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Clarity on Parity: New Federal Guidance on Addiction Treatment Reimbursement

Over the past year, addiction treatment programs nationwide have experienced a steep rise in the level of health insurance plan denials of coverage, audits and investigations, and other obstacles to payment of billed claims. While insurance companies have asserted that they are responding to problems of fraud and abuse in addiction treatment, one looming question has been what limitations the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) imposes on health plans. The MHPAEA prohibits health insurers from discrimination in coverage for behavioral health conditions relative to traditional medical health. In essence, it constrains insurers from making it harder for patients to access behavioral health benefits and for providers to be paid for mental health and addiction services.

In some cases, addiction treatment insurance coverage practices have developed in ways that appear to be inconsistent with the MHPAEA's mandate for non-discrimination. Addiction treatment programs, for example, have grown accustomed to seeking pre-authorization for coverage of new patients at the time of admission, including submission of data to utilization review nurses – a step that has no equivalent in hospital or skilled nursing facility admission. In recent months, insurers have attempted to add new requirements, such as requiring proof of collection of deductibles or coinsurance or requiring the patient to join a live telephone call with utilization review nurses (providing an opportunity for the health plan to attempt to reroute the patient to a different provider). These kinds of requirements appear to be distinctively imposed only on addiction treatment programs. Are they discriminatory? What can providers do about it?

In recent months, some "clarity on parity" has been achieved, some for better and and some potentially for worse. The "bad news" is that mental health/addiction parity remains a long way off. A June 2016 report from the National Center on Addiction and Substance Abuse (CASA) suggests that insurance plans nationwide are not even coming close to meeting their obligations under the MHPAEA. According to CASA, over two-thirds (2/3) of plans are not covering the necessary services they are required to cover for patients needing addiction treatment, in violation of the law. As a consequence, access to badly needed addiction treatment remains unavailable and a long way off for countless people in need.
Even more problematic is that the MHPAEA does not provide "teeth" to help addiction treatment providers or patients do anything about it. There are no MHPAEA penalties for health plan or states that do not comply. Moreover, in May 2016, the U.S. Second Circuit Court of Appeals issued a ruling in *American Psychiatric Association v. Anthem Health Plans* that the MHPAEA (as well the federal benefit plan law, ERISA) do not provide healthcare providers with standing to sue health plans for parity violations. In the absence of any statutory right of action or provider standing, the only remedy for violations of the MPHAEA by health plans will be complaints to government agencies for investigation. The *APA v. Anthem* decision, if followed in other federal circuits, will limit the ability of addiction treatment providers to utilize the MHPAEA to advocate for access to care for their patients.

At the same time, there is good news in terms of federal regulatory clarification. On June 2, 2016, the federal government (through the U.S. Department of Labor) released new guidance on the MHPAEA that should put greater pressure on health plans. Specifically, the Department clarified what types of activities by health plans would be deemed violative of the MHPAEA. Entitled "Warning Signs," the guidance addresses Non-Quantitative Treatment Limitations (NQTLs), a complicated acronym for things insurers do to delay or deny coverage. A Quantitative Treatment Limitations (QTL) would be a health plan practice that quantifiably limits care, such as a cap on the number of visits covered by health insurance. A NQTL is a non-numerical limit on the scope or duration of coverage,

such as preauthorization requirements in general, requiring proof of collection of coinsurance, or requiring patients to be on the telephone call during preauthorization.

The guidance notes that the MHPAEA distinguishes between QTLs and NQTLs, and focuses on NQTLs. Under MHPAEA regulations, a health insurer may not impose an NQTL on addiction treatment (aka substance use disorder (SUD) benefit) unless the coverage would treat traditional used in applying the limitation with respect to medical benefits the same way. Some of the types of NQTLs that the MHPAEA regulations (26 CFR § 54.9812-1(c)(4)(ii); 29 CFR § 2590.712(c)(4)(ii); 45 CFR § 14) limit include:

- medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review);
- formulary design for prescription drugs;
- network tier design;
- standards for provider admission to participate in a network, including reimbursement rates;
- plan methods for determining usual, customary, and reasonable charges;
- fail-first policies or step therapy protocols;
- exclusions based on failure to complete a course of treatment; and
- restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

The new guidance describes certain “red flags” on health plan NQTLs that appear to be discriminatory against addiction (and mental health) treatment in comparison to medical or surgical (med/surg) coverage. These are broken into four main categories: (1) preauthorization requirements; (2) “fail first” requirements; (3) probability of requirements; (4) written treatment programs; as well as limitations on coverage for patient noncompliance, limitations on residential treatment, geographic limitations, and licensure requirements.

It is essential for addiction treatment programs (and their billers and legal counsel) to understand these red flags, because a detailed review of the guidance reveals many practices that, in our experience are widespread. The preauthorization “red flag” examples include **Blanket Preauthorization Requirements** (*i.e.* plans requiring preauthorization for all mental health and substance use disorder services); **Treatment Facility Admission Preauthorization** (*i.e.* plans providing that non-emergent admissions to treatment programs without prior authorization will not be covered); **Medical Necessity Review Authority** (*i.e.* plans delegating medical precertification and concurrent review to physicians but conducting their own reviews for addiction treatment); **Prescription Drug Preauthorization** (*i.e.* plans requiring preauthorizations of pain medications for mental health and SUD conditions); and **Extensive Pre-notification Requirements** (*i.e.* plans requiring pre-notification for all inpatient, IOP, and extended outpatient visits in excess of 45-50 minutes).

While these preauthorization red flags may appear familiar to many addiction treatment billing personnel, the “fail-first” protocols may be less commonly known. These include **Progress Requirements** (*e.g.* demonstrating that outpatient (OP) care at a lower frequency was not effective before authorizing IOP) and **Treatment Attempt Requirements** (*i.e.* requiring a patient to try PHP, IOP or outpatient detoxification before authorizing residential treatment). The “probability of improvement” red flag is **Likelihood of Improvement** requirements **(***i.e.* plans requiring probability of measurable improvement as a condition for coverage of residential treatment). While there are coverage decisions in medical care that may have some relationship to success or failure, these fail-first and probability of improvement requirements are suspect based on their overuse as a tool to deny mental health and addiction treatment coverage.

The fourth category, “written treatment plan” requirements include requiring a **Written Treatment Plan** to be prescribed and supervised as a condition of coverage; making a **Treatment Plan Required within a Certain Time Period** (*i.e.* provided within 7 days, based on complex bio-psychosocial evaluation, or updated weekly); or requiring **Treatment Plan Submission on a Regular Basis** (*i.e.* every 6 months).

Finally, the guidance identifies four specific types of red flags: (1) **patient non-compliance** (including treatment against the provider’s medical advice); (2) **residential treatment limits** (*i.e.* flatly excluding residential treatment in favor of outpatient); (3) **geographic limitations** (*i.e.* limiting geographic service area for mental health or addiction care, but not for medical care or surgery); and (4) **licensure requirements** (*i.e.* plans requiring state licensing for mental health/addiction without imposing the same requirement on med/surg facilities).

The guidance on these types of NQTLs should be a clarion call to health plans to take stock of the extensive coverage requirements that they are specifically imposing on addiction treatment (SUD) and mental health services, without applying to medical/surgical services. In the mean time, addiction treatment providers encountering these

types of coverage limitations should investigate whether similar limits are being applied to med/surg benefits. If not, addiction treatment providers should consider complaining and (in light of the standing issues) urging patients to complain. Complaints can be directed to numerous federal agencies (the Departments of Labor, the Treasury, and Health and Human Services), as well as to State agencies charged with oversight. The Department of Labor is also receiving complaints about employment-based group health plans on MHPAEA at of Labor here. It will be interesting to see whether the latest “clarity on parity” reduces discrimination against addiction treatment insurance coverage. At a minimum, it will help patients and providers understand and assert their rights.

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