



CALIFORNIA
PSYCHIATRIC
ASSOCIATION

CAPITOL INSIGHT

2012 Legislative Highlights

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The California Legislature has a two year legislative bill cycle, and 2011 was the first year in this cycle. The legislative year ended on Friday, September 9, 2011 and the Governor has until Sunday, October 9, 2011 to sign or veto bills. In 2011, 2719 bills were introduced in the California Legislature. The California Psychiatric Association reviewed several hundred bills for relevance to psychiatry and its patients; reviewed 126 bills very carefully and ultimately took positions on 65 of those bills - although it simply monitored closely several dozen of those. Through attrition in the legislative process only 24 of those bills were active in the late stages of the 2011 legislative session. Of the last group of 24 bills, 3 were vetoed, 7 were signed and the rest were on the Governor's desk at press time. Those bills are below.

The highlights:

AB 201 (Butler D) Veterans courts. Summary: Would authorize superior courts to develop and implement veterans mental health courts. Location: 8/5/2011-A. VETOED. Position: Support.

AB 312 (Lowenthal, Bonnie D) Civil rights: homeless persons. Location: 8/5/2011-A. VETOED. Summary: Would specify that homeless persons have the right to be free from violence or intimidation by threat of violence. Position: Support.

AB 366 (Allen D) Defendants: involuntary antipsychotic medication. Location: 9/21/2011-A. ENROLLED to Governor (enrolled means on its way to the Governor). Summary: Would require a court to determine if the defendant lacks capacity to make decisions regarding

antipsychotic medication before seeking consent in state hospitals.

Position: Support.

AB 396 (Mitchell D) Medi-Cal: juvenile inmates. Location: 10/2/2011-A. CHAPTERED (Signed into Law). Summary: allows counties to receive available federal financial participation for acute inpatient hospital services provided to juvenile inmates. Position: Support.

AB 604 (Skinner D) Needle exchange programs. Location: 9/23/2011-A. ENROLLED to the Governor. Summary: Would authorize certain entities to provide hypodermic needle and syringe exchange services in any location deemed high risk. Position: Support.

AB 655 (Hayashi D) Healing arts: peer review. Location: 9/30/2011-A. CHAPTERED. Summary: Provides clarification of conditions under which peer review bodies exchange information. Position: Coordinate with CMA.

AB 922 (Monning D) Office of Patient Advocate. Location: 9/20/2011-A. ENROLLED. Summary: Would transfer the Department of Managed Health Care to the California Health and Human Services Agency. Position: Support.

AB 956 (Hernández, Roger D) Marriage and family therapy: interns and trainees: advertisements. Location: 8/3/2011-A. CHAPTERED (signed by the Governor). Summary: The bill would require an intern, prior to performing professional services, to provide a client or patient with the intern's registration number. Position: Support.

AB 989 (Mitchell D) Mental health: children's servic-



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es. **Location:** 9/16/2011-A. **ENROLLED** to Governor. **Summary:** Would require county mental health programs to consider the needs of transition age foster youth. **Position:** Support.

AB 1059 (Huffman D) **Emergency medical care.** **Location:** 10/2/2011-A. **CHAPTERED** (signed into law). **Summary:** Requires reporting that helps emergency physicians claims to be paid. **Position:** Support.

AB 1114 (Lowenthal, Bonnie D) **Inmates: involuntary administration of psychotropic medications.** **Location:** 9/16/2011-A. **ENROLLED** (to the Governor). **Summary:** Provides shorter timeframes to a noticed hearing to determine capacity to consent to psychotropic medications for inmates. **Position:** Support.

AB 1297 (Chesbro D) **Medi-Cal: mental health.** **Location:** 9/22/2011-A. **ENROLLED.** **Summary:** would allow counties to directly claim many additional millions of dollars in federal aid. **Position:** Support.

AB 1424 (Perea D) **Franchise Tax Board: delinquent tax debt.** **Location:** 10/4/2011-A. **CHAPTERED** (signed into law). **Summary:** Allows the Franchise Tax Board to publish the type, status, and license number of a professional license for delinquencies in excess of \$100,000. **Position:** Oppose.

SB 33 (Simitian D) **Elder and dependent adult abuse.** **Location:** 9/30/2011-S. **CHAPTERED.** **Summary:** Extends financial elder abuse laws indefinitely. **Position:** Support.

SB 36 (Simitian D) **County Health Initiative Matching Fund.** **Location:** 10/2/2011-S. **CHAPTERED.** **Summary:** provides that counties can provide the matching funds for health care coverage to eligible children whose family income is at or below 400% of the federal poverty level. **Position:** Support.

SB 51 (Alquist D) **Health care coverage.** **Location:** 9/16/2011-S. **ENROLLED.** **Summary:** The bill would authorize regulations to implement requirements relating to medical loss ratios of managed care organizations. **Position:** Support.

SB 105 (Yee D) **Public safety: snow sport helmets.** **Location:** 9/7/2011-S. **VETOED.** **Summary:** Requires for youth under 18 years of age to wear a helmet while operating snow skis or a snowboard. **Position:** Support.

SB 695 (Hancock D) **Medi-Cal: county juvenile detention facilities.** **Location:** 9/16/2011-S. **ENROLLED.** **Summary:** provide that Medi-Cal benefits may be provided to an individual awaiting adjudication in a county juvenile detention facility if the individual is eligible to receive Medi-Cal benefits at the time he or she is admitted to the detention facility. **Position:** Support.

SB 866 (Hernandez D) **Health care coverage: prescription drugs.** **Location:** 9/16/2011-S. **ENROLLED.** **Summary:** requires the development of a prior authorization form for use by every health care service plan and health insurer that provides prescription drug benefits. **Position:** Support.

SB 913 (Pavley D) **Juvenile offenders: medical care.** **Location:** 9/6/2011-S. **CHAPTERED.** **Summary:** Would permit a probation officer to authorize a medical exam related to a minor's need for medical care.

SB 946 (Steinberg D) **Health care coverage: mental illness: pervasive developmental disorder or autism: public health.** **Location:** 9/16/2011-S. **ENROLLED.** **Summary:** This bill, effective July 1, 2012, would require those health care service plan contracts and health insurance policies to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. **Position:** Support.

Achieving the Promise of the Mental Health Parity and Addiction Equity Act

(Irvin L. "Sam" Muszynski, J.D., is the Director, Office of Healthcare Systems & Financing, American Psychiatric Association.)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, the Parity Act) ushered in a new era for health insurance coverage for mental health and sub-

stance use (mh/sud) disorders. The foundation for this was laid by the Mental Health Parity Act of 1996, and, significantly, the Patient Protection and Affordable Care Act (the ACA) that was passed in 2010 contains a number of provisions that expand the reach of the mental health parity requirements of MHPAEA through yet-to-be-established health plans .

These laws have the potential to create significant changes in the coverage for and medical management of individuals with mh/sud conditions. However, experience and research tell us that the requirements and potential of the law will not be fulfilled without our involvement. It is vital that we understand the law and target our intervention priorities based on that understanding.

The law and the regulations for its implementation are complex, and it is a difficult task to create practitioner and patient/consumer awareness of what is covered in them. Health plan provisions will likely flow from narrow rather than broad interpretations of the law's requirements. Federal and state authorities have limited resources for overseeing compliance and enforcement. The advocacy community clearly has its work cut out for it.

In brief, the Parity Act bars health plans from having separate cost sharing or treatment limits for covered mh/sud benefits than for medical and surgical (med/surg) benefits. The Act also prohibits a plan from imposing any financial or treatment limitations that are more restrictive than those in place for medical surgical benefits. These parity requirements apply to both in- and out-of-network benefits.

The Parity Act generally covers all insured or self-insured group health plans that offer medical and surgical as well as mh/sud benefits, and this includes plans where the mh/sud disorder benefits are managed by "carve-out" companies such as ValueOptions or Magellan.

It is important to understand that plans are not required to offer mh/sud coverage, and that plans offering these benefits may limit the range of disorders they do cover. However, insured health plans remain subject to state insurance and mental health parity laws in addition to the federal Parity Act requirements. The parity requirements also apply to Medicaid managed care plans and state CHIP programs. CMS has regrettably not yet issued definitive guidance to states to assure compliance with the Interim Final Rule (IFR) implementing the Parity Act.

The IFR was issued on February 3, 2010, and the regulations became effective for health plan years beginning on or after July 1, 2010. The regulations are far reaching, including both quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs), but since space precludes a complete analysis, our primary focus here is given to the provisions regarding:

- NQTLs
- Scope of services
- Medical necessity and coverage criteria

NQTLs

The regulations define treatment limitations to include both QTLs and non-quantitative limitations (NQTLs). The NQTL provision is critical. An NQTL is a limitation that, while not expressed numerically, otherwise limits the scope or duration of benefits for treatment under the plan. The regulations include the following as illustrations of NQTLs:

- Standards for provider admission to participate in a network, including reimbursement rates;
- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Plan methods for determining usual, customary, and reasonable charges; and
- Refusal to pay for higher cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first or step therapy protocols).

It is highly significant that the regulations have identified these non-quantitative elements as parity issues. It is clear this creates the potential for redressing many existing health plan practices that are discriminatory.

Despite the advent of these parity regulations, we have witnessed a number of health plans instituting new non-quantitative requirements that limit access to mental health and substance use disorder services.

The IFR sets forth a special test for determining whether an NQTL is acceptable, but at this point there is still ambiguity about how this test will be applied. The implications of this for bringing health plan practices into alignment with the parity regulations are discussed more fully below.

Scope of Services

Respecting scope of services, the IFR establishes a classification of benefits scheme that includes inpatient and outpatient care, both in-network and out-of-network; as well as emergency care and prescription drugs. A plan that provides mh/sud must provide those benefits in every classification in which it provides medical/surgical benefits.

The regulations, however, are silent on the scope of services a plan must provide within each classification and how comparable they must be to the scope offered for med/surg benefits within the same classification. The regulators have made it clear that this will not be addressed until the final regulations are issued in the future. This has presented a number of problems for mh/sud services coverage. As the rule currently stands, a plan may offer just one service within a classification and still be in compliance. For example, for psychiatric inpatient care, it can offer care only in a general hospital and no other settings or levels of care. Some health plans have dropped specialty hospital care and residential care because there is no medically analogous service. Similarly, many plans have dropped partial hospitalization coverage, stating that because there is no medically analogous service, the Parity Act does not require them to cover this. These developments are alarming, and proper resolution of this “scope” issue will require considerable work by the advocacy community. Without satisfactory resolution, the parity requirement could result in some adverse, unanticipated consequences for the delivery of mental health care.

Medical Necessity and Coverage Criteria

The regulations require that the criteria for medical necessity determinations made under the plan for mh/sud benefits be made available to any current or potential participant, beneficiary, or contracting provider upon request. It is important to note that medical necessity determinations are NQTLs and are subject to the regulations’ comparability test. It is critical to be able to compare the criteria for denial of mh/sud services with the criteria used for med/surg services.

While the reason for any specific denial of reimbursement or payment for mh/sud services must be made available by the plan upon request, it will be critical to determine if these denials, in fact, meet the NQTL test. Discovery, review, and analysis of discriminatory medical review issues will be essential.

The Parity Act and the Challenges it Presents

Much has been accomplished in laying a foundation for future parity work. However, collectively we have only touched a small part of the universe of parity issues that have already arisen or are likely to arise in the future.

There are several operational factors that impede the translation of the Act’s potential into reality, including:

1. The actualization of requirements embedded in the complex rules set forth in the IFR is not automatic or straightforward. While the IFR rules are favorable, they do not provide a bright line on the NQTL and scope of practice issues. Hence, these are open to different interpretations by completing stakeholders and will require extensive adjudication by federal and state regulators.
2. Health plans, other than making adjustments to more favorable copays, deductibles, etc., are establishing new or maintaining prior medical management protocols, which, in our view, are not lawful. These plans invariably claim compliance with the Parity Act. They need to be challenged aggressively and most must be handled on a case-by-case basis. We have already been successful with some of these challenges, but it is clear we will have to remain vigilant.
3. The federal agencies charged with compliance and enforcement of the Parity Act are now simultaneously overwhelmed with the health reform provisions of the ACA. Their ability to do the fact-finding and development necessary to perform appropriate reviews is very limited. In order to receive due consideration of an issue by the federal regulators, the advocacy community must fully develop a “case.” This is extremely labor intensive and requires a high level of technical expertise.

In summary, the Parity Act requirements represent considerable potential for redress of discriminatory practices by health plans. However, as noted, the process is complex and the amount of work needed to adjudicate disputed matters is considerable.

It is imperative that the mental health and substance use disorder communities understand the significance the Parity Act can have, and that all of their members monitor the health plans with which they’re involved so that infractions can be reported to the regulators and action taken. The website maintained by the American Psychiatric Association and the Parity Implementation Coalition, www.mentalhealthparitywatch.org, provides timely information about the Act and serves as a conduit for asking questions, securing guidance, and reporting issues. We need input from the troops in the field to be able to effectively advocate for enforcement of the Act. We urge you to participate in this process.