MEMORANDUM

To: **Deb Beck**
Drug and Alcohol Service Providers Organization of Pennsylvania

From: **Greg Heller**

Dated: **February 2, 2011**

Re: **The Affordable Care Act and Inpatient Nonhospital Rehabilitation Facility Care for the Treatment of Substance Use Disorders**

The package of essential health benefits that will be required under the Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA") is currently being developed. *See* ACA § 1301(a)(1)(B), 42 U.S.C. § 18021(a)(1)(B). At some point, the Secretary of the United States Department of Health and Human Services will issue definitive regulations defining what will and will not be covered.

An early guidance document from the Substance Abuse and Mental Health Services Administration gives reason to hope that in the area of substance use disorder treatment, the essential benefits package will include the full continuum of care needed to treat these disorders. That document, however, quite literally includes an asterisk next to residential services, and notes that these "will need to be further defined in the next several months." In light of the importance of residential addiction treatment services, their status merits attention.

The public health case for the full continuum of care for the treatment of substance use disorders – a continuum that by all accounts and under settled practice includes a range of residential treatment settings – has been made elsewhere and will not be repeated here. This memorandum asks,

and answers, a slightly different question: to what extent is residential addiction treatment required to be included as an essential benefit because of the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Parity Act"). The Parity Act expressly applies to the Affordable Care Act and its essential benefits package. Section 1311(j) of the ACA provides that "[s]ection 300gg-26 of this title shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans." ACA § 1311(j), 42 U.S.C. § 18031(j). Section 300gg-26 of title 42 sets forth the substantive parity requirements of the Parity Act, and "qualified health plans" are health plans that include the essential benefits package and comply with other requirements of the Affordable Care Act. ACA § 1301(a)(1)(B), 42 U.S.C. § 18021(a)(1)(B). The Parity Act requires that residential treatment be included in the essential benefits package.[1]

At the outset, a terminology point is in order. When applied to substance use disorder treatment, the term "residential rehabilitation" covers a range of treatment settings, and can mean different things in different regulatory, accreditation, contractual, and clinical contexts. Other common terms are marginally more precise, but likewise mean different things in different contexts.

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[1] State laws also require coverage for addiction treatment, and both the Affordable Care Act and the Parity Act preserve State laws. The overwhelming majority of States have laws that require private insurers to cover treatment for addiction to alcohol or other drugs. Nat'l Conf. of State Legislatures, State Laws Mandating or Regulating Mental Health Benefits, available at http://www.ncsl.org/ programs/health/Mentalben.htm (last updated February 11, 2010). In general, and with respect to insurance products currently on the market, both the Affordable Care Act and the Parity Act leave these State laws untouched. This memorandum is limited to what is required by federal law, and does not discuss the extent to which coverage of inpatient nonhospital rehabilitation facility care might also be required under the laws of a particular State.

This memorandum will use Pennsylvania's regulatory terminology as a fixed reference point and as an example, and will use the term "inpatient nonhospital rehabilitation facility" (or "INRF") to refer to the scope of settings encompassed within Pennsylvania's licensing regulations for facilities that provide "inpatient nonhospital activities - residential treatment and rehabilitation" for substance use disorders. *See* 28 Pa. Code §§ 709.51-54 (titled Standards for Inpatient Nonhospital Activities - Residential Treatment and Rehabilitation, and applicable to freestanding facilities), 711.51-58 (titled Standards for Inpatient Nonhospital Activities - Residential Treatment and Rehabilitation, and applicable to facilities that are part of a health care facility). It should be noted that while Pennsylvania's regulatory terminology provides a fixed and convenient reference point, this definition is hardly unique. Every State has formal oversight mechanisms applicable to substance use disorder treatment facilities and services, and those oversight mechanisms include definitions that are well known to and understood by the applicable treatment community.

Part One of this Memorandum provides an overview of how the Parity Act operates. The Parity Act prohibits the imposition of treatment limitations on behavioral health care benefits, if those treatment limitations would be more restrictive than treatment limitations applied to medical/surgical benefits. If a particular form of or setting for treatment is provided on the medical/surgical side of the ledger, it must also be provided to treat substance use disorders. Part Two applies this analysis to INRF care. For physical health, inpatient nonhospital care in a rehabilitation facility is covered and will continue to be covered. The physical health care provided in inpatient nonhospital rehabilitation facilities, and the reasons why that setting is a necessary part of the continuum of care for physical health care, correspond strongly with INRF care for substance

use disorder treatment, and the reasons why that setting is likewise a necessary part of the continuum of care for substance use disorder treatment.[2] Because of this clear correspondence, INRF care cannot be excluded from, and therefore must be included in, the essential benefits package.

I. The Parity Act

A. The General Framework

Under the Parity Act, a health plan or health insurer cannot impose financial requirements or treatment limitations on behavioral health care (more precisely, on "mental health and substance use disorder benefits") that are more restrictive than "the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage)." 42 U.S.C. § 300gg-26(a)(3)(A)(ii).[3] Furthermore, a health plan or health insurer cannot impose any "separate

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[2] The treatment of substance use disorders as separate from physical illness is a distinction drawn under the ACA, *see* ACA § 1302(b), and under the Parity Act, and is therefore a distinction that is necessarily adopted for the purposes of this memorandum.

[3] In full, the section reads:

(3) Financial requirements and treatment limitations

(A) In general – In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that –

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or

treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." *Id.*

Under the Parity Act, it is not permissible to make a form of treatment available as a medical/surgical benefit, and then refuse to make that same form of treatment available as a substance use disorder benefit. Removing a benefit entirely from the menu of options available to treat a disease or condition is the most powerful form of "treatment limitation" available.

The only question, therefore, is whether the inpatient nonhospital rehabilitation facility care that will undoubtedly be a required medical/surgical benefit for a stroke, a traumatic brain injury, an orthopedic injury, and other illnesses is the same thing – for purposes of Parity Act comparison – as INRF care.

B. For Purposes of the Parity Act Comparison, an Exact Correspondence Is Not Required.

Before turning to the specifics of this comparison it is important to establish, as a threshold matter, how precise the correspondence needs to be. Viewed at a sufficiently precise level of detail, no form of treatment is identical to any other form of treatment. Rehabilitation treatment plans – whether for a stroke, a traumatic brain injury, or a substance use disorder – need to be individualized to meet the needs and capabilities of the individual patient. No patient's rehabilitation treatment is exactly identical to any other patient's treatment, and no one patient's rehabilitation treatment –

> substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

42 U.S.C. § 300gg-26(a)(3).

whether for a stroke, a traumatic brain injury, or a substance use disorder – remains exactly the same over time.

Thus, common sense tells us that the comparison must necessarily be made at some level of generality.

This approach is also supported by the language of the Parity Act, the intent of the Parity Act, and the Interim Final Rules that were issued by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (the "Departments") in February, 2010. *See* Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410 (Feb. 2, 2010) (codified at 29 C.F.R. pt. 2590, Treas. Reg. pt. 54, and 45 C.F.R. pt. 146).[4] The Interim Final Rules break down benefits into six different classifications, and require that "mental health or substance abuse disorder benefits must be provided in every classification in which medical/surgical benefits are provided." 29 C.F.R. § 2590.712(c)(2)(ii) (ERISA regulations); *see also* Treas. Reg. § 54.9812-1T(c)(2)(ii) (identically worded provision in Department of the Treasury regulations); 45 C.F.R. § 146.136(c)(2)(ii) (identically worded provision in Department of Health and Human Services regulations). These rules establish six different classifications, and these are "the only classifications used in applying the rules of this paragraph (c)":

(1) Inpatient, in-network.

(2) Inpatient, out-of-network

[4] While these are interim final rules and not final rules, they have the force and effect of final rules, until final rules are issued. *See generally Coalition for Parity, Inc. v. Sebelius*, 709 F.Supp.2d 10 (D.D.C. 2010) (dismissing a managed care industry challenge to the Interim Final Rules, and explaining the role and legal status of interim final rules).

(3) Outpatient, in-network

(4) Outpatient, out-of-network

(5) Emergency care

(6) Prescription drugs

Id.[5] As the Departments explained in the prefatory comments that accompanied the Interim Final Rules, providing benefits in a particular classification for medical/surgical benefits but not for behavioral health or substance use disorder treatment "is a limit, at a minimum, on the type of setting or context in which treatment is offered." 75 Fed. Reg. at 5413. These classifications remind us yet again that for purposes of the parity analysis, comparisons are to be made at a fairly high level of generality. The classifications, after all, collapse the entire world of medical/surgical treatment and behavioral health and substance use disorder treatment into six categories.

Other parts of the Interim Final Rules take a similar approach, and do not require an exact correspondence of benefits at a microscopic level of detail, but rather conduct the inquiry at a necessarily more general level of detail.

The Interim Final Rules offer the example of a plan that conducts concurrent utilization review for mental health and substance use disorder benefits, but not for medical/surgical benefits. This violates parity, because concurrent utilization review is concurrent utilization review, even though one could readily identify differences between concurrent utilization review as carried out for medical/surgical benefits and for mental health/substance use disorder benefits. 29 C.F.R. § 2590.712(c)(4)(iii); *see also* Treas. Reg. § 54.9812(c)(4)(iii); 45 C.F.R. § 146.136(c)(4)(iii).

[5] Obviously, the inpatient categories are the ones that cover INRF care.

The Interim Final Rules' discussion of "black box" warnings provides yet another example. "Black box" warnings are required to be included among prescribing information for certain medications, and are essentially especially prominent warnings of a significant risk of serious adverse effects. The Interim Final Rules expressly state that a black box warning cannot be used as a basis for excluding coverage for a class of drugs used to treat behavioral health disorders if the presence of a black box warning is not also a basis for the exclusion of drugs on the physical health side. 29 C.F.R. § 2590.712(c)(4)(iii), at Example 4; *see also* Treas. Reg. § 54.9812(c)(4)(iii), at Example 4; 45 C.F.R. § 146.136(c)(4)(iii), at Example 4. It would certainly be possible to identify specific differences between antidepressants with a black box warning and (say) cardiology drugs with a black box warning, but at a general level the criterion is the same (the presence or absence of a black box warning). If the presence of a black box warning will disqualify an antidepressant but not a cardiology drug, that violates parity and is not permissible.

With this framework in mind, it is clear that if the essential benefits package includes an inpatient nonhospital rehabilitation facility benefit for medical/surgical treatment, it must also, in order to comply with the Parity Act, provide inpatient nonhospital rehabilitation facility care for the treatment of substance use disorders.

II. Applying the Parity Act to the Essential Benefits Package

A. Inpatient Nonhospital Rehabilitation Facility Care as a Medical/Surgical Benefit

On the medical/surgical side, the essential benefits package will include care in an inpatient nonhospital rehabilitation facility as a covered benefit.

"Rehabilitative and habilitative services" are expressly enumerated as a category of benefit to be included. ACA § 1302(b)(1)(G). As a medical proposition, it is beyond dispute that an inpatient setting is an essential component of the continuum of care. Patients receiving rehabilitation care following a traumatic brain injury, a stroke, an orthopedic injury or orthopedic surgery, and any number of other diseases and conditions often require and receive inpatient treatment. Sometimes this is in an acute care hospital; sometimes this is in a specialty rehabilitation hospital; and sometimes this is in a skilled nursing facility, which is by definition both inpatient and not a hospital.

An inpatient rehabilitation setting allows the coordination of care across a number of different treatment types and modalities; allows constant supervision by clinical personnel (either through the direct administration/supervision of treatment, direct observation, or careful management of the physical setting); and removes or minimizes the practical and logistical problems that could otherwise readily overwhelm a newly disabled patient and thereby make timely, effective treatment impossible.

The federal Medicare regulations applicable to reimbursements for skilled nursing facility care reflect the consensus that an inpatient nonhospital setting is a necessary part of the continuum of care. Significantly, those regulations expressly credit the practical considerations that can make an inpatient stay necessary, and provide for Medicare coverage in a skilled nursing facility where the

patient needs skilled nursing or rehabilitation services on a daily basis that "as a practical matter, can only be provided in a [skilled nursing facility], on an inpatient basis." 42 C.F.R. § 409.31(b)(3). The "practical matters" standard expressly allows consideration of logistical concerns (such as transportation) and physical hardships that would otherwise interfere with rehabilitation. *Id.* § 409.35(b).

Those regulations define "skilled services" in a way that goes well beyond the direct, hands-on administration of a particular form of rehabilitation therapy.

Overall management and evaluation of a care plan "constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety." 42 C.F.R. § 409.33(a)(1).

Observation and assessment of a patient's changing condition constitute skilled services "when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized." *Id.* § 409.33(a)(2)(i). Patient education services "are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance." *Id.* § 409.33(a)(3)(i). In their discussion of patient education, the regulations offer the example of a patient with a recent leg amputation who needs gait training and needs to learn prosthetic care, and the example of a newly diagnosed diabetic who needs to learn foot care, and how to self-administer insulin." *Id.* § 409.33(a)(3)(ii).

"Ongoing assessment[s] of rehabilitation needs and potential" qualify as skilled rehabilitation services, as do therapeutic exercises that "because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment." *Id.* §§ 409.33(c)(1), (2). Maintenance therapy qualifies as a skilled rehabilitation service "when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance." *Id.* § 409.33(c)(5).

Even if a condition does not normally require skilled services, the condition may require skilled services "because of special medical complications." 42 C.F.R. § 409.32(b).

These are all services that support an inpatient stay in a skilled nursing facility when they are ordered by a physician, are needed on a daily basis, need to be provided by or under the supervision of technical or professional personnel, and are services that "as a practical matter" can only be provided in a skilled nursing facility, on an inpatient basis. 42 C.F.R. §§ 409.31(a), (b)(1), (b)(3).

It is important to bear in mind that the inclusion of these skilled services as covered services does *not* guarantee that they are available to a particular Medicare beneficiary in every situation. There are various conditions and requirements that control access to these benefits. For example, while therapeutic exercises are indisputably a covered benefit, the benefit can only be accessed when "because of the type of exercises employed or the condition of the patient" they "must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment." 42 C.F.R. § 409.33(c)(2). Another

example of restrictions on access is found in Medicare regulations that require a prior qualifying hospitalization. For many Medicare enrollees, a skilled nursing facility admission must (a) follow a 3-day (or longer) hospitalization, 42 C.F.R. § 409.30(a)(1), and (b) occur within 30 days after discharge from the hospital. 42 C.F.R. § 409.30(b). Also, the skilled nursing facility stay must be for the purpose of providing needed skilled nursing or skilled rehabilitation services for a condition that was either treated during the hospital stay itself or arose during the hospital stay itself or during a subsequent skilled nursing facility stay. 42 C.F.R. §§ 409.30, 409.31(b).

These conditions and requirements, however, are limitations only on the circumstances in which the benefit can be accessed. These limitations on access to the benefit do not disturb one iota the more fundamental proposition that these services, including an inpatient nonhospital setting for the services, are covered benefits.

It is also important to note that the prior hospitalization requirement does not apply to all Medicare enrollees. Medicare Advantage[6] plans are essentially capitated private health plans, offered as an alternative to traditional Medicare benefits. Roughly one in five Medicare beneficiaries is enrolled in a Medicare Advantage plan. Medicare Advantage plans are allowed to offer a benefit package that does not require a prior qualifying hospital stay as a condition of skilled nursing facility care, 42 C.F.R. § 422.101(c), and for those enrolled in such a plan there is no need for a prior qualifying hospitalization, so long as a physician has determined that admission to a skilled nursing

[6] The regulations refer to “”Medicare+Choice”; this is a reference to the Medicare+Choice program, in which Medicare beneficiaries receive their Medicare benefits through private health plans. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 renamed this program “Medicare Advantage”.

facility without a prior qualifying hospitalization is medically appropriate. 42 C.F.R. § 409.31(b)(2)(iii).

While hardly an exhaustive catalogue of the clinical and policy rationales supporting inpatient nonhospital care for physical health rehabilitation, the Medicare skilled nursing facility regulations both illustrate and underscore the consensus supporting coverage for this inpatient care setting. It is fair to anticipate that the essential benefits package under the ACA will include, on the medical/surgical side, benefits for inpatient nonhospital rehabilitation facility care that are at least as comprehensive as those currently provided under the Department of Health and Human Services' current Medicare regulations.

B. Inpatient Nonhospital Rehabilitation Facility Care as a Substance Use Disorder Treatment Benefit

For Parity Act comparison purposes, inpatient nonhospital rehabilitation facility care as part of the continuum of care for substance use disorder treatment is the same thing as inpatient nonhospital rehabilitation facility care as part of the continuum of care for patients recovering from a stroke, a traumatic brain injury, or orthopedic surgery.

The services that are part of substance use disorder treatment correspond to services that are covered on the physical health side. Overall management and evaluation of a care plan are essential first steps in addiction treatment, and these are services that require skilled professional personnel. *Compare* 42 C.F.R. § 409.33(a)(1) (management and evaluation of a care plan as covered medical/surgical skilled services) *with* 28 Pa. Code §§ 709.52(a) - (b) (Pennsylvania facility licensing regulations requiring formulation and periodic review of care plans in inpatient nonhospital rehabilitation facilities). Observation and assessment of a patient's changing condition and ongoing

assessments of rehabilitation needs and potential, which can be covered skilled services under Medicare's physical health regulations, 42 C.F.R. §§ 409.33(a)(2)(i), (c)(1), are also an essential part of substance use disorder treatment. Much of the therapy for substance use disorders needs to be performed by or under the supervision of a qualified therapist "to ensure the safety of the patient and the effectiveness of the treatment," a criterion that supports coverage of physical health therapeutic services. *See* 42 C.F.R. § 409.33(c)(2). Likewise, the development of a maintenance program, and the patient education needed to develop self-maintenance skills, both of which are expressly covered on the medical/surgical side, *see* 42 C.F.R. §§ 409.33(c)(5), (a)(3)(i), are important parts of – one might fairly call them the central projects of – substance use disorder treatment.

As set forth above, these services support inpatient nonhospital rehabilitation facility care on the medical/surgical side when (a) the patient requires the services on a daily basis, (b) the services need to be provided by or under the supervision of technical or professional personnel, and (c) the services "as a practical matter" can only be provided in a skilled nursing facility, on an inpatient basis. 42 C.F.R. §§ 409.31(a), (b)(1), (b)(3).

Each of these applies to INRF care.

People with addictions who are newly in recovery require services on a daily (or more frequent) basis.

Substance use disorder treatment services need to be provided by (or at the direction of) technical and professional personnel. This is required by the standard of care, as well as formal oversight standards.

For many patients suffering from a substance use disorder, effective treatment services can, as a practical matter, only be provided in an inpatient setting. The same practical considerations that justify a stay in an inpatient nonhospital rehabilitation facility for rehabilitation after a stroke or a traumatic brain injury also apply – often with much greater force – to those suffering from diseases of addiction. Creating, controlling, and where appropriate managing a patient's milieu is a necessary staple of much addiction treatment. It is often essential that the patient be in a securely alcohol- and drug-free environment where volatile issues that might otherwise drive a return to active addiction can safely be explored. Patients need to be removed from relapse triggers while immersed in learning about the illness and how to maintain recovery. Stigma and denial, which work so powerfully together to keep people with drug and alcohol addictions using and drinking, can be most effectively addressed in a controlled inpatient setting. Transportation (expressly credited as a "practical matter" factor in the Medicare regulations) can also be a factor supporting INRF care, particularly when consideration is given to the safety of both the addicted individual and a traveling public that would otherwise share the road with an addict in fragile early recovery. Constant supervision by clinical personnel is essential. And logistical hurdles associated with independent living can easily overwhelm someone struggling to recover from a substance use disorder, just as they might overwhelm someone trying to productively engage in rehabilitation while simultaneously dealing with a new physical disability.

In light of these many clear correspondences between inpatient nonhospital rehabilitation facility care as medical/surgical treatment and INRF care as substance use disorder treatment, the Parity Act requires that INRF care be included in the essential benefits package.

III. Inpatient Nonhospital Rehabilitation Facility Care as a Benefit for the Treatment of Substance Use Disorders Is Required Today, And Need Not Await Resolution Of The Continuum Of Services Issue.

The analysis set forth in this memorandum assumes that it is necessary to compare specific forms of medical/surgical treatment to specific forms of substance use disorder treatment. In the administrative process that resulted in the Interim Final Rules, many commenters suggested that if a plan covers the full scope of services needed to treat medical/surgical conditions, then a plan must also cover the full scope of services to treat mental health conditions and substance use disorders even though "not all treatments or treatment settings for mental health conditions or substance use disorders correspond to those for medical/surgical conditions." 75 Fed. Reg. at 5416. This is sometimes referred to as the "scope of services" or "continuum of services" issue. The Departments expressly noted that the Interim Final Rules "do not address the scope of services issue," but affirmatively invited comments "on whether and to what extent [the Parity Act] addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage." 75 Fed. Reg. at 5416-17.

This Memorandum explains why the Parity Act as written, and as treated in the Interim Final Rules currently in effect, requires that INRF care be included as a covered benefit. If subsequently issued rules interpret the Parity Act as endorsing the "continuum of services" view, the case for parity is even more self-evident and there is no need to carefully compare specific treatment settings. The continuum of service issue does not, however, have any bearing on the analysis set forth in this Memorandum. There is certainly no need to await resolution of the continuum of services issue before ensuring that the essential benefits package complies with the Parity Act.

IV. Conclusion

Completely withholding a benefit from a package of benefits is, rather obviously, a significant treatment limitation. The Parity Act prohibits treatment limitations on the behavioral health side of the ledger that are not also present on the medical/surgical side of the ledger. Inpatient nonhospital rehabilitation is indisputably available for physical illness. INRF care as a form of substance use disorder treatment corresponds clearly and powerfully to inpatient nonhospital rehabilitation facility care for physical illness, a correspondence that is confirmed not only by clinical consensus, but also by the Secretary of the Department of Health and Human Services' own Medicare regulations. INRF care needs to be included in the essential benefits package.