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Mental Health Parity and Addiction Equity Act (MHPAEA): Improving Patient Care & the Bottom Line

A Webinar for Hospital Healthcare Associations

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Independent Compliance Administrator (ICA)

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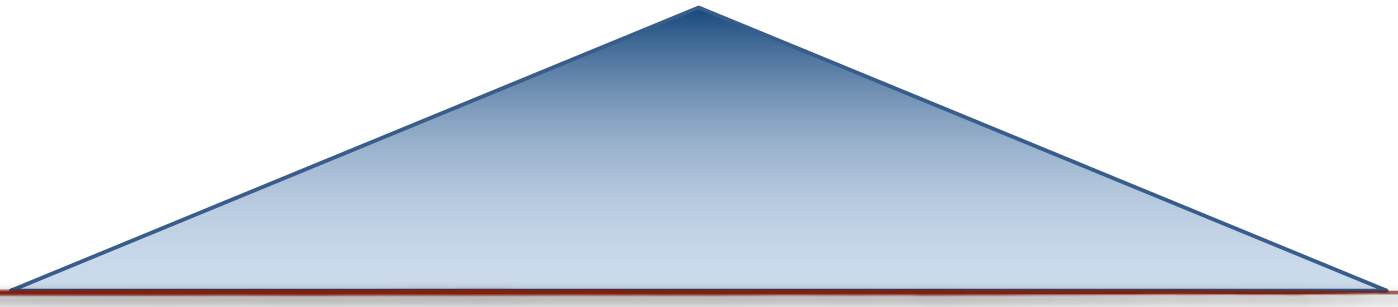
Objectives

- Provide a brief overview of the MHPAEA rules.
- Review payer UM/UR practices and key metrics for tracking payer LOC determination patterns.
- Discuss how parity rules might improve patient care and the bottom line.



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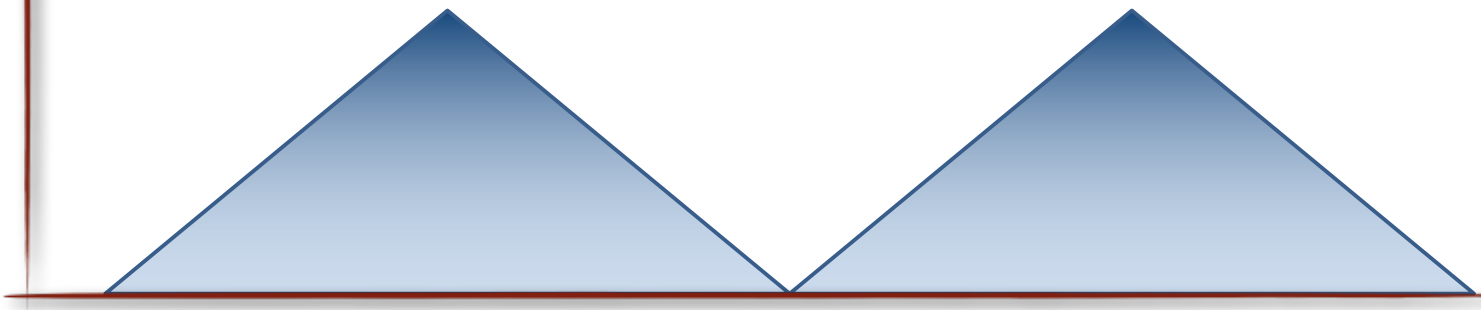

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What is Parity?

The 2008 MHPAEA generally prohibits employment-based group health plans and health insurance issuers that provide coverage for MH and SUDs from imposing less favorable benefit limitations on those benefits than on med/surg. benefits.

- Financial requirements (such as co-pays) and Quantitative Treatment Limitations can be no more restrictive than the predominant requirement or limitation applied to substantially all med/surg. benefits within a specific classification.
- For Non-Quantitative Treatment Limitations (NQTLs) and concurrent reviews), the processes, strategies, evidentiary standards used for MH/SUD determinations must be comparable to, and no more stringent than, those applied to med/surg. benefits.

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What are Quantitative Treatment Limitations?

Quantitative Treatment Limitations (QTLs) include:

- Restrictions on the number of visits/days
- Restrictions on frequency of visits
- Restrictions on the duration of care

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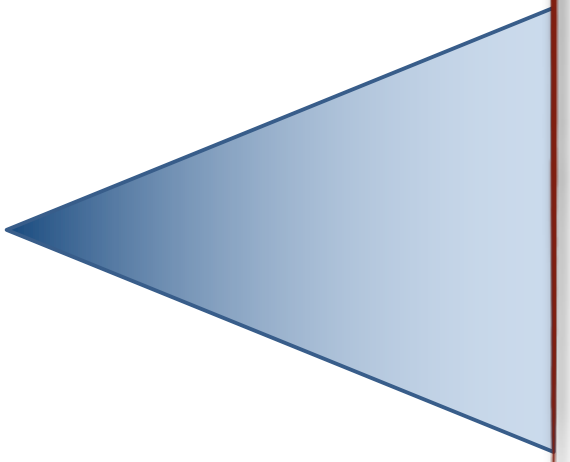
What are Non-Quantitative Treatment Limitations?

Non-Quantitative Treatment Limitations (NQTLs) are restrictions or criteria sets "which otherwise limit the scope or duration of benefits for treatment" and are not expressed numerically.

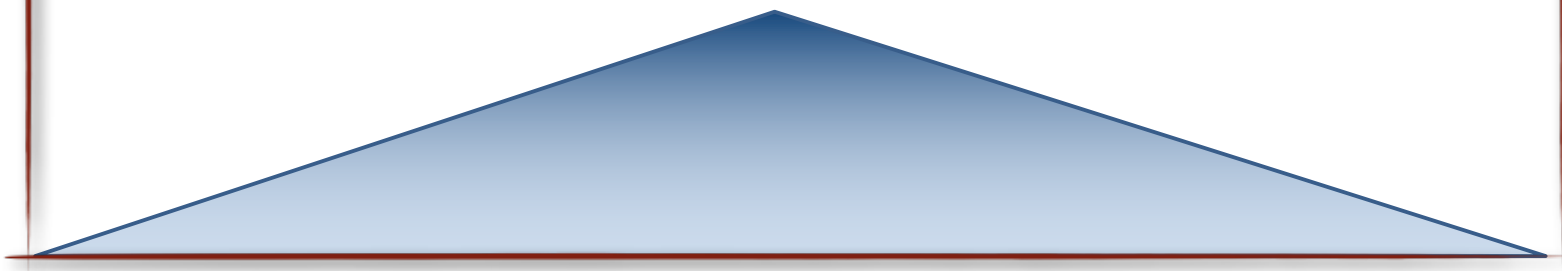
These include non-quantitative management techniques (NQMTs) such as:

- Prior authorization
- Utilization review
- Fail-first policies
- Prescription design
- Access to intermediary levels of care



Parity Resources

- https://www.dol.gov/ebsa/mentalhealthparity/
- http://store.samhsa.gov/product/SMA16-4983
- http://store.samhsa.gov/shin/content//SMA16-4937/SMA16-4937.pdf



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Impact of Parity

- Employers and Health Plans have made progress in implementing the parity law, especially in the area of financial requirements and QTLs
  - Increased access to MH and SUD services since passage
  - Decreased financial burden for households accessing MH and SUD care (lower out of pocket costs)

HOWEVER

- NQTL enforcement: still a problem in terms of:
  - UM/UR
  - Application of MN criteria
  - For hospitals' behavioral health services

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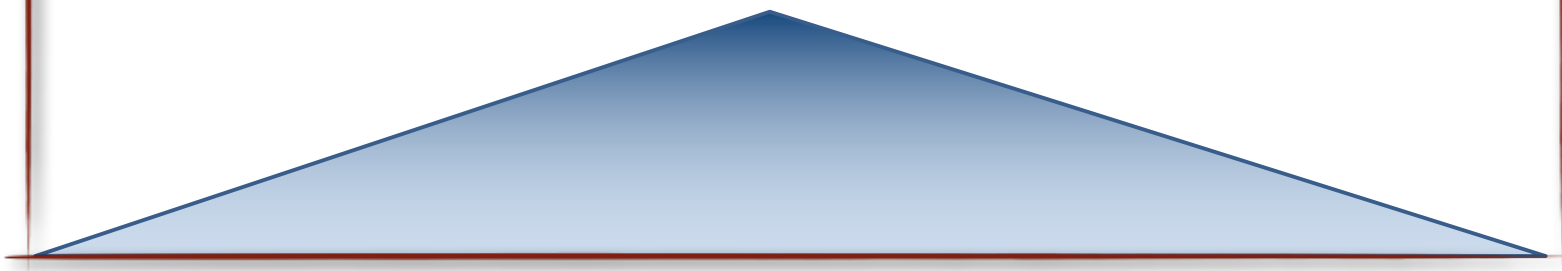
UTILIZATION MANAGEMENT
UTILIZATION REVIEW



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Why is UM/UR So Important?

DENIALS OF CARE COST HOSPITALS $$ *and lead to poor clinical outcomes*

CONSIDER:

- What are your costs in terms of lost revenue from denials of care? What is your actual denial rate? Are you measuring it correctly?
- How "strong" is your hospital's UM/UR denial review process?

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What You Need to Know About UM/UR

- There is no advantage to agreeing with an MCOs decision to deny care.
  - Hospital UM/UR process must be responsive to MCOs.
- Clinicians performing patient assessments as well as UR staff must become very familiar with Medical Necessity Criteria for each MCO as well as NYS LOCADTR for SUD treatment.
- LOCADTR must be done with every request for additional days/visits.
- **Medical Necessity requirements are based on functional deficits.**

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What You Need to Know (Continued)

- Clinicians performing patient assessments as well as UR staff must become very familiar with how the MCO is interpreting the MN criteria. Examples are:
  - The role of a suicidality threat in SUD patients' treatment.
  - The role of a supportive home environment where substance use is taking place.
  - The Impact of co-morbidities on the LOC determination.
- **Documentation of Functional Assessment and Functional Deficits must be emphasized in patient assessments.**
- Poor documentation leads more likely to denials: Clinicians must document for clinical reasons, and also to meet medical necessity criteria for a particular level of care, based in terms of functional deficits.

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What You Need to Know (Continued)

Knowledge of the medical necessity criteria used by MCOs and how they are applied to denials of care is vital to advocating for authorization of care by a hospital for Inpatient or Outpatient treatment.

Pay Attention to the process:

- Physician to Physician Reviews can include non-physician clinicians or UR staff, if physician is unavailable.
- Medical Necessity Criteria are met if no appropriate lower level of care is available.
- Make it a point to know the availability of alternate levels of care and their accessibility.

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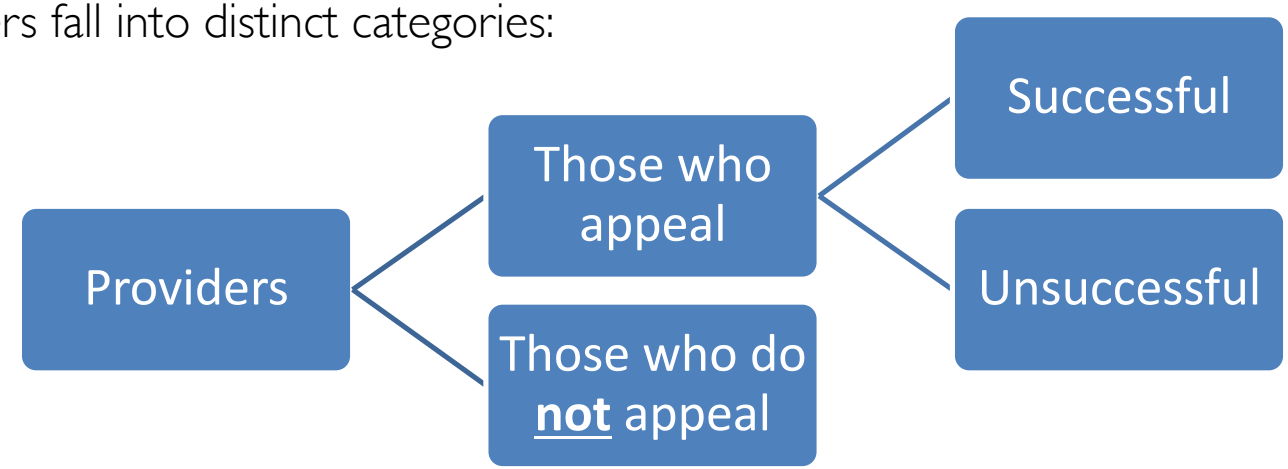
What You Need to Know About the Appeals Process

More time spent on Appeals means less time spent on patient care

Providers fall into distinct categories:



Common reasons why providers choose not to appeal:

- Lack of staff/resources
- Revenue loss does not outweigh cost to file appeal
- Feel probability of success is low

Managed care organizations understand these issues and more importantly have a good idea of what bucket you fall into

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So What?

- If BH book of business is negligible to the overall hospital book of business, paying attention to the requirements of the parity law may not have a large financial impact (though the clinical impact remains).
- If however BH plays a significant role in the Hospital's overall book of business, the MHPAEA is an important tool in your relationship with plans.

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Consider

- How much revenue is lost because of inappropriate claims denials?
- How much time does the treatment team use to process concurrent reviews?
- How often does the treatment team have to respond to concurrent reviews, to yield an average length of inpatient psychiatric stay of 10 days?

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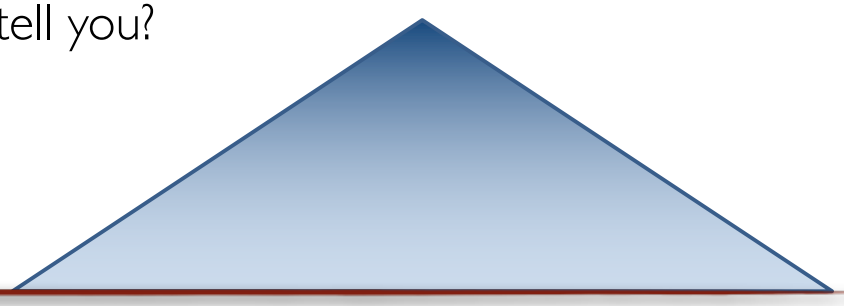
Consider (continued)

- What is the impact of the treatment team's time spent on response to managed care queries on an individual patient's care?
- For example, would it cost effective to establish a permanent claims analyses team consisting of UM/UR staff, a clinician and finance person to address UM/UR issues involving the MCO?
- What does your data tell you?



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DATA METRICS

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Data Metrics (Data is King!)

Examples of key metrics to track:

- # of denials as percent of number of requests for authorizations.
- Reasons for denial.
- Disposition following denial (e.g., if request for inpatient admit is denied, what LOC was approved).
- Average # of days/visits approved per authorization.
- Metrics need to be developed for both BH and M/S services.

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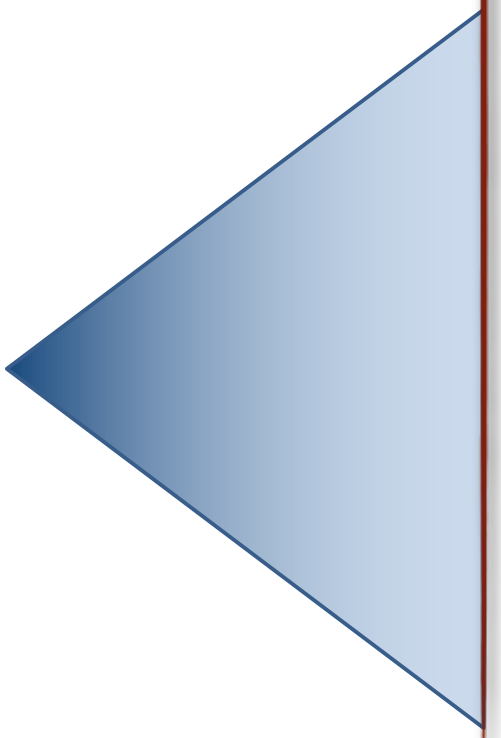
Data Metrics: Takeaways

- Differences in similar metrics for BH and M/S (e.g., 30% denial rate for BH services vs. 10% for M/S).
- Low # of authorized days/visits relative to your normal length of stay or duration of treatment for similar conditions.
- Routine outpatient behavioral health services are subject to pre-authorization or continued treatment review within the first 30 visits.



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Summary

- MHPAEA is shifting the paradigm to improving access to and utilization of Behavioral Health services
- Devote time and resources to tracking a plan's performance and case dispositions
  - Monitor denial trends and individual case dispositions
  - Be alert to consistent misapplication of certain MN criteria
  - Consider approaches that might ease the demands on the treatment team for appeals and denial responses, such as a special BH claims analysis team noted in previous slide.

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Summary (continued)

- Educate staff about the MHPAEA, especially the NQTLs
- Document, document, document in the case records
  - Be willing to launch and sustain appeals
  - Consider establishing a financial/clinical team to monitor plan performance in light of the MHPAEA rules

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Thank you!

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