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Behavioral Health Parity and Compliance: Structural Flaws Between the Patient, Provider, and Payer

This essay is an edited transcription of a larger interview conducted by Communications Director Zillah Glory from SAE Behavioral Health Consulting and Consultant Expert, Alex Hutchinson, MBA. The following key talking points were selected by Consultant Expert Dr. Maria Messina, reflecting initial structural obstacles that open the door to a deeper dive into the 2008 Mental Health, Parity, Addictions and Equity Act that requires Insurers who offer behavioral health services, to do so on a par with medical/surgical services.

SAE: *Alex, thank you for this conversation. You had mentioned that you recognize there are fundamental structural flaws in the healthcare system and that if we don't address them, we would continue to chase this problem of affordable, accessible healthcare. What do you think some of those structural flaws are, and how do they impact insurance agencies, healthcare providers, patients or clients?*

The Behavioral Health Tripod

Alex Hutchinson, MBA: We need to recognize that there are fundamental structural flaws in the healthcare system, and if we do not address them, we will continue to chase this problem of affordable, accessible healthcare. My view of the world is driven by an economic and business perspective, an analytical approach to drive change. Having said that, in healthcare there is the key tripod: you have the providers of care; you have the payers of care, and you have the insurance companies. The patient is the center and common denominator of all of this and should not be minimized. It is the patients' money that goes to the insurance carrier. The insurance carrier passes that money on to the provider for services provided, the provider provides services to the patient. The point is not to try to minimize the importance of the patient because the patient is central to all of this. However, the patient really has very little influence over the dynamic among these three key players.

When considering structural problems, that is, if your provider of care, your revenue source, your business is dependent on services you provide and how much you get paid for those services, that payment is driven by what sort of arrangement you have negotiated with the insurance company to receive those. The Insurance company, in turn, receives premium payments from the patient. Again, this could be through an employer or it could be through the government, but ultimately the money comes from us as individuals through premium payments, through payroll

deductions, and through tax payments. It comes from us. It doesn't just materialize. The money comes in the form of a premium to the insurance company, and the insurance company is charged with trying to figure out how it can pay for the services but maximize the profit they are getting on the premium that they receive.

The third leg of this tripod is the purchaser; whether it is the employer or a state or federal government, it is the entity that has arranged for the benefits for which the individual patient is eligible. If it is Medicaid, it is through the State of New York through combined federal, state money, and there is a prescribed program and prescribed set of benefits. The purchaser sets the rules to the insurance company to say, “Here's what I'm willing to pay you to administer this plan and make sure that benefits get to my population.” It is ultimately the purchaser that has the financial responsibility to make sure that that arrangement works as effectively as possible.
If you are an employer, what you are worried about is what the annual premium cost is going to be and what you are going to have to charge your employees as parts of their contribution. It must be affordable. If it is not affordable, then it is not a very attractive benefit, and is not going to help you with your overall retention improvement.

Value-Based Payment

Value based payment can have many different forms and definitions, but the way I look at it is simple. Take it out of the healthcare context. Imagine that you are a local grower of apples, and I buy bushels of apples from you, but lately, what I've been noticing is that one in ten of the apples are just rotten. When I get them, they're no good, and at some point I come back to you and say, "You know, I'm willing to maybe have one in a hundred bad apples, but I do not want one in ten, so I'm going to tie my payment to you to the value I'm getting from this. If I'm getting more rotten apples, I'm going to pay you less money. If I'm getting more less-rotten apples, I'm paying you more money. Now, take that into healthcare, specifically into behavioral health.

The nightmare that insurance companies have, and in some cases, it could be the purchasers too, the Medicaid programs, Medicare programs, is that somebody gets into long term mental health therapy. All I know is that I'm writing a check every month as the insurance company to you, (let's say) Dr. Smith, for the patient. I'm paying the provider $2,000 a month to treat this patient. What I want to know is “Is the patient getting better? How long is this going to go on? Is there value in what you are doing? Could a different provider produce a better outcome?” And so, the value-based payment is much more difficult to try to develop and apply in a behavioral health setting because there are no absolutes.

Simplify it: somebody who goes in with appendicitis has an absolute diagnosis. The patient has the surgery, the appendix is taken out. If there are no complications, all is well; the patient goes home, and you know what you paid for. The nature of behavioral health conditions, whether it is mental health or substance abuse, is a lot less conclusive and definitive, and is very individually driven by the unique circumstances of the patient. Many of those are not necessarily medically related. They could be socioeconomic. They could be environmental. There could be different factors that are influencing the mental health of an individual or individuals’ environments, including misusing substances or alcohol, something that might make it easier to cope with their

life. Thus, the value-based payment is really trying to define what is a reasonable or optimal outcome, and then I pay you to achieve that outcome. If that outcome is not achieved, I'm going to pay you something less.

Fee for Service

It's extremely hard, and what's hard about it is that ultimately the purchaser wants to get maximum value for the dollar they're putting into the system. The insurance company is more of a conduit of that money to the providers, but is trying to do so in a way that maximizes its competitive position in the marketplace. Then, the provider is saying, “Well, you know, I want to do right by my patients, but I want to make sure I get paid properly.” So, the structural flaw that we have had forever in our healthcare system is the fee for service basis of payment.

Now, for the last 10 years or so, we've been going through a transition to move - we can call it value-based payment - to performance or outcomes-based payment arrangements. In some cases, it goes all the way to some sort of a capitated arrangement. What all of this does is try to involve the provider more in the financial risk of the services that are being provided. There's been a lot of pushback from the provider community, understandably so, because providers have viewed this as insurance companies and purchasers basically dumping a mess at their feet, saying “You must do more, we want to pay you less.” That's essentially the message that's getting out there, and providers are saying “Hey, listen, we're willing to do this, but it must be shared pain. We're not going to be the ones that are left holding the bag on this.” That's the fundamental structural problem we've got. We're trying to move from volume-based fee for service payment to outcome-based value-based services, and the way in which that shift is attempting to take place is through shifting more of the financial consequence of decisions made by providers to the provider.

SAE: *How inextricably woven together each of these are. I'm also hearing how a structural shift is going to take a lot more effort and a lot more time - where would you start with that shift? I'm bringing us back to the flaw that you can identify in those three legs; what do you see? Am I on to something by thinking that change is hard when each component connects to the next?*

Structural Change

Alex Hutchinson, MBA: Although the duration and variety of dimensions of treating a behavioral health condition versus a medical/surgical one may be part of the resistance from insurance companies to properly address the needs of behavioral health conditions, another dimension of this structural problem we have is that the behavioral health field has been incredibly fragmented and separated from mainstream medical health care. Thus, there has been a mindset that has developed over time that "Behavioral health is something to look at and treat independently and separately from any medical situation that's going on," and we all know that's not the case.

We know people have chronic illnesses and suffer from chronic depression because of the chronic illness, and that that depression is a mental health/behavioral health problem directly

related to their medical problem, and that if you can address one, you might be able to impact the other. Therefore, the other structural change is in reintegrating behavioral health as part of the total picture; it should not be segmented, it should be fully integrated. The concern is less about how many therapy sessions are being provided to the patient, rather, it is the overall characteristics of the healthcare needs of the patient that: the patient is going to the ER a lot less frequently, the patient is significantly more compliant with their meds, and that we are not dealing with, for example, insulin problems and diabetes or other chronic diseases or outbreaks.
When I consider all of that, that's where I would say, do not focus on the quantity of a particular service that they're consuming; look at the total picture of the health status of the patient, and, can you objectively determine that the patient is better off today than they were a year ago because of how we have structured the care that they are getting.

Unfortunately, patients play a much smaller role than they should, but, implied in the models that payers are using, as well as how they want to compensate providers, there is an implication that they are trying to drive the provider to involve patients more substantially in the process.
It is necessary for providers to engage with patients and to understand what the needs of the patients are, not just simply see the patients for fifteen minutes in order to be paid and then see them again in a month where the patients become an encounter to obtain a fee. What the payers are trying to do through this transitional process is to say “At least for some patients that's fine, but for other patients that had very complicated, comorbid conditions, it will require a lot more time. Providers need to focus their time and possibly their staff's time more effectively to engage that patient to be more compliant, to better understand what their objectives are, and to understand how all the pieces fit in order to take self-responsibility.” It is a heavy lift. Again, this is where the provider community is pushing back to basically say “I cannot make them take their meds. I cannot make them do this, I cannot make them do that,” which is a legitimate thing, but it could be that if you found a way to engage with patients more effectively, and it doesn't need to be the physician, it could be a member of the staff, or an outreach coordinator that has developed a relationship that would call and say to patients “How are you doing? Are you taking your meds? Are you checking your blood sugars?” The patient says then, “Well, somebody cares about me.” Patients may look forward to those calls and decide that they want to be compliant and do the right thing. Theoretically, these are the goals.

However, currently we are in a real mishmash because in healthcare, we are transitioning from one payment model to another. There is not necessarily the infrastructure in place - certainly not on the provider side yet - to support this, and there is not necessarily the payment levels necessary to compensate provider organizations to invest in the resources to be able to engage patients this way.

I think the insurance companies have created the segmentation between medical/surgical and behavioral health conditions, and it has evolved over time. When you think back to how insurance companies previously provided benefits, certainly there was poor managed care in the 1970’s and 80’s, and it was in the 90s where this segmentation started to take place. What the insurance companies began to realize was that, and behavioral health is a perfect example, behavioral health historically has represented about three (3%) to five percent (5%) of the premium cost in terms of medical claim cost for an insurance company. So, it is a relatively small slice. Having said that, it does require expertise and resources to be able to manage it properly.

What insurance companies have realized is that they do not want to commit a lot of their time and attention to this if we can carve this out.

SAE's Parity Team, Brian Baldwin, LCSW, Alex Hutchinson, MBA and Maria Messina, PhD provide an intersectional view of parity and compliance with unique and complementary approaches to assessing parity, considering the impact of structural flaws in the U.S. healthcare system.