



Tailoring Peer Services How Health Reform, Parity and Recovery Inform The Mission

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Lots of Moving Parts

- Concept of Peer Services Not New, But Increasingly of Interest to Payers
- Health Reform Altering Who Has Access To Insurance, How Care Is Structured
- Parity Legislation Addresses Part of Historic Discrimination
- Deep Cuts In State Funding Imperil Existing Programs

Peer Services

- The Concept of the “Good and Modern” Addictions and Mental Health Service System
- The Concept of Recovery as Possible and Necessary
- The Concept of Qualified Peers As An Integral Part of Treatment and Recovery
- Examples of Services Under Consideration

Patient Protection and Affordable Care Act (ACA)

The Act Does Several Things:

- Expands Insurance Coverage
- Institutes Insurance Reforms
- Builds Infrastructure To Provide Improved Health Outcomes
- Puts In Motion Structural Changes To How Healthcare Delivery Is Structured & Financed

Goals of Act Are To:

- Increase Access
- Provide Comprehensive Care → Better Health Outcomes
- Control Costs

Most Provisions of ACA Are Implemented Over The Next Four Years

- Phased Implementation Is Needed To:
 - Build Needed Infrastructure
 - Plan and Implement Provisions Well
- Changes To Benefits and Insurance Reforms Began To Be Implemented In 2010
- Some Provisions Must Be Implemented Over Several Years
- Major Coverage Expansion Occurs in 2014
- Longer-term Benefits Result From Sum of Structural and Cultural Changes

Expanded Health Insurance Coverage - 2014

- Insurance Coverage Expands From 83% to 94%
- Individual Mandate Applies
- Subsidies For Those Under 400% FPL
- Medicaid Eligibility Set At 133% FPL
- Medicaid Expands from 34 to 50 Million
- 25 Million Get Insurance Through State Exchanges

Result of Coverage Expansion

- Result of Change in Coverage for non-elderly individuals (by 2019)
 - 158 M will have coverage through employers
 - 50 M will have coverage through Medicaid/CHIP
 - 25 M will have coverage through exchanges
 - 26 M will have coverage through non-group plans
 - 26 M will remain uninsured

Source: Congressional Budget Office

What Do We Know About the Newly Covered?

Traits	<100% FPL	100- 200%	>200% FPL
Poor or fair <i>physical</i> health	25%	18%	11%
Poor or fair <i>mental</i> health	16%	11%	6%

Source: Center on Budget and Policy Priorities

What Do We Know About the Newly Covered?

- Individuals Near the Federal Poverty Level—
More diverse group than we think
 - 40% under the age of 29
 - 56% are employed or living with their families
 - Conditions are more acute when they present
 - Care is more costly
 - They are apt to have small children

Source: Center on Budget and Policy Priorities

What Do We Know About Coverage?

- 2014 - Requirement To Have Essential Benefit Coverage In Exchanges
- Final Decisions Not Yet Made – Categories Mandated By Law:
 - Mental health and substance abuse services
 - Rehabilitation and habilitation services
 - Pharmacy
 - Preventive and wellness services

ACA Expands Parity - What Is It?

- ➔ Dictionary – equal or equivalent, at symmetry, not favoring one over another, fairly matched
- ➔ Parity As A Legal Construct:
 - ➔ A group of State Laws Beginning In the mid 1990s – Over Half of States Have Some Form of Parity Law
 - ➔ 1996 Federal Mental Health Parity Act:
 - ➔ Prohibit different annual and lifetime dollar limits
 - ➔ did not extend to substance use
 - ➔ 2008 Medicare Improvements for Patients and Providers Act
 - ➔ By 1/1/2014 Phases out higher coinsurance for outpatient mental health care
 - ➔ 2008 Federal Mental Health Parity and Addictions Equity Act:
 - ➔ Effective October 3, 2009
 - ➔ Regulations Effective As Policies Renew On/After July 1, 2010
 - ➔ 2010 Health Reform Law Expands To Broader Population In 2014 and Puts in Place Incentives for Integrated Care

Parity – Why Does It Matter?

→ Historical Discrimination

- Additional Financial Costs
- Annual and Lifetime Maximums on Benefits
- Stricter Management of the Benefit
 - Medical Necessity
 - Treatment Limitations

→ Goal Of Parity Law Is To:

- Increase Access To Treatment
- Remove Discriminatory Financial Costs
- More Equal Treatment For These Medical Conditions

Who Does The Law and Regulations Cover?

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- Employer Based Insurance of Groups Over 50 Lives which choose to offer both a mental health or substance use condition benefit as well as medical/surgical benefits
 - 111 Million Covered By Private Employer Plans
 - 29 Million Covered By State and Local Government Plans
- Medicaid Managed Care Plans, But Scope Unclear At This Time – 33.4 Million
- Union Negotiated Plans and Some Government Plans (not Medicare, VA, Tricare, FEHBP, Medicaid)
- Through Health Reform Parity Protections Extended:
 - Individuals and Small Group Employer Plans Thru Exchanges – 2014 – 25 Million
 - Newly Eligible Medicaid Recipients Thru Benchmark Plans – 2014 – 16 Million
 - CHIP Enrollees – 2010 – 40 Million
- Total Impacted = 244.4 million – 80+% of population and growing

What Is Excluded From Parity Requirement?

- The law does not require that an employer offer mental health and/or substance use benefits
- The law permits an employer to limit the diagnosis which will be covered
- The law provides a possible cost exemption:
 - If cost is more than 2% greater in first year due to parity employer can request exemption for next year.
 - If cost in subsequent year is 1% greater due to parity employer can request exemption for further year.

How Is Parity Determined?

→ The Law Stipulates:

- Covered group health insurance plans that offer both medical/surgical and mental health/ substance use benefits must offer them at parity

→ Parity Is Defined To Include:

- Financial requirements including deductibles, coinsurance, co-payments, and other cost sharing requirements, as well as annual and lifetime limits on the total amount of coverage.
- Treatment limitations include restrictions on the number of visits or days of coverage, or
- Other limits on the duration and scope of treatment.

→ Does Not Preempt Stricter State Laws – This Impacts State Regulated Insurance Policies, But Not Self Insured Plans

Regulatory Standards For Determining Parity

- MH/SUD benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits
- If a group plan provides for out of network medical/surgical benefits, it must provide for out of network mental health and substance use benefits
- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD must be disclosed upon request

Non Quantitative Treatment Limitations

- Nonquantitative treatment limitations include medical management, step therapy and pre-authorization.
- Processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitations to MH/SUD benefits to MH/SUD in a classification are comparable to and applied no more stringently than what is applied to medical/surgical benefits except to the extent that recognized clinically appropriate standards of care may permit a difference.

Appeals and Complaints Process

- Reasons for Denials must be provided
- Criteria for Medical Necessity Available Upon Request
- Appeals related to Fully Insured Plans can be directed to State Insurance Commissioner
 - http://www.naic.org/state_web_map.htm
- Department of Labor has primary federal responsibility
 - <http://www.dol.gov/ebsa>
 - Call toll- free 1-866-444-EBSA (3272).
- CMS has secondary federal responsibility
 - http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.asp
 - Call toll-free 1-877-267-2323 extension 6-5511

Impact of Affordable Care Act

Focus on coordination between primary care and specialty care:

- Significant enhancements to primary care
 - Workforce enhancements
 - Increased funding to SAMHSA, HRSA and IHS
 - Bi-directional
 - MH/SUD in primary care through FQHCs
 - Primary care in MH/SUD settings through CMHCs and other agencies
 - Services and technical assistance
- Health Homes and Accountable Care Organizations
- Recovery and Peer Services Need To Fit Into These Paradigms

Implications For States & Providers

- Need For Infrastructure To Work With Insurance
- Grant Funds Reconceptualized To Not Duplicate Insured Benefits
- Medicaid Changes and State Insurance Mandates
- Integration of MH/SU with Primary Care
- Health Homes and Accountable Care Organizations
- Electronic Health Records
- Payment Reform Pilot Programs
- Evidence Based Practices
- Licensure and Credentialing Standards

Final Thoughts

- ACA and MHPAEA Will Meaningfully Help Those Who Are At Risk For or Need Behavioral Health Services
- Change Is Complex and Imperfect – It Takes Time
- New Partnerships and Ways of Doing Business Will Be Needed
- Getting A Seat At The Table Will Depend On Value Brought To The Table
- We Cannot Expect That Others Will Understand The Value of Peer Services
- We Need To Educate, To Inform, To Persuade, To Perform, To Measure and Communicate Impact
- We Who Serve Others Will Need To Keep Up With The Changes
- We Need To Keep Our Compass On True North

True North For SAMHSA

Four Simple Truths:

- Behavioral Health Is Essential To Health
- Prevention Works
- Treatment Is Effective
- People Recover

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover