for a sample letter on appealing scope of coverage and the legal justification to do so

If an Appeal Is Required

- Ultimately, if a health plan refuses to provide medical necessity criteria, UR/precertification information, or the level of coverage on the medical/surgical side:
  - Tell them nicely that they are required to provide this information and ...
  - If they do not, you will need to file a complaint with the insurance commissioner or Department of Labor. (See pages 56-58 in the Parity Implementation Coalition Parity Toolkit for appeals contacts.)
Keep NAPHS Informed of Trends

✓ Please share any information (or questions) with Mark Covall at mark@naphs.org
✓ Aggregate information on the types of challenges our members are facing as they work with covered individuals will help NAPHS and the Parity Implementation Coalition continue our advocacy at the national level.

Health Care Reform

Reform Falls Into Four Areas:

1. Insurance reform
2. Expanding coverage
3. Payment reform
4. System delivery reform
Health Care Reform
Behavioral Health Provisions

- 32 million uninsured covered
- Mental health/substance use benefits are part of the essential benefit package
- Mental health/substance use parity coverage through health insurance exchanges
- Quality reporting for psychiatric hospitals
  - Effective July 1, 2013
- Pay-for-performance pilot/psychiatric hospitals (no later than January 2016)
- Centers of Excellence for depression – grants

IMD/EMTALA Demonstration
Passed as part of health care reform

About the IMD/EMTALA Demo

- IMD Demo passed as part of health care reform
- 3-year, $75 million (federal share) demonstration project
- Will allow non-governmental psychiatric hospitals to receive Medicaid payments for emergency inpatient psychiatric care for adult Medicaid patients
- Backed by some 27 national associations, including NAPHS, the American Hospital Association, American Psychiatric Association, National Alliance on Mental Illness, American Nurses Association, and others
What Is HBIPS?

- A major national leadership effort to improve quality, safety, and performance of hospital-based inpatient psychiatric services through the collaboration of hospitals, physicians, and consumers
- Is now an integral part of The Joint Commission accreditation process

Starting January 1, 2011

- HBIPS reporting:
  - Is mandatory for psychiatric hospitals as of 1/1/11
  - Is available for general hospitals with psychiatric units to use to meet or exceed ORYX performance measurement reporting requirements
HBIPS Core Measures

• Were developed with the same rigor as core measures for other medical specialties

Part of Medical Core Measures

• HBIPS are one of the first sets of core measure sets available:
  • Acute myocardial infarction
  • Heart failure
  • Community-acquired pneumonia
  • Children's asthma care
  • Pregnancy and related conditions
  • Surgical care improvement
  • Hospital outpatient

HBIPS Core Measures

• Focus on critical issues that affect the course of an individual’s psychiatric hospitalization
  • From the moment they enter the facility ...
  • ... through discharge
HBIPS Measures
- The assessment process
- The use of antipsychotic medications
- Seclusion and restraint
- Discharge summary/aftercare

HBIPS Core Measures
- Are evidence-based
- Have a direct impact on the quality of care

Summary
Much Progress Has Been Made in Our Field ...

- ... But challenges remain:
  - Growing number of psychiatric patients in ED
  - Inadequate supply of inpatient psychiatric beds
  - Public sector shrinking
  - Budgets tight
  - Community-based system underfunded

Many Opportunities Also Exist ...

- Opportunities:
  - Parity
  - Stigma reduced
  - Effective treatments are available
  - More recognition of the role of behavioral health within general health care (medical cost offsets)
  - Reform should result in fewer uninsured

So ... Our Time Is Now!

- Let's get to work!
Thank you

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Questions