



ASAM

American Society of Addiction Medicine

Public Policy Statement on Managed Care, Addiction Medicine, and Parity¹

Background

The Mental Health Parity and Addiction Equity Act of 2008 for the first time requires employer and union-funded group health plans which offer mental health and addiction benefits, even those falling under the exemptions of the ERISA Act,² to maintain the same financial requirements and benefit limitations (in the form of caps on outpatient visits and caps on days of hospitalization, in-network and out-of-network benefits, as well as co-pay and deductible levels) for addiction and psychiatric care that apply to general medical and surgical care. Significantly, this landmark legislation does not require any insurer to offer mental health and addiction benefits; employer group health plans of less than 50 employees are exempt; and insurance plans may opt out of the mandate for one year if costs rise by more than 2% in the first year of implementation or 1% in succeeding years. But the federal policy changes adopted in this 2008 Act will likely mean that the management of private insurance benefits for Addiction Medicine and psychiatric care will be brought into even sharper focus.

Managed care analysts generally concur that in order for the removal of benefit limitations to occur without significant cost increases for the purchasers of insurance, access to psychiatric and addiction care will be determined by even tighter management of utilization than has heretofore been applied. Providers are faced with the likelihood of having to 'make the case' even more clearly for the 'medical necessity' of their proposed care plans in order to receive authorizations from managed care organization (MCO) employees. In such an environment, it becomes imperative that the utilization management activities of MCOs be conducted appropriately, and for clinicians to be familiar with the structure and operations of managed care. Only in this way will clinicians be able to interface with care managers effectively, convince utilization

¹ Formerly titled "Public Policy Statement on Managed Care and Addiction Medicine."

² ERISA, the Employee Retirement Investment Security Act of 1974, pertains to an employer's self-insured retirement and healthcare insurance employee benefit plans. As a Federal Act, ERISA regulation overrides individual state insurance regulation; such self-insured plans, which have heretofore been exempt from state insurance laws, are called "ERISA-exempt health plans."

managers to allow patients' health insurance benefits to be used to pay for proposed care, and thus secure optimum clinical results for their patients.

Understanding the background of managed care's rise to importance in this area is important. Concern over ever rising costs of healthcare, both as a dollar amount per patient and as a percentage of the U.S. Gross Domestic Product, set the stage for the introduction of managed care in the 1980s. Managed care seemed more attractive to purchasers when they experienced egregious clinical practices that manifested as a disconnect on the part of some treatment providers between treatment costs and insurance benefits (e.g., listing "Admit until insurance is exhausted" as one of the admission orders).

With the development of health maintenance organizations (HMOs) and other prospective payment and capitation systems in the 1980s came the development of behavioral health care (BHC) 'carve-outs', in which capitated risk for the management of health care expenditures was subcontracted from the overall health care insurance provider to a managed behavioral health care organization, or managed care organization. The MCO would assume risk for costs of care and develop provider panels to deliver psychiatric and addiction care. Behavioral health care (psychiatric and addiction care) became saddled with the biased perception by some insurers and employers that such treatment was not evidence-based, was unnecessary, or was provided inefficiently. These biases have been experienced especially by Addiction Medicine clinicians and treatment organizations.

Issues Specific to Managed Care and Addiction Medicine

ASAM has identified several pertinent issues in the relationship of managed care to Addiction Medicine.

1. Ideally, managed care aids an addiction patient by authorizing, in a convenient manner for all stakeholders, the right treatment at the right level of care for the right length of time. This assumes an understanding that addiction is a chronic medical disease requiring acute stabilization and continuing care to manage waxing and waning symptoms, with the patient striving for long-term recovery and addressing occasional relapses with return to more intensive and/or higher levels of care where needed. MCOs and their UR processes have the potential, however, to limit access to treatment by restricting access to benefits and having an authorization process so complex that the provider and the patient are discouraged from seeking treatment that is truly medically necessary.
2. Through subcontracting or 'carve-out' arrangements, managed care companies usually separate behavioral health care benefits from general medical and pharmacy benefits, with different teams of case managers and medical directors undertaking UR in each area. Behavioral health 'carve-outs' tend to communicate minimally with their medical and pharmacy benefit counterparts regarding an individual patient's benefit utilization and biopsychosocial treatment needs. This fragmentation may

lead to inappropriate treatment authorization decisions on managed care's part. For example, a patient with alcohol addiction may be denied authorization for residential treatment, relapse quickly in or soon after intensive outpatient treatment and require more costly medical hospitalization for hepatic encephalopathy. The behavioral health 'carve-out' may save benefit dollars while the medical 'carve-out' expends more dollars. As a result, the patient's health may be avoidably compromised, while the parent managed care organization or primary insurer spends more healthcare dollars than is necessary.

3. When an MCO develops its own addiction treatment level of care admission and continuing stay guidelines for authorizing or denying requested treatment rather than adhering to nationally validated, reliable, and accepted guidelines, it may appear that decision-influencing factors such as cost considerations outweigh valid evidence-based authorization requests for medically necessary treatment.
4. MCO Level of Care guidelines may be less than rigorously or fairly adhered to in the UR process by MCO Case Managers or MCO MDs. Several examples include:
 - A case manager may request that a medical director deny a health care provider's request for more than ten sessions of a Partial Hospitalization Program (PHP) for a patient simply because that is the average number of sessions that the MCO approves.
 - Before authorizing residential treatment for a patient, an MCO may arbitrarily require that the patient first fail recent treatment at lower levels of care, regardless of the patient's clinical presentation or treatment history.
 - Any authorization request for opioid or sedative-hypnotic detoxification at an inpatient or residential level of care may be denied arbitrarily and categorically regardless of the patient's clinical presentation.
5. MCO Case Managers - even those state-licensed as Master's or Ph.D. level mental health clinicians - and MCO MDs may have insufficient training and experience treating addiction patients to conduct Utilization Reviews and authorize or deny requested treatment.

Supplement for Physicians and Others on Step-by-step Utilization Review Procedures

A detailed supplement titled *The Step-by-step Utilization Review Process: Authorizations, Denials, and Appeals* accompanies this public policy statement.³ Physicians and others will find this supplement of significant help as a guide through the somewhat complex Utilization Review process.

³ Public Policy Statement on Managed Care, Addiction Medicine and Parity Supplement for Physicians and Others on the Step-by-step Utilization Review Process: Authorizations, Denials and Appeals.

ASAM recommends that:

- 1. The paramount consideration in evaluating the need for any addiction treatment service should be the therapeutic need and value of the service at a given time for a given patient. At the same time, treatment costs should be carefully monitored by providers, third-party payers, and managed care organizations.**
- 2. Addiction Medicine treatment services should be provided in the most effective and economical manner possible, consistent with medical necessity and the well-being of the patient. Treatment should be individualized and take place at the most appropriate level of care for the most appropriate length of time, as defined by the American Society of Addiction Medicine's *Patient Placement Criteria* (latest edition), which are nationally validated, reliable, and accepted by the medical community. Treatment planners should consider the extent of the patient's support resources; family and home environment; the nature and severity of the patient's addiction; and any associated physical or mental health problems. Addiction treatment benefit limits in both the public and private spheres should be equal to those for other chronic medical diseases (e.g., diabetes, hypertension, asthma).⁴**
- 3. Managed care benefits should be clinically informed regarding inclusion of all levels of care and evidence-based treatments. Managed care companies should not design and sell to employers benefit plans that exclude certain levels of care (e.g., detoxification only, detoxification plus Partial Hospitalization Program - PHP, Intensive Outpatient Program - IOP, or Outpatient - OP only) or treatments (e.g., Buprenorphine limited to 1 year of treatment, or methadone maintenance time-limited or listed as a 'non-covered benefit of the plan').**
- 4. Because addiction diseases are medical diseases, which require comprehensive treatment, it is strongly recommended that their coverage not be 'carved out' into a separate 'risk pool' and care management process from general medical benefits. In cases where 'carved out' structures and processes exist, there should be close coordination between the 'behavioral health carve-out' and general medical benefits. Such coordination promotes a long-term and comprehensive view regarding a patient's overall health that results in better health and higher quality of life, as well as more efficiently delivered health care that saves overall treatment dollars. The staff managing the 'carve-out' should work closely with the staff of the primary managed care company and, if possible, be located in the same place.**

⁴ See ASAM's Public Policy Statement on Parity in Insurance Benefit Structure between General Medical Services and Services for the Evaluation, Management and Prevention of Behavioral Health Conditions, including Addictive Disorders (2002).

5. **The managed care Utilization Review process should be convenient, with fair and transparent rules of engagement.**
 - a. **Managed care admission and continuing stay level of care guidelines should be publicly available and easily accessed by treatment providers and patients. Each MCO should have an easily accessible ombudsperson to help resolve disputes that arise in this process, separate from the clinical merits for or against a treatment authorization request.**
 - b. **Treatment authorization decisions should be made at the time of service and not retrospectively after treatment has been provided, unless agreed to in advance by the treatment provider and the managed care company.**
 - c. **Clinical appeal processes regarding treatment denial decisions should be convenient and expeditious.**

6. **Providers should familiarize themselves with the procedures and expectations of MCOs during the Utilization Review process,⁵ in order to maximize treatment authorizations and a smooth relationship with the health maintenance organizations. Further, it is desirable to appoint one staff person, ideally a licensed clinician, in the provider's office or treatment center to be responsible for all treatment authorization requests to MCOs.**

7. **Managed care case managers and medical directors involved in the Utilization Review process for addiction patients should have sufficient training and experience.**
 - a. **Managed Care case managers should be:**
 - i. **state-certified or state-licensed addiction counselors; *or***
 - ii. **nationally or internationally certified addiction counselors (e.g., by the National Association of Alcohol and Drug Abuse Counselors – NAADAC, or by the International Certification and Reciprocity Consortium – IC&RC); *or***
 - iii. **certified addictions registered nurses (e.g., by the International Nurses Society on Addictions); *or***
 - iv. **actively on a path toward securing such certification within the next three years.**

 - b. **Managed Care medical directors should be:**
 - i. **certified by ASAM in Addiction Medicine; *or***
 - ii. **certified by the American Board of Psychiatry and Neurology, ABPN, in addiction psychiatry; *or***
 - iii. **certified by the American Osteopathic Academy of Addiction Medicine, AOAAM, in Addiction Medicine; *or***
 - iv. **actively on a path toward securing such certification within the next three years.**

⁵ See the Supplement to this Public Policy Statement for physicians and others: "The Step-by-Step Utilization Review Process: Authorizations, Denials, and Appeals."

- 8. Managed care organizations should credential Addiction Medicine physicians in provider panels, have appropriate billing codes, and reimburse these providers for addiction treatment services. When a managed behavioral healthcare organization is contracted to provide both psychiatric and addiction ‘behavioral health care,’ clinicians on the provider panel should not be limited to mental health professionals only.**

Adopted by ASAM Board of Directors November 1990; **revised** March 2009.

© Copyright 2005, 2009, American Society of Addiction Medicine, Inc. All rights reserved. Permission to make digital or hard copies of this work for personal or classroom use is granted without fee provided that copies are not made or distributed for commercial, advertising or promotional purposes, and that copies bear this notice and the full citation on the first page. Republication, systematic reproduction, posting in electronic form on servers, redistribution to lists, or other uses of this material, require prior specific written permission or license from the Society. ASAM Public Policy Statements normally may be referenced in their entirety only, without editing or paraphrasing, and with proper attribution to the Society. Excerpting any statement for any purpose requires specific written permission from the Society. Public Policy statements of ASAM are revised on a regular basis; therefore, those wishing to utilize this document must ensure that it is the most current position of ASAM on the topic addressed.

American Society of Addiction Medicine

4601 North Park Avenue • Upper Arcade Suite 101 • Chevy Chase, MD 20815-4520

TREAT ADDICTION • SAVE LIVES

PHONE: (301) 656-3920 • FACSIMILE: (301) 656-3815

E-MAIL: EMAIL@ASAM.ORG • WEBSITE: [HTTP://WWW.ASAM.ORG](http://WWW.ASAM.ORG)