

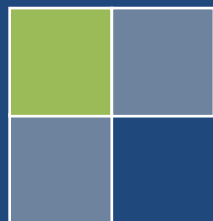


Implementing Healthcare Reform: First Steps to Transforming Your Organization

A Practical Guide for Leaders

Recommendations from
the Moving Forward Alliance.

A collaborative effort coordinated by:



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The Moving Forward Alliance

Recognizing the tremendous challenges and opportunities facing the addiction services field as a result of the passage of parity and healthcare reform legislation, a group of field leaders and national organizations began to meet informally. The purpose of their meeting was two-fold:

- ✓ To share the latest information on implementation activities related to this ground-breaking legislation;
- ✓ To explore opportunities for cooperation and collaboration to ensure that effective policies are in place and that addiction services providers are prepared for healthcare reform and parity implementation.

This guide is a product of those discussions.

The authors of this document wish to thank the Alliance members for their commitment and dedication, to this effort and to the field of addiction healthcare and the millions of Americans in need of substance use disorder (SUD) services:

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Introduction

The goal of a "good" and "modern" system of care is to provide a full range of high-quality services to meet the range of age, gender, cultural and other circumstances.

—John O'Brien, SAMHSA Senior Adviser for Health Finance

Purpose of this guide

I wish I had an instruction manual that would tell me, step-by-step, how I am supposed to make my agency ready for healthcare reform. I don't even know where to start.

—CEO of an addiction treatment agency upon hearing that healthcare reform had passed and business practices would have to change as a result.

Even before the passage of healthcare reform legislation in early 2010, experts were predicting that specialty addiction services providers would need to assess and adjust their business philosophies and practices to take advantage of the many opportunities that would follow reform.

Reform is now a reality. It is time for organizations to determine how they are going to

transform in order to reach the more than 20 million people who need treatment and are not getting it. Reform also means an expansion in available funding for prevention, treatment, and recovery support services as Medicaid reimbursement expands and the door opens to third-party payer reimbursements. However, to capitalize on the opportunities created by parity and healthcare reform, organizations will have to:

- Recognize the need to transform;
- Help their boards of directors, managers, and staff to understand not only the elements of transformation but *why* change is crucial to the survival of the organization;
- Honestly assess the strengths and weaknesses of the organization at every level;
- With conscious thought and purpose, develop a workable strategic plan and/or business plan that comprehensively addresses all aspects of the organization's culture, practices, and processes;
- Develop or enhance partnerships with primary health clinics, physician group practices, and hospitals;
- Implement the plan, immediately assess its effectiveness, and identify areas for sustainment and improvement.

This guide is not intended to be all-inclusive but rather to serve only as a starting point for the transformation process. The information contained in this document is an initial set of recommendations and resources to aid in preliminary planning efforts. Its purpose is to serve as a resource to help leaders change their organization's business practices to meet requirements under healthcare reform.

Agencies that can accomplish the following will be positioned to succeed in the era of healthcare reform:

- ✓ **Recognize the need to transform**
- ✓ **Educate boards, managers, and staff**
- ✓ **Assess the strength and weaknesses of the organization**
- ✓ **Strategically plan and implement transformation**
- ✓ **Create partnerships with primary health entities**
- ✓ **Assess changes and adjust as needed**

Failure to Act

In most significant transformation efforts, some individuals and groups hold out. They choose to do nothing in the hope that the experts are wrong in their assessments. However, in the case of healthcare reform, alternate ways of doing business are already occurring.

While no one can predict what will happen to an organization that does not undertake the type of transformative processes discussed here, the expert consensus is that organizations that fail to adjust will struggle to survive:

- ✓ Inadequate or poor billing practices will result in rejected claims and lost revenue.
- ✓ Lack of partnerships with primary health providers will reduce referral opportunities, leaving many people without access to critical addiction services. This will result in a loss of potential revenue for specialty addiction services agencies. Individuals in specialty treatment with other health-related illnesses may also fail to gain access to needed primary care services.
- ✓ Other enterprises will step in to fill the void left by specialty treatment agencies unwilling to adjust to the changing environment, threatening the existence of the specialty treatment system. This contradicts the belief held by addiction healthcare agencies that specialty treatment services should be provided by those most knowledgeable and with the most experience in addiction sciences.

The bottom line: millions of people will continue to go untreated; millions of dollars will be lost to organizations in desperate need of revenue sources beyond the cash-strapped, publicly funded system; specialty treatment services will become obsolete as primary healthcare enterprises fill the void to meet the demand.

A Note for Prevention

Prevention will be a key component of healthcare as reform evolves. Language in the *Patient Protection and Affordable Care Act* refers to wellness, health promotion, and prevention. This underscores what SUD prevention advocates have known for decades—prevention saves lives and saves money.

As a result, prevention will also need to undergo significant transformation in the new environment—perhaps even more so than treatment agencies. Prevention programs are not structured to bill on a fee-for-service basis, a billing method required by insurance and other third-party payers.

So what will prevention look like in the new environment? That answer is unknown. However, prevention agencies should be prepared to undergo the same level of transformation as their treatment counterparts.

Preventionists should read this guide, keeping in mind that while the future is unclear, transformation is likely in their future as well.

Use this guide as a resource and a starting point for organization transformation efforts. The time to act is now!

Resources for Getting Started

There are many resources available to organizations on the topics discussed in this guide. Before an organization begins this process, the Moving Forward Alliance recommends the following reading:

✓ ***A Path Forward to Measuring Continuing Care Management for Substance Use Illness: Patient-Focused Episodes of Care***, developed by the National Quality Forum, November 4, 2009

<http://www.niatx.net/PDF/AcceleratingReform/NationalQualityForum.pdf>

- ✓ ***National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices***, developed by the National Quality Forum
<http://www.rwjf.org/files/research/nqrconsensusreport2007.pdf>
- ✓ ***Effects of State Health Care Reform on Substance Abuse Services in Maine, Massachusetts, and Vermont: Considerations for Implementation of the Patient Protection and Affordable Care Act (PPACA)***, developed by National Association of State Alcohol and Drug Abuse Directors (NASADAD), June 2010
http://www.nasadad.org/resource.php?base_id=2104
- ✓ ***Accountable Care Organizations, Health Cost Containment and Efficiencies: A brief to state legislators from the National Council of State Legislators (NCSL)***
<http://www.ncsl.org/default.aspx?tabid=19927>

- ✓ ***Transforming Your Organization: Global Organizational Development White Paper Series***, by John B. McGuire, Charles J. Palus, William Pasmore & Gary B. Rhodes, from the Center for Creative Leadership
<http://www.ccl.org/leadership/pdf/solutions/TYO.pdf>
- ✓ ***Strategies for Strengthening Substance Use Prevention, Treatment and Recovery Systems: Provider Networks and Impact on the Workforce***, prepared by State Associations of Addiction Services, January 2009
http://saasnet.org/PDF/SAAS_Provider_Networks_Report1-9-08.pdf
- ✓ ***California Primary Care, Mental Health, and Substance Use Services; Integration Policy Initiative, September 14, 2009***
- ✓ ***Preparing for Parity: Investing in Mental Health, A Milliman White Paper***
<http://publications.milliman.com/research/health-rr/pdfs/preparing-parity-investing-mental-WP05-01-09.pdf>
- ✓ Additional resources are also available at:
 - The SAMHSA Financing Center of Excellence at <http://www.samhsa.gov/Financing>
 - <http://www.managementhelp.org>, a free, online library for not-for-profit and for-profit managers
- ✓ Also check out <http://www.niatx.org> for information on the ACTION Campaign, the Accelerating Reform Initiative (ARI), and the Provider Toolkit. NIATx resources are free to providers.



R

eform: Transformed Healthcare

This legislation will not fix everything that ails our health care system, but it moves us decisively in the right direction.

– President Barack Obama following the passage of historic health care reform legislation, March 21, 2010

Healthcare 2010

On April 5, 2010, the final rule governing implementation of the Wellstone/Domenici Mental Health Parity and Addiction Equity Act went into effect. These regulations include several provisions that improve access to critically important addiction and mental health treatment for millions of Americans, primarily requiring many health plans to cover addiction and mental health services on par with other health conditions. Passage and implementation of parity marked a milestone for addiction and mental healthcare advocates who had for decades fought for its passage.

On March 23, building on the success of parity, advocates watched as President Obama signed into law H.R. 3590, the “Patient Protection and Affordable Care Act.” The new law, approved by the U.S. Senate on December 24, 2009, and the U.S. House of Representatives on March 21, 2010, includes a number of provisions aimed at improving coverage for and access to substance use disorder and mental illness prevention, treatment, and recovery services. The unified and coordinated effort by advocates for people in need of substance

use disorder and mental illness prevention, treatment and recovery support services contributed greatly to the passage of this federal statute.

The new federal healthcare law will expand coverage to tens of millions of uninsured Americans, resulting in coverage for approximately 95 percent of the legal population.

Key Provisions

The following is an overview of key components of the final legislation:

- **Substance use disorder and mental health (SUD/MH) services will be included in basic benefit packages.**
- **All plans in the health insurance exchange will be required adhere to the provisions of the Wellstone/Domenici Parity Act.**
- **Medicaid enrollees, including newly eligible childless adults, will receive adequate health coverage, including SUD/MH coverage.**
- **SUD/MH will be included in chronic disease prevention initiatives.**
- **SUD/MH workforce in health workforce development initiatives.**
- **SUD prevention, treatment, and MH service providers to be eligible for community health team grants aimed at supporting medical homes.**
- **Expanded Medicaid coverage for all Americans below 133 percent of the federal poverty level.**
- **Health insurance exchanges created for individuals and small employers to pool risk and purchase insurance.**

Who is affected?

- By various estimates, at least 111 million people
- 82 million are in self-insured plans
- Self-insured state and local government plans may opt out.
- 460 health insurers and 120 Managed Behavioral Healthcare Organizations (MBHOs)

For more information on other provisions in the new law go to:

The Commonwealth Fund

<http://www.commonwealthfund.org/content/publications/other/2010/timeline-for-health-care-reform-implementation.aspx>

Legal Action Center

<http://www.lac.org>

The Kaiser Family Foundation

<http://www.kff.org/healthreform/upload/8061.pdf>



Transformation

Just focusing on [how to bill], and not understanding why the change has occurred, won't by itself be helpful. [Providers] need to understand clinically who they're serving and what they're offering them.

– Victor Capoccia,
Alcoholism and Drug Abuse Weekly, May 31, 2010

Transformation in a new world

As health reform legislation is the most sweeping social policy change in decades, the changes required of the substance use disorder and mental health fields in response will be just as sweeping.

The amount, depth, and breadth of the transformation necessary to implement reform effectively go far beyond any change the field has seen in the past. Reform will necessitate not only organizational restructuring, but the development of new services and the use of new technology. To be successful and sustained over time, reform demands a radical shift in the philosophy, culture, behavior, and mindset of an organization.

This shift in mindset is similar to shifts that have occurred in other industries as technology has

evolved. For example, in response to the customer’s desire for smaller, better quality, and more fuel-efficient vehicles, automakers changed their business practices and the way they related to their customers. Communications companies and utility companies continue to evolve in response to technology and the “green” movement. In each of these examples, change was necessary for survival.

Without transformation, millions of people will continue to go untreated and millions of dollars will be lost to organizations in desperate need of revenue sources beyond the cash-strapped, publicly funded system.

Addiction service providers can expect to face the same magnitude of change as a result of healthcare reform. In this new environment, transformation is not just a matter of thriving, but of surviving.

In the broadest sense, behavioral health care providers can expect the following:

1. Agreements with managed behavioral healthcare organizations (MBHOs) or other forms of managed care.
2. More rigorous professional credentialing of staff and organizations.
3. Utilization management (pre-certification and/or service and benefit authorization).
4. Increased use of diagnostic and screening tools to substantiate diagnoses.

5. Increased use of decision-support and treatment-planning tools that help plan and track treatment across longer episodes of care.

6. Expanded communication and collaboration with other healthcare providers, such as primary care physicians, federally qualified health centers (FQHC), and other specialty providers.

7. Documentation that care is consistent with evidence-based (scientifically-validated) best and promising practices.

8. Incentives to:

- ✓ Develop new levels of services and new services for co-morbid or co-occurring disorders,
- ✓ Expand geographic coverage, and
- ✓ Create or enhance relationships with primary care clinics.

In order to lead transformation, leaders must first transform themselves.

9. Encouragement to develop disease management programs and services for those with serious mental illness and various other chronic conditions.

10. Incentives to ensure timely, accurate, and efficient reporting of health information. Electronic health record systems to coordinate care, safety (especially in prescribing medications), and electronic billing will be a part of standard business practices.

11. Different plans will cover different services resulting in an array of coverage and more complex contracts than those that exist today.

12. Increased need for data management to report performance outcomes, enable quality improvement, and financial analysis and efficiency.

13. Increased collaboration with utilization management (usually Masters-level behavioral healthcare professionals) in treatment planning.

14. New funding streams will stimulate competition for new resources.

(Parity: A Call to Action for Mental Health & Addiction Treatment Providers, Advocates for Human Potential, June 2009. Download a copy at

<http://www.ahpnet.com/documents/AHPBHParitySeries3ProviderWhitePaperFinal6.16.09.pdf>)

In order to successfully transform any organization in the new environment, its leaders must transform their way of thinking, behaving, and operating. The challenges of transformation will require leaders with a deeper understanding of why change is important and what changes are needed. Leaders must also stay current in best practices and research as they and their organizations evolve. ***In order to lead transformation, leaders must first transform themselves.***

Opportunities

Reform presents many opportunities for organizations that acknowledge the need for transformation. One of the greatest opportunities health reform offers organizations is the expansion and diversification of revenue sources. The majority of non-profit, specialty-treatment providers rely heavily, in some cases solely, on state and federal funds to cover the cost of providing services. This dependence on public funds places agencies at the mercy of state budgets, legislative politics, and state economies. In recent years, depressed state economies have decimated the publicly-funded prevention and treatment system

Health reform expands the numbers of individuals who can access treatment services while

simultaneously expanding the available revenue for treating them by opening the door to third-party payers.

Health reform also significantly expands the need for specialty treatment agencies to develop ongoing and close relationships with primary care providers. Screening, brief intervention, and referral to treatment (SBIRT) has been an important component in discussions about health reform. SBIRT places early screening and brief intervention in the primary care setting where people generally come into contact with the healthcare setting most frequently. By connecting to a primary care physician who is conducting SBI, treatment providers can position their agencies to receive the referral to treatment from physicians. This enhanced relationship will serve to not only increase the specialty treatment providers' access to referrals from the primary care system, but also increase referrals of patients from treatment providers to primary care physicians. This symbiotic relationship will improve overall service for the patient.

“SBIRT research has shown that large numbers of individuals at risk of developing serious alcohol or other drug problems may be identified through primary care screening. Interventions such as SBIRT have been found to:

- ***Decrease the frequency and severity of drug and alcohol use,***
- ***Reduce the risk of trauma, and***
- ***Increase the percentage of patients who enter specialized substance abuse treatment.***

In addition to decreases in substance abuse, screening and brief interventions have also been associated with fewer hospital days and fewer emergency department visits. Cost-benefit analyses and cost-effectiveness analyses have demonstrated net-cost savings from these interventions.”

– SAMHSA

Threats

What happens to the government-sponsored, block grant-driven system when 30 million people enroll in Medicaid and other health insurance providing SUD treatment benefits?

The system, as it exists today, cannot meet the need. Agencies do not have an adequate number of trained staff to meet the potential influx of people who, under health reform and parity now have access to SUD treatment.

As a result, primary healthcare systems will develop their own competency in and capacity for prevention, treatment, and recovery support services, further marginalizing the addiction services field.



A

gency

Transformation

Significant organizational change occurs, for example, when an organization changes its overall strategy for success, adds or removes a major section or practice, and/or wants to change the very nature by which it operates.

– Unknown

Creating change

The kind of change discussed here is vast organizational transformation. Organizations that succeed under health reform will make significant modifications in their:

- Culture
- Philosophy
- Policies
- Business practices
- Business tools
- Staff competencies

Steps to transforming your agency

Planning

Planning for change is critical to any successful change effort. In order to succeed, an organization must have a detailed plan that identifies the current structure and where the organization wants to be in the future.

Planning is a cornerstone of this process. An organization should have:

- ✓ A strategic plan—an organization-wide plan for the future
- ✓ A business plan—a plan to develop a new product or service

Planning to Plan

Even before beginning the process to create a strategic or business plan, an organization should consider four key areas:

- ✓ ***Is the board strong enough to support this process from start to finish? Are the right people on the board?***

The Right Board of Directors

A strong board with the right members will make or break this transformation process. Uncertainty will cause stress and require solid, timely, and well-informed decision making.

Reform requires more than a quarterly update or progress report. It requires significant board buy-in and is only be possible if the board is thoroughly educated and committed to transformation.

The agency may need to identify new board members with competencies that will directly benefit the organization during the transformation process, i.e., board members experienced in primary healthcare or managed care.

- ✓ **Does the organization have the right staff in place?**

The Right Staff

It is not enough for CEOs to be committed to transformation. Ultimately, success will depend on a strong, mid-level management team that understands “why” transformation must occur. Mid-level managers can educate other staff and help to build the commitment to successful implementation.

- ✓ **Does the organization have the financial capacity to undertake this process?**

The Financial Capacity

As organizations develop potential new markets and new contracts, it is essential to have the financial data to support making solid business decisions. (For example, organizations with experience in Medicaid contracting and reimbursement will be ahead of those that do not.)

- ✓ **Does the organization have the change management capacity to undertake this process?**

The Change Management Capacity

An organization capable of successfully transforming has developed the internal capacity to manage change. Change management requires an understanding of change tools and techniques. It also requires the ability to motivate staff at all levels. A good place to find change management tools and process improvement techniques is the NIATx web site: <http://www.niatx.org>. The Provider ToolKit is designed to help organizations develop a culture of process improvement. Process improvement uses incremental change and will help an organization’s leadership develop the agility to implement large systems change.

If any of these four areas are lacking when conducting a pre-planning analysis of the organization's readiness to change, leaders should make every attempt to fill the void(s). The time to add the right board members, hire the right staff, or increase financial or change management capacity is before the transformation process develops further. Once the process has begun, addressing organizational deficiencies may require restarting the process.

Developing the Strategic Plan

A strategic plan outlines the future course of the organization. It should answer all of the following questions:

- 1) What services do we provide?
- 2) Who is/are our customer(s)?
- 3) How can we improve our services?

An analysis of current practices and the operating environment should accompany the strategic plan. Many organizations use a standard SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis, or an organization's leaders may choose to use an assessment tool specifically designed for healthcare reform transformation efforts.

Several strategic assessment tools are available to organizations. Some are free, while others are available for a fee. Be a conscientious consumer when selecting the tool that best meets the needs of your organization. Free tools may come with hidden costs. For example, tools found on the Internet may appear to be free, but in reality only a partial assessment tool is free while the complete tool is available for a hefty fee. The following are two examples of assessment tools.

Organizational Capabilities Assessment Tool (Advocates for Human Potential)

This provider-focused instrument evaluates organizational competencies. Its results may provide a base upon which an organization can take the necessary steps to thrive in this competitive environment. AHP offers this tool at no cost to organizations.

Framework for Assessing Specialty Addiction Treatment Agency Readiness for Health Care Reform

This tool is designed to help assess an organization's ability to operate in the environment created by parity legislation, healthcare reform, state budget shortfalls and increased performance accountability expectations. It will help answer the question, "What organizational qualities are needed to survive?"

A copy of this tool can be downloaded at:

http://www.niatx.net/WordDoc/ARI/ARI_Framework.doc.

The results of an organizational assessment will drive the implementation plan by identifying where leaders need make changes to policies and procedures, and how training and marketing can be incorporated. Organizations that have already developed the capacity to bring about change (e.g. through the NIATx model) are better positioned to achieve this level of transformation.

A Business Plan

A business plan is a formal set of business goals, why the organization believes they are attainable, and the strategy to reach those goals.

A business plan should include:

1. **A new business summary**—describes the organization, business venture or product/service, its purpose, management, operations, marketing and finances.
2. **A description of the market opportunity**—Describes unmet needs and what the customer will pay to meet those needs; also includes an analysis of the competition, and a description of current and potential partnerships.
3. **A description of the people responsible**—describes who will be responsible for developing, marketing, and operating this venture.
4. **A description of the implementation**—the how-to section of the plan, where action steps are clearly described, usually in four areas: start-up, marketing, operations and financial. This section should also describe the risks and challenges associated with this plan.

5. **Contingencies**—outlines what might go wrong during the implementation of this plan, and how management is prepared to respond to problems if they arise.

(Excerpt from http://managementhelp.org/plan_dec/bus_plan/bus_plan.htm)

The NIATx ACTION Campaign II focuses on business tools designed to help behavioral healthcare organizations reduce costs, improve services, and increase revenue. All ACTION Campaign II resources are free. (www.niatx.net/action)

Resourcing the plan

While the financial plan is actually a component of the business plan, it is important enough address separately. Developing a plan to resource the implementation of an agency's transformation is absolutely critical. This level of transformation will not occur overnight. It will take weeks, months, or even years before an agency's leadership feels confident that the organization has fully transformed to successfully operate in the new healthcare environment. Organizational change at this level requires serious investment of resources: money, time, and people. Any executive faced with a changing market knows that a company worth succeeding is a company worth investing in. In the case of healthcare reform, successful transformation will produce long-term dividends on a short-term investment.

Before beginning the transformation process, CEOs must budget for:

- Planning
- Training
- Assistance

In the case of healthcare reform, successful transformation will produce long-term dividends on a short-term investment.

Hiring a consultant

At any time in the process, leadership may recognize the need to bring in an outside consultant. This may be necessary in the pre-planning phase or once the agency begins to develop the strategic plan or the business plan. Often, hiring a consultant is better early in the process before getting too far down the planning road. Regardless of when a consultant is hired, the decision to do so is an important one. Hiring the right consultant is critical and can make or break the transformation process.

Consultants knowledgeable in organizational development/change, strategic planning, and

healthcare reform can be great assets to organizations that are undertaking this level of change. Many individuals and firms across the country can provide the level of assistance an agency needs to navigate this process. This guide does not endorse any one firm or individual, but recommends that agencies seriously consider hiring outside assistance for this effort.

Consultants can be expensive. However, cost-sharing is one strategy to minimize costs while maintaining quality of consultant services. Agencies can agree to collaborate and collectively hire a consultant to conduct training and technical assistance. This is an effective and cost-efficient way for multiple organizations to implement the change process.

What to look for when hiring a consultant or consulting firm:

- Reputation: Who has the consultant worked with in the past? In what industries? What are past clients saying?
- Evidenced-based methods: Does the consultant use best or promising practices? Is the information and methodology backed by research?
- Portfolio: What other work has the consultant done? In what fields?
- Cost: What will they do for their fee? Do they charge one fee for an entire package of services, or are certain offerings “a la carte”?
- Time: How long do they estimate the process will take? Does their estimate seem reasonable?
- Staff: How many people will they dedicate to the project? What are their qualifications?
- Customer oriented: Are they willing to listen to the agency’s concerns and respond to questions, or do they simply want to impose a “one-size-fits-all” process?

Hot Topics

While there are many areas of concern, providers have identified the following major areas that “are keeping them up at night”.

- ✓ Integration with primary care

Integration with primary care is a critical component of the new healthcare environment. A successful specialty treatment organization is one that will develop partnerships with local primary care physicians, hospitals, and clinics.

Integration will not only increase the likelihood of success in the new environment, it will increase access to the more than 20 million people in need of substance use disorder services.

Additionally, it will:

- Improve care and address the needs of the whole person (e.g. substance use disorders and co-morbid physical conditions),
- Make treatment more accessible, closer to home,
- Offer services in a neutral site for those concerned about stigma,
- Increase service efficiency and reduce costs: more comprehensive array of service responses aligned with true service needs, and
- Improve health outcomes, increase patient satisfaction.

(FADAA, Physical/Behavioral Health Care Integration, Tips for Providers to Work Successfully with Physicians.)

✓ Information Technology (IT) Systems

This includes scheduling, billing, financial, and other systems to streamline operations. Effective IT systems also provide the mechanism to collect and analyze data necessary to measure and report on performance outcomes, productivity, operational efficiencies, and provide information that fosters informed decisions.

✓ Information Exchange

This also includes electronic health records. Integration with primary care will not happen without efficient and comprehensive communications methods.

“A key premise: information should follow the patient and artificial obstacles—technical, business related, bureaucratic—should not get in the way. Information must cross institutional and business boundaries...the goal is to have information flow seamlessly and effortlessly to every nook and cranny of our health system.” (FADAA, *Advancing Reform Initiative: Critical Factors Influencing Implementation: Information Systems*).

✓ Workforce

Successful linkages with, and payments from, commercial insurance and managed care

organizations (MCO) will depend heavily on a licensed/credentialed staff.

✓ Marketing

It will be extremely important to reach out to individuals and families as well as commercial insurers and MCOs. In addition to new, external marketing strategies, agency leaders will need to ensure they are marketing their organization to their clients. For example, the first impression a client receives when they walk through the door of an agency should be “warm and welcoming”. Enhancing the feeling of openness and welcome a client feels when he or she enters an agency has been shown to increase engagement and retention in treatment.

✓ Compliance

For many, reform will present a new world of extreme oversight. Not only do organizations need to have the capacity to bill for services, but recordkeeping and other procedures will be important in making sure the organization “keeps the money”.

✓ Recovery-oriented systems

Recovery-oriented systems will become even more important in the new healthcare environment. Systems will involve peers, treat the entire family, and recognize the importance of supporting individuals in recovery with a comprehensive network of recovery management and recovery support services.

Preparing for transformation

This is an abbreviated list of steps organizations can take to get started. As organizations prepare to transform, they should take many of these steps simultaneously rather than sequentially.

First Steps

1. Communicate the need for change to the staff and board
2. Assess the board
3. Assess the staff
4. Assess the financial capacity
5. Assess the capacity for change
6. Commit resources to the transformation

If the organization is lacking or unprepared in any of the following areas, leadership must:

- Identify and recruit the right board members and the right staff,
- Identify which board members and which staff must be removed from the organization,
- Determine where the organization lacks financial capacity and identify how to develop that capacity, and
- Determine what needs to occur internally to enhance the organization's readiness for change, i.e., increase training, hire technical assistance, remove potential saboteurs, recruit supportive staff members, motivate staff, etc.

Next Steps

7. Plan
8. Hire a consultant (alone or in a collaborative with other organizations)
9. Plan
10. Build partnerships with primary health entities
11. Plan

Future Steps

12. Develop technology capacity
13. Assess ongoing efforts



C onclusion

The time to lead is now. The time to act is today. Waiting only delays the inevitable.

– Anonymous

In Closing

Now is the time to begin this process. Start by renewing your vision, assessing your organization, and developing an implementation plan to transform your agency into one that is prepared to seize the coming opportunities resulting from parity and healthcare reform. Waiting to determine whether the threat is real or not only delays the inevitable. Change is here. Many “early adopters” began their transformation processes long before Congress passed reform. Now it is time for others to step up and lead the field in this system-wide effort.

Use this document as the “opening tab” in your transformation notebook. Your next “tab” will hold your assessment tool and results. Use these tools to develop a knowledge book unique to your individual organization based on your:

- Governance structure
- Needed changes to policy and procedure
- Training needs

- Employees education and skills
- Your primary care environment
- Insurance and managed care opportunities
- State and local policies

Each plan will be different, based solely on the organizational assessment your agency conducts at the outset of this process. Each tab in your knowledge book should correspond to a different section in your strategic and/or business plan.

Advocacy

Advocacy is far from an afterthought in this guide. The field would not be where it is today without years of effective advocacy from every level of the field that resulted in parity and reform. Healthcare reform and parity are a direct result of years of legislative work by thousands of dedicated individuals and organizations. While the field can celebrate the results and achievements recently attained, we must not forget to plan for the future; the future must include ongoing advocacy efforts. Advocacy at the Federal, state, and local level **MUST** continue to avoid losing the tremendous gains made in policy and legislation. Policymakers and key stakeholders need to continue hearing the voice of the field. Advocacy will play a crucial role in:

- Ensuring meaningful input into all future policies and regulations,
- Educating individuals, families, and communities on their new benefits and rights, and
- Monitoring for compliance on the part of payers.

Closing

Good luck in your transformation efforts. Your organization has the opportunity to succeed in this new environment, as your transformation becomes a reality.

While there is a lot of work ahead, you are not alone in your efforts. Your state associations can provide assistance and information. NIATx has many tools available for service providers at no cost. Members of the Moving Forward Alliance are available to assist in some areas. National organizations like SAAS can help answer your questions.

Perhaps the most important resource you have available to you are your colleagues—other agencies like yours that are going through this same process.

Frequently Asked Questions

1. We have not begun our systems transformation efforts yet. Is it really necessary? Is it too late?

Transformation is necessary if an organization intends to survive in the new healthcare environment. Healthcare reform is a reality. Addiction services providers have an unprecedented opportunity to expand services and access for the 23 million people who had no access previously. While the most significant changes will not take place until 2014, many changes are occurring now. It is not too late (nor too early) to begin systems transformation efforts. However, organizational transformation will not occur overnight. It will take extensive thought, planning, and implementation. Organizations that wait will find themselves behind the power curve, potentially losing opportunities to build relationships and partnerships with third-party payers and primary healthcare agencies. These relationships will be crucial to their future success.

2. How is substance use prevention included in the new federal healthcare reform law?

The new healthcare reform law creates a National Prevention, Health Promotion and Public Health Council that will coordinate prevention, wellness, and public activities on the federal level. Substance use disorders (SUD) and mental illness are included as national priorities for the Council's report to Congress.

The Director of the Office of National Drug Control Policy (ONDCP) is named as a member of the Council. The new law requires consultation with SAMHSA on issues related to preventing SUDs and mental illness. The new law also establishes a Prevention and Public Health Fund to provide for programs that improve the public health. It is unclear how prevention will be treated in the development of benefit guidelines.

3. How does my agency get included in a health plan to negotiate an in-network agreement?

Many SUD providers have yet to contract with commercial health plans and issuers and getting "in" can be difficult. Some health plans have online access to applications. Some plans and networks will tell providers they are not needed. Others will eagerly add capacity in certain areas. Start with the plan's Provider Relations department and speak to a manager if frontline personnel are not responsive. Ask to meet with Provider Relations in their offices. Dress professionally and be prepared to "sell" your program on its merits (access, quality, outcomes, etc.).

"Cold calls" may be difficult. Ask others, (e.g., your own physician or a business partner) to make a "warm referral". If you're actively networking in your community, you may know someone on the Board of Directors of your local health plan or large, self-insured employer. Board members may be able to get you "in the door".

The Mental Health Parity and Addiction Equity Act (MHPAEA) mandates admission to provider networks not be any more stringent for MH and SUD providers than it is for medical providers

so be willing to politely remind network managers and plans of that fact.

4. We have not billed third-party payers and insurers. Where do we start?

This is a common question among SUD providers who primarily provide services through publicly-financed programs. It emphasizes the importance of the strategic business planning process. It also stresses the importance of market research and understanding the needs of potential payers. Market research should include an informal survey of each plan's reputation with respect to contracting, utilization management, and claims processing. This is the first step in the strategic planning process.

Next, select which plans to approach, apply for in-network status, determine credentialing requirements, and negotiate rates. Billing for services follows only after these steps have been completed. These steps will set the tone of your experience and outcomes. Seek advice and make decisions deliberately. Long-term success will depend on successful completion of these steps.

In order to adapt to a commercial billing environment, SUD providers may be asked to implement new, more robust forms of:

- Documentation
- Coding
- Record-keeping
- Billing processes
- Book-keeping
- Revenue management
- Billing/claims information systems and infrastructure
- Reporting

Planning and market research must be the driving force behind implementation of these new systems. Each plan has different expectations for claiming and other core functions therefore your decisions should align with those expectations. For example, most health plans expect electronic billing with very high thresholds for auto-adjudication – which means claims are received, adjudicated, and processed for payment without being handled by a person. These requirements are demanding and involve systems that are compliant with HIPAA electronic data interchange (EDI) requirements for standard transactions. Cash flow can be severely affected by denied and pending claims. Planning is essential.

5. What is a Patient-Centered Medical Home (PCMH) and how can we be more involved with one?

Pediatricians developed the PCMH model several decades ago to coordinate care among multiple providers, always maintaining a shared sense of responsibility for the patient, their care, and information concerning their care. Today, PCMH models are piloted widely with primary care and community health centers serving as the hub. Specially trained staff act as

case managers, referring patients within pre-determined networks in the community. The PCMH model involves specially developed tools, documentation, communication, and health information management. Reimbursement can involve a mix of conventional fee-for-service and monthly per member fee. The National Committee for Quality Assurance (NCQA) certifies PCMH models, helping to establish standards and benchmarks for access and quality.

SUD providers should identify active medical homes and discuss becoming the SUD service provider for the PCMH. This relationship can feature a simple referral for services and exchange of health information where appropriate. SUD providers can also discuss the possibility of greater integration with primary care providers, including bi-directional integration and co-location of certain services.

6. What is an Accountable Care Organization (ACO) and what can we do to join one?

Accountable Care Organizations (ACOs) are provider-centric organized systems of care promoted in the Patient Protection and Affordable Care Act (PPACA). ACOs increase quality, reduce hospital readmissions, and save money. ACOs are required to create legal entities that include leadership, a management structure, infrastructure, and the means to distribute monies among partners. ACO agreements must be three years or longer.

ACOs need to demonstrate they have developed defined processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care. ACOs must also use telehealth, remote patient monitoring, and other enabling technologies that ensure patient engagement and care coordination. ACOs must demonstrate they meet patient-centeredness criteria specified by the Centers for Medicare and Medicaid Services (CMS), including the use of patient and caregiver assessments and individualized care plans.

ACOs are similar to PCMH models. They organize a wide range of providers – including behavioral health providers – around a hospital or group practice to meet the needs of a defined population. For Medicare purposes, that population must be no less than 5,000 eligible members. This approach is designed to enable integrated and highly coordinated treatment of entire populations including cases involving chronic conditions and co-morbidity. To demonstrate they are meeting or exceeding benchmarks and providing value, ACOs will be expected to gather and report significant clinical, outcomes, process, patient experience, and utilization data.

ACOs can include the PCMH model discussed above. ACOs are not intended to assume insurance risk in the same way prior models did in earlier approaches to managed care. The reward from the ACO perspective is a function of improved outcomes, reduced re-admissions, and cost savings. There is a great deal of information available on this topic and your decision to venture into an ACO will require research and strategic planning. High-performance SUD providers who are confident they have adequate business/clinical operations and health IT infrastructure should review their options, conduct local market research, and discuss their involvement with hospital partners who may also be considering ACO development.

7. We want to build our capacity for billing third-parties. How do we select a good billing system?

Implementing practice management systems (PMS) is a good idea if you are also making the decision to engage in Medicaid and other third-party billing. PMS ideally enable providers to better manage patient registration, benefits, scheduling, case load, service capture, and billing. Billing electronically in a HIPAA-compliant electronic data interchange will be critical to success in the private sector. There are a few things to consider before moving forward:

- Many implementations fail due to lack of forethought and commitment;
- Adoption and implementation takes time, sometimes more than a year—the process should not be rushed;
- Do not automate poor processes and workflow—fix your business processes first;
- Find systems that suit your business needs—do not twist your business and clinical operations around software;
- Understand that total cost of ownership involves hardware, software, networking, consultants, staff time, training, implementation, and disruptions to work in progress affecting billable time;
- Interoperability, standards, certification, and HIPAA EDI compliance are essential.

We recommend some of the following steps in your initial journey:

- Identify members of your staff for your PMS committee with support of the CEO
- Build a 12-24 month timeline for the process
- Review needs: type and size of facilities, specialties, core processes and documentation preferences
- Develop a budget with total cost of ownership in mind
- Conduct strategic planning including a business case for a PMS system
- Develop a complete Implementation plan. This exercise will give you the start of a roadmap that will evolve as you progress and a real sense for all the steps involved.
- Provide for project management human resources and tools
- Gather all forms, reports, and templates and assess your workflow. Conduct essential business process analysis in order to eliminate deficiencies and inefficiencies prior to selecting any PMS vendor

- Identify process quality and efficiency solutions and improvements
- Document your business rules and data definitions
- Document technical, functional, reporting, and financial requirements
- Seek the guidance of an experienced consultant before taking your requirements to vendors. A good consultant will be able to help you make objective decisions, scoring vendors on an “apples to apples” basis.

8. As we explore our billing options, we run across a lot of unfamiliar acronyms. What do CPT and HCPCS stand for?

These acronyms are used to describe billing and reimbursement.

The Current Procedural Terminology or CPT Code Set

CPT is maintained by the American Medical Association (AMA). The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

The Healthcare Common Procedure Coding System or HCPCS

HCPCS describes specific items and services provided. HCPCS coding is necessary for Medicare and Medicaid and other health insurance programs to ensure that claims are processed in a consistent manner. With the implementation of HIPAA, use of the HCPCS for transactions involving health care information became mandatory.

9. We have developed our practice around the needs of chronic cases who need wrap-around services and recovery supports. How is that viable in the commercial managed care sector?

It may or may not be viable to provide wrap-around and recovery support services in the commercial managed care sector. However, it may be viable for rapidly expanding Medicaid population and program, especially where Medicaid is managed by a Medicaid managed care plan.

There are three important steps to consider. 1) Document and describe your services for a “private sector” audience; acquaint yourself and align your promotional material with terms and vocabulary specific to that audience. 2) Learn about the services managed care organizations and health plans offer in your market. Do they offer case management? Do they offer disease management? Do they address chronic SUD conditions? 3) Meet with managed care industry professionals in your community to explore their perceptions and needs. This is a marketing exercise. Meet with a medical management professional, provider relations staff or other providers in your area to learn how you can fulfill the SUD services need in your area.

10. What SUD conditions will be covered under MHPAEA?

MHPAEA does not refer to specific conditions by name. Instead, the MHPAEA Interim Final Rule states:

“...mental health and substance use disorder benefits are benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. These regulations further provide that the plan terms defining whether the benefits are mental health or substance use disorder benefits must be consistent with generally recognized independent standards of current medical practice.”

It is important to note that specific conditions and diagnoses are defined by the plan, in accordance with applicable federal law and the laws of the state in which a plan is based and members covered. The net effect will be a variety of covered conditions around the country depending upon plan policies in accordance with the various state laws.

Providers and recovery advocates are encouraged to promote the most comprehensive definition of covered conditions they deem appropriate at the state level where rules are established. They can do so by urging their legislators and state departments of insurance to develop regulations specifically addressing the following ICD-9 (International Classification of Disease) diagnostic codes (keeping in mind that ICD-9 will give way to ICD-10 in 2013):

ICD-9 Codes Related to Psychoactive Substances and Substance Use Disorders

- (303) Alcohol Dependence Syndrome
 - (303.0) Alcohol intoxication, acute, unspecified
 - (303.9) Other and unspecified alcohol dependence, chronic alcoholism, Dipsomania
- (304) Drug Dependence
 - (304.0) Opioid type dependence
 - (304.1) Sedative, hypnotic or anxiolytic dependence
 - (304.2) Cocaine dependence
 - (304.3) Cannabis dependence
 - (304.4) Amphetamine and other psycho-stimulant dependence
 - (304.5) Hallucinogen dependence

- (305) Non-Dependent Abuse of Drugs
 - (305.0) Non-dependent alcohol abuse
 - (305.2) Non-dependent cannabis abuse
 - (305.3) Non-dependent hallucinogen abuse
 - (305.4) Non-dependent sedative, hypnotic or anxiolytic abuse
 - (305.5) Non-dependent opioid abuse
 - (305.6) Non-dependent cocaine abuse
 - (305.7) Non-dependent amphetamine or related acting sympathomimetic abuse
 - (305.8) Non-dependent anti-depressant type abuse

11. What SUD services will be covered under MHPAEA?

MHPAEA broadly addresses the continuum of care and types of covered services (with respect to scope of services):

“These regulations specify, in paragraph (c)(2)(ii), six classifications of benefits: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs..... If a plan does not have a network of providers for inpatient or outpatient benefits, all benefits in the classification are characterized as out-of-network...”

... If a plan provides benefits for a mental health condition or substance use disorder in one or more classifications but excludes benefits for that condition or disorder in a classification (such as outpatient, in-network) in which it provides medical/surgical benefits, the exclusion of benefits in that classification for a mental health condition or substance use disorder otherwise covered under the plan is a treatment limitation. It is a limit, at a minimum, on the type of setting or context in which treatment is offered...

... These regulations do not define inpatient, outpatient, or emergency care. These terms are subject to plan design and their meanings may differ from plan to plan. Additionally, State health insurance laws may define these terms. A plan must apply these terms uniformly for both medical/surgical benefits and mental health or substance use disorder benefits. However, the manner in which they apply may differ from plan to plan...”

This statement underscores the importance of establishing *generally accepted standards* for services in your state (bearing in mind that MHPAEA pertains to health insurers, commercial payers and issuers). Only a small proportion of states have mandated that health plans and issuers cover a robust continuum of care for SUDs. Providers operating in states where existing

regulations are ambiguous or limited will be well served by promoting and advocating for more comprehensive definitions of covered services with legislators and state departments of insurance.

The following statement may be helpful: *Whereas federal law (MHPAEA) stipulates that health plans, issuers and the State may use generally-accepted and reasonable medical standards to determine coverage for specific services, insurers/issuers should provide benefits for all of the levels of care found in the ASAM PPC-2R (and any future revisions).*

The issue of how services such as residential, partial, intensive outpatient program (IOP) and medication assisted treatment (MAT) “fit” into or align with the six classifications described in the Interim Final Rule (IFR) is the subject of some debate. Some stakeholders believe that the authors of the regulations need to clarify this section, specifying how the SUD continuum of care aligns with the six classifications while others believe that medical detoxification and residential align with the inpatient classification and most all other services align with the outpatient classification, including partial, IOP and MAT. This latter position is also likely to advocate for the widest interpretation of the pharmacy classification, promoting MAT, including in some cases methadone maintenance. Providers and recovery advocates are urged to take a consensus position to their legislators and department of insurance officials.

12. What levels or types of providers will be covered by MHPAEA?

Provider types are not specifically identified in the MHPAEA IFR. Rather, the IFR refers to classifications of benefits and addresses continuum of care as described above. The specific credentialing and licensure requirements of plans covering a given continuum of services will most likely be determined by state law and/or regulations and, by extension, health plan policies. This is especially important for SUD providers who may be “certified” and not licensed or for facilities that do not yet have CARF or JCAHO accreditation.

Providers are strongly encouraged to adopt a consensus position in order to advocate to the legislature and department of insurance. The following statement may be helpful: *Whereas MHPAEA stipulates that health plans, issuers and State law define acceptable standards for provider accreditation, credentialing and participation in health plan networks, insurers/issuers should provide coverage for services rendered by professionals or facilities licensed by the State to provide SUD services.*

This position is essentially attempting to apply the same standards to commercial health insurance as are used to establish qualified providers for federally and state-funded SUD treatment. Assuming providers can successfully advocate for a continuum of care consistent with ASAM PPC-2R, health plans would be required to negotiate in good faith with providers of those services using standards dictated by state regulation.

13. What kinds of care and utilization management can we expect from medical management professionals?

The answer to this question varies widely depending in part on the type of plan and the level of care. Providers working with a local managed behavioral health organization (MBHO) may have a different experience than those working with a national MBHO. Providers working with a health plan that doesn't "carve out" management of its SUD benefits to an MBHO may find themselves working closely with nurse case managers as opposed to master's level behavioral health professionals. In some cases, providers will encounter very little utilization management while in other cases, managed care organizations may have stepped up their utilization review efforts and demands for documentation. SUD medical and utilization management processes, strategies and standards should not be applied more stringently than they are for medical conditions.

Providers should be aware the MHPAEA IFR stipulated that the use of EAP as a gatekeeper is illegal for plans renewing effective July 1, 2010. More importantly, the IFR goes to considerable lengths to describe a significant shift in what are being referred to as Non-Quantitative Treatment Limitations (NQTLs).

"A non-quantitative treatment limitation is a limitation that is not expressed numerically, but otherwise limits the scope or duration of benefits for treatment...Such non-quantitative provisions are also treatment limitations affecting the scope or duration of benefits under the plan. These regulations provide an illustrative list of non-quantitative treatment limitations, including:

- *medical management standards;*
- *prescription drug formulary design;*
- *standards for provider admission to participate in a network;*
- *determination of usual, customary, and reasonable amounts;*
- *requirements 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 completion of a course of treatment...*

...The phrase, "applied no more stringently" was included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face are applied in the same manner to medical/surgical benefits and to mental health or substance use disorder benefits..."

The last statement is key to the first and most important NQTL – medical management standards. SUD medical management (utilization management) standards (processes, strategies and evidentiary standards) must be applied in the same manner as they would otherwise be for medical/surgical benefits. The potential exists that health plans and issuers may decide to adopt strictly medical processes, strategies and evidentiary standards concerning SUD treatment,

demanding in the process that providers rigorously demonstrate medical necessity. Some plans may constrain benefits to those services that are deemed medically necessary as opposed to *clinically-indicated* or *appropriate*. It is for this reason that providers are encouraged to advocate for ASAM PPC-2R. Evidentiary standards that are SUD-specific must be promoted lest plan members find themselves eligible for medical detoxification, outpatient counseling, and little else.

Additionally, because residential stays are substantially longer than medical stays, some residential providers are already discovering that plan medical managers are authorizing benefits in far shorter increments (3 days instead of 5 or 7 days) and are demanding more in the way of documentation that supports continued stay. This may be an example of a process and strategy that is applied consistently across medical and SUD benefits. In some cases, providers may argue that this practice is more stringent than they believe is just or fair. Providers are encouraged to develop a robust and efficient care management capability, use practice guidelines, employ standards-based screening, assessment and treatment planning tools, and maintain exemplary documentation. Moreover, learning the language of medical/utilization management will be helpful for providers who are new to commercial health insurance.

Providers who want to better understand the reasoning or justification behind an adverse benefit determination can request that the plan disclose its evidentiary standards and rationale. The following IFR language illustrates the new disclosure requirements:

“MHPAEA includes two new disclosure provisions for group health plans (and health insurance coverage offered in connection with a group health plan). First, the criteria for medical necessity determinations made under a plan (or health insurance coverage) with respect to mental health or substance use disorder benefits must be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. These regulations repeat the statutory language without substantive change

... MHPAEA also provides that the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available, upon request or as otherwise required, by the plan administrator (or the health insurance issuer) to the participant or beneficiary in accordance with regulations.”

14. How will “generally-accepted medical standards” affect our placement criteria and transitions in care?

By virtue of their specialized knowledge and practical alignment, plans that are knowledgeable about ASAM PPC-2R, for example, may be easier to collaborate with on utilization review for transitions in care. Managed care organizations that rely on very strict definitions and medical evidentiary standards may prove to be more difficult partners in managing care. This question highlights the importance of a comprehensive continuum of services and providers to ensure continuity of care. It also underscores the importance of ensuring (if not mandating) that

managed care professionals have adequate training and education in substance use disorder treatment.

15. What specific screening and assessment tools are we supposed to use to establish that we meet criteria?

The SUD field has produced many screening and assessment instruments which are highly regarded and commonly in use. These include the GAIN (Global Appraisal of Individual Need), the ASI (Addiction Severity Index), the AUDIT (Alcohol Use Disorders Identification Test), the NIDA-Modified Alcohol, Smoking, and Substance Involvement Screening Test (NMASSIST), NIDAMED which enables primary care and other physicians to screen for SUD, and DAST (Drug Abuse Screening Test). There are many more.

As for the specific requirements a plan or issuer may have, that question will be answered on a case-by-case or plan-by-plan basis. The requirement, however, cannot be applied more stringently to SUD than for medical benefits. Be advised that the gap between public sector screening and assessment tools and those used primarily in the private sector and/or in relation to medical management functions will need to be explored and closed over time.

16. Can we negotiate case rates with commercial payers like health plans and managed care organizations?

It depends on the plan and their policies. Some providers are already beginning to think innovatively about reimbursement and looking toward episode rates and case rates. It is important for providers to carefully evaluate their costs before entering into such agreements. Self-insured employers and third-party administrators (TPAs) may be more willing to work with you on a case rate basis than traditional health plans and managed care organizations by virtue of their autonomy and flexibility. It may be in your best interest to develop a model you are comfortable with and market it directly.

17. MHPAEA refers to Usual, Customary and Reasonable (UCR) methods for negotiating reimbursement where Non-Quantitative Treatment Limitations are concerned. What does UCR really mean?

MHPAEA stipulates that insurers and plans negotiate UCR with MH and SUD providers on the same basis they would with medical providers and that they do not apply more stringent processes, strategies, or standards. UCR is the maximum amount an insurer will consider eligible for reimbursement. This amount is determined in part on a review of the prevailing charges for a specific service within a geographic area. Commonly, UCR is set at a certain percentage of all charges made by providers of similar services, most often at the 80th-90th percentile. In practice, payers look across a specific geographic area and determine the most common and reasonable charges. This is not the same as the “billed amount” on a remittance advice. It is more akin to “allowed amount”. From there, they may negotiate discounts with providers and a plan member’s coinsurance would apply, further decreasing the “paid amount”. For example, a residential provider may want to bill \$700 per day whereas a plan may establish that the UCR

rate is \$350.

UCR is not determined scientifically. It is at the plan's discretion but takes into account what they view as "prevailing" and "reasonable". This particular stipulation in the IFR simply establishes that plans cannot approach the determination of UCR in a fashion that is unfair or discriminatory to MH and SUD providers in order to keep their costs low. They are required to approach UCR for MH and SUD purposes in the same way they would for primary care.

18. Can we contract directly with a self-insured (ERISA) employer?

Self-insured employers that are subject to the Employee Retirement Income Security Act (ERISA) essentially operate their own health plans and utilize third-party administrators or TPAs to handle such core functions as enrollment, plan design, claims processing, marketing, premium billing and, in some cases, utilization management. The employer and/or their TPA may assume responsibility for network development but often outsource to Preferred Provider Organizations (PPOs) and other networks. In some cases, ERISA employers and/or their TPAs will engage a managed behavioral health organization or MBHO to outsource some or all core MH and SUD functions. SUD providers are encouraged to approach human resource and benefits department leadership to promote their services, stressing approaches and the ability to meet economic and cost-savings needs. Providers are also encouraged to consider innovative approaches to reimbursement.

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For more information or to request additional copies of this document, contact Becky Vaughn, CEO, SAAS, at bvaughn@saasnet.org, or call 202.546.4600. Copies can also be downloaded from <http://www.saasnet.org>.