HEALTH REFORM

AND PRIVATE PRACTICE MFTS

In the last FTM, we outlined how the federal Affordable Care Act (also called Obamacare) is expected to work, and summarized ways in which it may affect MFTs in a variety of practice settings. This article will provide more specifics on how private-practice MFTs will be affected.

For private practitioners, here are the eight key questions you should answer:

Brian Rasmussen, PhD

1 **Does your practice either routinely have at least a 10% rate of unfilled appointments, or are you willing to expand your appointment hours by at least 10%?**

IF YES TO EITHER, then your practice likely could take on added clients who will be newly insured under Medicaid and/or Exchange (also called Marketplace) programs. (The 10% figure is used because nationally about 10% more people will gain insurance.)

IF NO, your practice probably is unsuited to taking on these new clients now, but as the reform law affects the entire healthcare financing system, you should re-evaluate your situation at least annually.

2 **Where is your practice located?**

As a general rule, states on the West Coast and in the Northeast will expand Medicaid and run their own Exchange (Marketplace) programs, while Southern and Great Plains States will not. Midwestern States are split. This distinction is generally due to having Democratic versus Republican state leaders making these choices. Yet, even among states in the same region, there will be administrative differences in their Exchange programs.

Despite these administrative differences, all states will have Exchange health insurance plans (called Qualified Health Plans, QHPs), but only half will expand Medicaid. BECAUSE EACH STATE WILL VARY FROM ALL OTHERS, AAMFT HAS DEVELOPED A STATE-BY-STATE DATABASE (available to members only at www.aamft.org/HealthReformStatesDatabase) TO OUTLINE YOU PARTICULAR STATE'S PLANS.

If your practice is located near a state boundary (such as in the tri-state New York City area), some potential clients may live in an adjoining state, but find it convenient to visit your practice (e.g., because they work nearby). While this is seldom a problem under current health plans, it is unknown how the Exchange and expanded Medicaid programs will address this situation.

3 **Is your state expanding its Medicaid program?**

IF YES TO THIS AND TO QUESTION 1, AND YOUR STATE COVERS PRIVATE PRACTICE MFTS UNDER MEDICAID (see www.aamft.org/HealthReformStatesDatabase), then you should consider becoming a Medicaid provider if you are not already. However, be aware that Medicaid pay rates generally are lower than for other payers, and that most Medicaid clients will be subject to managed care rules, including selective provider contracting. So, you likely would need to be a Medicaid provider panel member. Yet, because Medicaid clients must have low incomes, serving them has a pro bono element.

IF NO, you likely need do nothing about Medicaid. However, analysts expect an enrollment increase in "regular" Medicaid programs, as outreach efforts identify some people who are already eligible but not Medicaid-enrolled. In non-expanding states that cover private MFTs, there could be new clients who will have very low incomes.

4 Are you already in multiple private-payer provider networks, especially for Blue Cross and Blue Shield Plans?

IF YES TO THIS AND TO QUESTION 1, you are probably well positioned to treat new clients from Exchange plans (QHPs). Blue Cross will offer QHP products in nearly all states, while insurers such as Aetna and CIGNA will have plans in many fewer states. It is expected that each insurer's QHPs generally will use that insurer's already-established network of providers. But because the law requires mental health and substance abuse coverage, some Exchange plan insurers may need to expand their panels of behavioral providers, especially in rural and inner-city locales. In some cases, an insurer will subcontract with a behavioral-only provider network, like CIGNA Behavioral or MHN. Such networks serve as "middlemen" between practitioners and insurers.

Exchange plan enrollment begins October 1, 2013, so the list of network providers for each of these plans will need to be publicly available by that date.

If No, you should seriously consider applying for the provider panels used by the largest private insurers in your locale. Most new enrollees in both Exchange and Medicaid programs will be referred to providers in these existing networks.

However, in most cases, these networks are not legally required to accept all applicants. Section 2706 of the law has a weak "provider-type non-discrimination" provision, but the Obama Administration has declined to issue regulations to enforce it. But some States have "vendorship" and/or Any Willing Provider laws that may apply (see www.aamft.org/HealthReformStatesDatabase). It is not yet known how these state laws will interact legally with the ACA law.

In addition, early reports show that these networks are attempting to negotiate for lower pay rates in exchange for the increased service volume resulting from newly-covered persons. It would be unlawful for AAMFT to advise you on "appropriate" or "acceptable" pay rates, but you can assess how Medicaid and Exchange rates compare to the average of your existing pay sources. For instance, if—after deducting bad debts and insurers' charge reductions—you average $X in pay actually received per treatment hour, how does Exchange plan A's allowed pay rate per hour compare to $X?

When you consider such rates, remember that an unfilled appointment slot is potential income lost forever, but also that your professional time and skills are valuable.

5 If you said Yes to Question 1, and are able to participate in large insurers' provider networks, should you actually decide to treat new Exchange and/or Medicaid clients? The answer will depend on your practice's unique circumstances. Here are some factors to consider:

• It is expected that most private payers who offer Exchange products will use their existing provider networks for those new products also, so that each provider can be used regardless of the client's specific type of health plan. But, if an insurer tried to require you to participate in its Exchange plan(s) as well as its other plans, that could be seen as an unlawful "tying arrangement." However, as a practical matter, suing an insurer over this would be very expensive and lengthy.

• New clients from Medicaid and Exchange plans will tend to have challenging clinical and demographic characteristics. Because many newly-covered people have deferred behavioral treatment due to inability to pay, collectively they are expected to have relatively high rates of diagnoses including substance use disorder and depression. It also is likely that no-show, non-compliance (for between-visits home programs), and dropout rates will be higher than for persons with employer-based insurance. About one-third of newly-eligible people are fluent in Spanish, and some of them are not fluent in English.

• New clients also will pose administrative and financial challenges. Because the majority have never been insured, they lack understanding of insurance procedures, especially managed care rules, such as differential copayments for using preferred versus non-preferred providers. And it is projected that most Exchange enrollees will choose low end (Bronze and Silver) plans, which may have client copayments of $50 or more per specialty (e.g, behavioral) visit. As these clients have relatively low incomes, your collecting of these copays may well be difficult, yet you must make a good-faith effort to do so, or be subject to insurer claims of fraud.

6 What if my practice has mainly self-pay and/or employer-based insurance clients? Because self-pay clients pay cash, and employer-covered clients already have health plans, you might expect no effects. But some clients of these types will face changes.

A few self-pay clients will gain Exchange coverage, and some employer-covered clients will be transferred to Exchange plans. Other clients—those in lower-paying jobs such as at restaurants, retail stores, and local government—may have their hours cut to under 30 per week, to avoid the law's coverage mandate applicable to employers with at least 50 full-time staff. Regardless of these specifics, such clients will be less willing or able to pay for all or much of an MFT treatment in cash.

The law also reduces the tax-favored treatment of healthcare expenses that are unreimbursed by insurance, such as costs covered under a Flexible Spending Account (FSA). Previously, people could use an unlimited amount of pre-tax FSA funds to pay for such costs, and also could deduct from income tax any unreimbursed costs exceeding 7.5% of their Adjusted Gross Income (AGI). Effective this year, the law limits FSA health funds to $2,500, and raises the Medical Expense deduction threshold to 10% of AGI.

While tax changes will not affect initiation of treatment, some clients may drop out once their annual FSA limit for all uncovered health costs (including MFT services) is exceeded. (There is anecdotal data that "elective" treatments such as most dental and Lasik services have already been reduced by these changes.) Clients with several chronic health conditions (typically between 50 and 64 years old) are most likely to be affected.

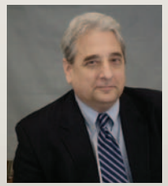
7 What if my practice is located in a rural or inner-city area? Lack of insurance is more widespread in those locales, as are shortages of behavioral and other healthcare practitioners. If you practice in such an area, you are more likely to see large effects than will private MFTs in suburban locales.

On the one hand, it should be easier to participate in managed-care provider panels, and you should gain more new clients. Though, these new clients' payments likely will be lower than those for existing clients.

8 What if I have a specialty practice such as pediatrics? Most children in low-income families already are covered, either under Medicaid or your state's version of the Children's Health Insurance Program (CHIP). While kids will comprise some Exchange plan enrollees, they won't predominate.

Perhaps the most affected specialty will be substance abuse disorder (SAD). Current health plans' coverage of SAD is less extensive than for non-SAD mental health, so SAD network providers are relatively few. Because the law requires SAD coverage on the same basis as for physical (and other mental) health conditions, there should be relatively high demand for new SAD network practitioners. However, because SAD is often treated by Substance Abuse Counselors (with their own credentialing system) rather than traditional "mental health" practitioners, the mix of plan networks' professions (e.g., MFTs vs. SA counselors) is uncertain.

In the next article in our series, coming in the November/December issue, we will update you on the latest developments, especially the launch of Exchange plans on October 1. To stay current on the situation in your state, visit **www.aamft.org/HealthReformStatesDatabas**e often. We welcome members' reports about your experiences, which may be submitted to advocacy@aamft.org.



Brian Rasmussen, PhD,
is the government affairs manager at AAMFT.