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Advocates for Human Potential (AHP), Inc., is pleased to submit the attached package of materials in response to the Request for Information regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. AHP is a national technical assistance and consulting firm with expertise in private insurance markets and public mental health and substance abuse treatment. Our experience in both the private and public sectors gives us a unique vantage point from which to assess the impact MHPAEA will have on payers, health plans, providers, mental health consumers, and family members. The following documents are attached:

- **Our response to the Request for Information**. We provide detailed answers to the specific questions included in the *Federal Register* notice of April 28, 2009. In particular, we outline the impact MHPAEA will have on policies, procedures, practices, and costs. We also raise questions and concerns designed to help guide development of the Act's final regulations.

- **An Environmental Scan**. We reviewed parity research, examined Federal and State experiences, and conducted key informant interviews with leaders in the private and public sectors. Representatives of the private and public sectors have varying viewpoints on the challenges and opportunities that come with implementation of MHPAEA. Nonetheless, private and public sector interests are multifaceted and overlap in numerous areas. Their perspectives are reflected in this document.
- **Two white papers**. Each provides a situational analysis and highlights the impact of parity for two key stakeholder groups:
    - *Mental Health and Addiction Providers' Impact Statement & Call to Action* outlines the impact of parity for behavioral health providers in four critical areas—policy, people, process, and information technology—across three organizational divisions—administration, clinical operations, and executive teams.
    - *Health Plan & Healthcare Purchasers' Strategic Guide to Implementation* details the implementation issues payers can expect, particularly those new to mental health and substance use disorder treatment. It also offers a roadmap to help purchasers navigate the path to full implementation of MHPAEA.

We offer these documents to help Federal regulators in the Departments of Labor, Treasury, and Health and Human Services develop clear and precise regulatory guidance that will smooth the transition to full parity for all stakeholders. We are pleased to note that passage of MHPAEA signals growing recognition of the importance of mental health to overall health and wellbeing, and we welcome the opportunity to help promote equitable health care coverage for all Americans. Please feel free to contact us if we can help further in this important endeavor.

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Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Submitted in response to a notice in the Federal Register, 74(80), April 28, 2009, 19155-19158

Advocates for Human Potential, Inc., (AHP) is a national technical assistance, social research and consulting firm with extensive experience in private insurance markets and public mental health and substance abuse treatment.

We offer the following response to the Request for Information regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Our responses to the questions below represent the expertise of our senior consultants and subject matter experts, as well as thought leaders in both the private and public sectors.

It is clear that representatives of the private and public sectors have varying viewpoints on the challenges and opportunities that come with the implementation of MHPAEA. Nonetheless, public and private sector interests are multifaceted and overlap in numerous areas. The environmental scan that accompanies our response addresses the nature of and intersections between public and private sector interests—both of which are important to consider as regulations are promulgated. We welcome further discussion and would be honored to participate in any fashion.

A. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

i. What policies, procedures, or practices of group health plans and health insurance issuers may be impacted by MHPAEA? What direct or indirect costs would result? What direct or indirect benefits would result? Which stakeholders will be impacted by such benefits and costs?

We believe that policies, procedures, and practices will vary by status of the plan relative to State-level parity statutes. Plans in States with existing, comprehensive parity will have fewer policies, procedures, and practices to modify. Conversely, plans operating in States with lesser coverage or third-party administrators serving ERISA groups with lesser coverage will have more changes to make.

Policies, Procedures, and Practices

MHPAEA will have immediate impact on policies, procedures, and practices noted below.

Department	Impact
Compliance	❑ Establish benefits and policies and file with State departments of insurance ❑ Develop guidelines and regulations regarding patient protection
Marketing	❑ Communicate new policies to groups and subscribers (certificates of coverage, summary plan descriptions)
Customer Service	❑ Develop subscriber/consumer education and information for mail and telephone liaison
Provider Contracting	❑ Build greater access into provider networks at a time of significant provider shortage, particularly prescribers ❑ Identify provider resources that address culture, language, gender, and special needs

Department	Impact
	❑ Develop contracts that reflect modified services based on interpretation of the Act and benefits/policies/services ❑ Develop reimbursement schedules to reflect changes
Provider Relations	❑ Manage rollout with effective provider communications, e.g., developing responses to need for providers capable of addressing autism, ADHD, and serious emotional disturbances ❑ Develop provider networks capable of addressing substance use disorders if currently covered at much lower levels
Medical Management	❑ Develop level-of-care (medical necessity review) guidelines based on new policies and guidelines for coverage of non-medically but clinically necessary services ❑ Develop utilization management standard practices ❑ Develop policies regarding utilization review ❑ Develop standards and practices regarding case management, covered services, and the sharing of medical necessity criteria and rationale ❑ Develop the guidelines and frameworks for States and insurers to develop protocols pertaining to evidence-based practices
Claims Processing	❑ Establish rules governing covered providers, covered services, service levels, duration, frequency, diagnosis, mixed-service claims, and financial limits ❑ Reconfigure systems ❑ Train claims staff ❑ Clarify rules and processes related to deductibles
Finance	❑ Determine “predominant” levels of coverage that will enable the identification of a comparison benchmark for mental health/substance abuse benefits ❑ Determine risk (conduct predictive modeling and actuarial studies) for pricing purposes, especially concerning greater levels of coverage for conditions such as substance use disorders that may have been covered to a far lesser degree prior to MHPAEA ❑ Develop approach to allocation of such factors as psychotropic medication costs
IT, Data Analysis, and Reporting	❑ Reconfigure benefit structures according to new processes and plan rules/policies ❑ Code new providers, service levels, diagnoses ❑ Test systems and validate outcomes ❑ Transition operations to new systems ❑ Modify electronic data interchange (EDI) protocols to reflect changes among external partners ❑ Manage for impact of ICD-10 ❑ Develop new analysis and reporting constructs concerning cost, quality, and access and manage any new business reporting requirements ❑ Manage separate or integrated deductibles (single, integrated deductibles require claims accumulators)
Carve-Out and Vendor Contracting	❑ Address financial aspects of carve-out capitation or administrative fees as well as assignment of risk ❑ Address deductible and claims accumulators across organizational

Department	Impact
	boundaries where Managed Behavioral Health Organization (MHBO) carve-out exists ❑ Develop performance expectations and measures

Costs

Direct Costs

Direct costs will reflect market share and the breadth and number of changes plans must make. However, a complete and more accurate assessment will take into account non-monetary costs and benefits as well as the potential expense of improper or inconsistent implementation.

Predictions of the overall cost of parity have been drawn from earlier reports of compliance with State parity and the Federal Employee Health Benefits Program. These demonstrate a less than 2 percent increase, including the cost of initial implementation. This figure will vary depending on the organization's current approach to coverage for mental health and substance use disorders. Similarly, much will depend on whether or not there is an MBHO carve-out or carve-in vendor in place.

Organizations that are more capable and "ready" today by virtue of expanded coverage or State law will experience lower costs. Plans that are starting with less "mature" or "ready" policies, procedures, practices, and infrastructure will initially have greater costs. Implementation costs will also be higher for plans that have not been able to accurately anticipate the scope of pending regulations.

Direct costs of implementation will be absorbed largely in:

- Manpower dedicated to implementation project management, tactical planning meetings, implementation activities, and training
- Public and provider communications campaigns and marketing materials
- Medical management (utilization management), where changes may be required in level-of-care guidelines and authorization systems
- Development of adequate capacity in provider networks
- Claims processing where reconfiguration of systems and business rules may be required; this may be problematic for plans with inflexible legacy systems

To assess accurately the ongoing expense of providing parity benefits, we believe it will be important to establish guidelines around cost analysis. Plans that choose to use this opportunity to ascribe the costs of mental health and substance abuse services provided by emergency departments, primary care physicians, and pediatricians and/or that ascribe the cost of psychotropic medications to mental health/substance abuse benefits will produce inflated cost results. We believe that "before and after" cost reporting should be consistent with standards in place at present or be transparent in terms of calculating costs prior to and after MHPAEA.

Indirect Costs

Given the broad parameters of MHPAEA in its current form, plans may have an incentive to pursue the short-term cost savings gained by implementing parity according to the most limited

and expedient definition. Although such choices may appear advantageous to purchasers in the short-term, the long-term economic impact will be born by both consumers and payers. Market forces ultimately will apply pressure on plans that don't implement parity fully, resulting in re-implementation costs and long-term waste in the name of short-term savings. The failure to realize the potential benefits listed below would also represent significant opportunity costs to the relevant stakeholder groups.

Elimination of behavioral health coverage

The potential consequences of dropping behavioral health coverage will impact both insurers and consumers. Increased costs will accrue for the insurer/employer as mental health issues manifest as medical (and more expensive) issues and are treated in expensive settings like the emergency department. Untreated behavioral health issues manifest in a variety of workplace costs to the employer, as well. Consumers with chronic medical conditions who lose access to behavioral health services may incur higher overall health costs and be more prone to absenteeism, presenteeism, and injury.

An additional risk to coverage exists due to the nature of the cost exemption. Under the rules of the MHPAEA as written, it is conceivable that a consumer could lose and regain behavioral health coverage in alternating years. The administrative burden a cost exemption would impose on plans may be an adequate disincentive. If not, the cost to the consumer with behavioral health issues would be severe as their conditions and providers fluctuate between being covered and not being covered.

Management of behavioral health networks

Depending on the manner in which provider networks are managed, there is a risk that behavioral health networks will be adversely affected by the availability of out-of-network coverage. Without adequate incentives providers may forgo participation in the network. Credentialing practices in the behavioral health field are inconsistent at present. Proper credentialing and monitoring of network providers is critical to ensure high quality care and cost-effectiveness. Both subscribers and employers would bear the cost of inadequate provider monitoring.

In addition, mental health and substance abuse treatment providers are at risk of being marginalized by primary care providers already accustomed to working within the confines of managed care. This could result in an increasing shift toward the use of medication and away from ancillary, effective and cost-effective treatments such as psychotherapy. Primary care and behavioral health care specialists should be encouraged to integrate their efforts and should be supported in doing so. Primary care providers need to be reimbursed appropriately for behavioral health screening, assessment, and referral.

Benefits

The benefits of a comprehensive and competent implementation of the MHPAEA will accrue to several stakeholder groups. Most of the benefits noted below are theoretical and rely entirely on the scope and success of MHPAEA implementation.

Stakeholder Group	Benefits
Health Plan Staff/Personnel	Health plan employees will benefit from a proper implementation effort that includes revised policies, procedures, workflow, forms, system reconfiguration, and modified job descriptions (where necessary). Thorough implementations include effective training, support, and supervision. Well-coordinated and executed policies, practices, and business processes produce greater efficiency and an improved overall employee/customer experience.
Plan Subscribers and Families	Improved communication, coverage, and access can result in improved utilization of appropriate treatment resulting in improved clinical outcomes and quality of life. This is particularly true for people suffering from more complicated conditions. In some plans, individuals will benefit from assistance in the form of population management, disease management, and case management.
Contracting/Participating Providers	Mental health, substance abuse, and primary care providers may benefit from the opportunity to expand services. Similarly, primary care providers and hospitals may benefit from making referrals to specialists, assuming there are adequate numbers of specialists. Behavioral health and primary care providers may benefit from integration and collaboration on medical home models.
Employers	Employers will benefit from improved overall health and functioning of staff that avail themselves of treatment services. When mental health and substance use disorders are treated properly, employers can expect reduced absenteeism, "presenteeism," accidents, injuries, workplace violence, theft, and lower overall health care costs. Individuals with mental health and substance use disorders whose care is not coordinated have an increased number of claims, particularly if they have co-morbid conditions.
Shareholders	When people with mental health and substance use disorders are screened, diagnosed, and treated in a coordinated fashion, using evidence-based practices through effective episodes of care, other health care costs such as inappropriate prescription drug costs and inappropriate use of emergency rooms will be mitigated. These savings will accrue to agency shareholders.

ii. Are there unique costs and benefits for small entities subject to MHPAEA (that is, employers with greater than 50 employees that maintain plans with fewer than 100 participants)? What special consideration, if any, is needed for these employers or plans? What costs and benefits have issuers and small employers experienced in implementing parity under State insurance laws or otherwise?

We are not aware of any unique costs and benefits for small entities subject to MHPAEA. Smaller plans tend to be community rated and do not have the cost of broad administrative and operational changes attributed to them. There are, however, costs associated with making changes to many different plan designs. Some plans offer a very wide range of choices due to market pressures for choice and options. Those plans will be required to make more plan document changes and file more plan policies with their State departments of insurance.

iii. Are there additional paperwork burdens related to MHPAEA compared to those related to MHPA 1996, and, if so, what estimated hours and costs are associated with those additional burdens?

While it varies depending on State law, the scope of the MHPAEA in 2008 is greater than the Mental Health Parity Act of 1996—particularly as it relates to substance use disorders. The

reality is that the 2008 Act can result in greater utilization and longer episodes of care for substance use disorders and serious emotional disturbances. Paperwork burdens may include:

- Increased demand on customer service (calls and print materials)
- Changes to marketing materials (summary plan descriptions and certificates of coverage)
- Increased need for case management and related "paperwork," including exchange of health information between plans and providers
- Increased claims handling and processing due to increased utilization
- Increased claims accumulation analysis in the event of a single deductible
- Increased utilization management (authorizations and referrals)
- Change in provider contracts and reimbursement schedules
- Change to level-of-care (medical necessity) guidelines, policies, and forms
- Change to member grievance and appeals processes

The time involved is entirely variable and dependent on processes and systems in place as well as volume at each plan.

B. Comments Regarding Regulatory Guidance

1. The statute provides that the term ``financial requirement'' includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit. The statute further provides that the term ``treatment limitation'' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

    a. Do plans currently impose other types of financial requirements or treatment limitations on benefits?
    Yes, when they limit subscribers to *"one episode per year"* and *"two episodes per lifetime,"* for instance. This approach is often taken with substance use disorders and residential treatment.

    b. How do plans currently apply financial requirements or treatment limitations to (1) medical and surgical benefits and (2) mental health and substance use disorder benefits?
    This varies tremendously. We recommend data be gathered from plans for this purpose.

    c. Are these requirements or limitations applied differently to both classes of benefits?
    There can be and often are.

    d. Do plans currently vary coverage levels within each class of benefits?
    Yes.

2. What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?

We appreciate this question and the opportunity to provide some very important feedback. Our response reflects our own experience and the input we have received from stakeholder groups around the country. Explicit and detailed regulatory guidance can ensure that the MHPAEA is implemented in accord with the intent of the law.

The Departments are urged to clarify the following:

Dimension/Category	Question/Concern
Policy	❑ How do the Departments envision "predominant" medical/surgical benefits being defined? Will there be direction provided to establish a comparison benefit in order to arrive at parity or will it be left to State and plan discretion? ❑ Do the Departments anticipate any modifications to the Parity Act or the October regulations as a consequence of health care reform? ❑ Will the conflict between the need for integrated care and the privacy standards of HIPAA and CFR 42 be addressed? ❑ Will the Departments clarify whether someone enrolled in a plan subject to parity can also qualify for public benefits?
Public Health/Social Service	❑ Will court-ordered treatment be covered or left to State discretion? Please answer with respect to substance use disorders (following a DUI, for instance), post-suicide attempt, and anger management treatment following domestic violence episodes. ❑ Will State hospital stays be a covered service or left to State discretion? ❑ Will involuntary "holds" be covered?
Diagnostic	❑ Will there be a list of covered diagnoses "at a minimum" or will diagnoses be left to State discretion? ❑ Are serious emotional disturbances covered by the MHPAEA? ❑ Is autism covered or left to State discretion? ❑ Is ADHD covered or left to State discretion?
Service Level	❑ Will the Departments mandate any evidence-based practices? ❑ What kinds of services will constitute the "minimum" for substance use disorders treatment? Should plans be required to provide access and coverage for medical detoxification, inpatient treatment, residential, intensive outpatient programs, and recovery support services? ❑ Should prevention services be mandated? ❑ Will "devices" be covered? ❑ Should there be a mandate to cover telemedicine and telehealth for people living in medically underserved areas? ❑ Will neurological services be covered or left to State discretion? ❑ Will case management be a covered service or left to State discretion?
Health Care Providers	❑ Will there be any access standards for providers and/or services? ❑ What kinds of access should plans provide their members to qualified professionals and services such as child psychiatrists for serious emotional disturbances?
Primary Care	❑ Will primary care providers (PCPs) be permitted to provide more than one service/session per day in order to be reimbursed for the provision of integrated care? ❑ With the advent of integrated care models and the existing prevalence of behavioral health services provided by PCPs, there may be a tendency for plans and payers to provide adequate access to PCPs and inadequate access to specialists. Will the Departments be providing any guidance to States/plans with respect to discriminating between care provided by a primary care physician and/or specialist (e.g., psychiatrist, psychologist, master's level counselor)?
Claims Processing &	❑ Will the regulations mandate a single deductible for all health care services

Dimension/Category	Question/Concern
Deductible	or will plans be allowed to develop a separate deductible for mental health and substance use disorders? ❑ How should "mixed claims" (involving medical and mental health/substance abuse services) from general hospitals and emergency rooms, for example, be handled by plans and MBHO vendors with exclusive risk arrangements?
Reporting	❑ Do the Departments envision mandates for health information/data concerning quality, cost, encounter, episode, clinical outcomes, access, and patient satisfaction?
Technical Assistance and Research	❑ Will the Departments be providing any technical assistance for States, plans, providers, and consumers? ❑ Will the Departments be providing any kind of State/Federal law gap analysis? ❑ What treatment interventions work most effectively with which specific population groups (age, gender, culture, SCS)

3. What information, if any, regarding the criteria for medical necessity determinations made under the plan (or coverage) with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

Standards vary from State to State and plan to plan but, for the most part, accrediting agencies and State regulations (concerning Member Rights and Responsibilities, for instance) provide consumers with the right to see level-of-care and medical necessity determination guidelines that form the basis for medical review and decision-making.

Medical necessity determinations should be properly supported by qualified, licensed staff; URAC and NCQA accreditation; and scientifically validated, evidence-based guidelines and decision support systems.

Failure to cover certain specialists, services, and levels of care for children with serious emotional disturbances and adults with serious mental illnesses and substance use disorders will result in people being undertreated at inappropriate levels of care by inappropriate providers. Plans that do not offer adequate services may inadvertently contribute to economic burdens and social ills such as incarceration, domestic violence, school drop-outs, unemployment and underemployment, homelessness, and suicide.

This is an area where Federal and State guidance and oversight must be managed closely. Otherwise, the benefits of the Act will be lost and people who are seriously ill will continue to suffer from discrimination, poor quality of life, and unacceptable mortality rates.

4. What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

Member Rights and Responsibilities should govern this issue as well.

5. To gather more information on the scope of out-of-network coverage, the Departments are interested in finding out whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. If so, how is such coverage the same as or different than out-of-network coverage provided for medical and surgical benefits?

In our experience, some but not all plans provide out-of-network coverage at lower rates of coverage. This is particularly true when there is a carve-out in place. Managed Behavioral Health Organizations often do not provide out-of-network coverage. The advent of out-of-network coverage will cause all plans to reexamine their policies and practices.

Out-of-network coverage may have the unintended consequence of attracting providers to out-of-network status. Some providers may find it more appealing to operate on an out-of-network basis, obviating participation in contract negotiations, data exchange, quality assurance initiatives, and some utilization management practices. Some providers may find this out-of-network status financially rewarding but consumers will not. Consumers can expect greater out-of-pocket costs associated with out-of-network coverage.

6. Which aspects of the increased cost exemption, if any, require additional guidance? Would model notices be helpful to facilitate disclosure to Federal agencies, State agencies, and participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption?

We recommend that the Departments provide guidance in the way costs are calculated to avoid an “apples to oranges” cost comparison. The greatest risk for this involves plans changing their cost reporting approach to now include emergency department, primary care physician, and pharmacy costs in the total mental health/substance abuse cost analysis. Most plans did not do so prior to MHPAEA and should be managed closely to discourage this practice unless they are doing so transparently.

We also recommend adequate scrutiny and oversight of MBHO carve-out cost reporting where data most often reside in separate and distinct databases. These arrangements often feature a wide variety of administrative cost structures, risk arrangements, claims processing, and performance incentives, and they will require transparency and accountability.

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Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

An Environmental Scan of the Impact of Parity on the Public and Private Sectors

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Background

Enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (2009 Parity Act) signals the "beginning of a new era, with new challenges" (Shern, Beronio, and Harbin, 2009). Private and public stakeholders in the mental health community are preparing for this important transition, which is taking place in the context of an uncertain economy and national health care reform. To inform the development of regulations governing the 2008 Parity Act, Advocates for Human Potential (AHP), Inc., has prepared the following environmental scan based on a review of research, Federal and State experiences with parity, and key informant interviews with leaders in the private and public sectors. AHP is a national technical assistance, social research, and consulting firm with expertise in private insurance markets and public mental health and substance abuse treatment.

Preliminary Review of Available Data

Background and History

Historically, insurance coverage for mental illnesses and substance use disorders (collectively referred to as behavioral health conditions) has been much more restrictive than that for any other illnesses. Employer-sponsored health plans typically have imposed higher out-of-pocket costs and limited both annual and lifetime visits and lengths of stay for treatment of behavioral health conditions. Though mental health advocates have long argued for parity of coverage, philosophical and financial factors have contributed to an ongoing dichotomy:

- Some prominent 17 century European philosophers—notably France's Rene Descartes—viewed the "mind" as completely separate from the "body," a belief that underlies much of Western medicine. As Shern et al. (2009) note, "These false distinctions discourage people from seeking help and encourage health care payers and plans to limit coverage."
- Mental illnesses were believed to be lifelong conditions with no hope for recovery.
- Insurers and health plans believed that offering coverage for behavioral health conditions on par with that for other illnesses would drive up the cost of health care; early research confirmed their assumptions (see below).
- Some opponents of parity argued that insurance regulation is a State, not a Federal, function.

Likewise, several factors influenced a push for parity at both the State and Federal level:

- A landmark 1999 report by the U.S. Surgeon General reported that *people with mental illnesses can and do recover* and that effective treatment is available (U.S. Department of Health and Human Services [HHS], 1999).
- With research supporting differential coverage, mental health benefits shrank in relation to benefits for other conditions during the late 1980s and early 1990s (Barry, Frank, and McGuire, 2006).
- Evaluations of parity at both the State and Federal level revealed little impact on overall health care costs (see below).
- Research revealed that people with serious mental illnesses die, on average, 25 years earlier than the general population. They die from treatable medical conditions caused by modifiable risk factors, including smoking, obesity, substance abuse, and inadequate access to medical care (Parks, Svendsen, Singer, and Foti, 2006).

Parity at the State level

Most legislative action on parity has occurred at the State level. The majority of activity in the 1970s and 1980s related to substance use disorders, specifically alcoholism. The first parity statues requiring equal insurance coverage for mental and physical illnesses were enacted in 1991 in North Carolina and Texas. Today, 46 States have some type of insurance law that falls into one of the following three

categories (National Conference of State Legislatures [NCSL], 2009; Robinson, Connolly, Witter, and Magaña, 2007):

- **Mandated offering**: Coverage that requires insurers to provide equal mental and physical health benefits *if the insurers choose to offer coverage* for behavioral health conditions. Mandated offering laws also may require that insured individuals have the option of coverage for behavioral health conditions, which they may accept or decline.
- **Mandated benefits**: Coverage that requires insurance for *specific* behavioral health conditions. These laws are not considered full parity because they allow discrepancies in the level of benefits provided for behavioral health and other conditions.
- **Parity**: Coverage that requires insurance for behavioral health conditions *equal* to insurance provided for physical health conditions. Some States, such as Vermont, provide coverage for all behavioral health conditions, including substance abuse. Others, such as California, limit coverage to serious mental illnesses and serious emotional disturbances.

Beginning in the early part of this decade, some States began to restrict the scope of existing laws, reacting in part to concerns that required benefits were increasing health insurance costs. A number of States have more than one law pertaining to mental health insurance coverage. Still others have used the Mental Health Parity Act of 1996 (see below) as the basis for their laws. As a result, the National Conference of State Legislatures notes, "Parity is a patchwork of Federal and State legislation, with all the complications that such a structure implies" (Wood, 2005).

Parity at the Federal level

Two major developments mark the history of parity at the Federal level. The first relates to the Federal Employees Health Benefits (FEHB) Program, which first began offering parity in the late 1960s. However, in the mid 1970s, when more flexibility in benefit design was permitted, coverage for behavioral health conditions began to erode. From 1980 to 1997, the share of total claims accounted for by mental health and substance abuse claims declined from 7.8 percent to 1.9 percent, a trend that mirrored behavioral health coverage in the larger health care market (HHS, 2004).

A renewed call for parity by President Bill Clinton resulted in changes to the FEHB Program beginning in 2001. Covered services include "clinically proven treatment" for mental illnesses and substance use conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (American Psychiatric Association, 1994). Providers are encouraged to manage the care process by developing treatment plans, applying medical necessity criteria, employing utilization management methods, and creating networks of providers, among other techniques. Parity benefits may be limited to in-network providers only (HHS, 2004).

The second major development at the Federal level was passage in 1996 of the Mental Health Parity Act, the first Federal parity legislation. Implemented in 1998, this legislation focused on only one aspect of the difference in mental health insurance coverage—catastrophic benefits. It prohibited using lifetime and annual limits on coverage for mental health care that were different from general medical care (HHS, 2004).

Advocates felt the 1996 Parity Act was a first step in ending discriminatory insurance coverage, but they argued it did not go far enough. They noted that parity provisions did not apply to other forms of benefit limits, such as per-episode limits on length of stay or visits, copayments, or deductibles and that substance abuse was not covered by the legislation. The 2008 Parity Act attempts to correct some of the earlier legislation's shortcomings.

Research Findings

There have been two significant waves of research into mental health parity. As Barry et al. (2006) note, studies conducted in the early and mid 1990s used actuarial estimates to determine the effect of prices

on demand for ambulatory mental health care. They produced widely disparate estimates, ranging from a 1 percent to an 11 percent increase in total premiums due to parity, with the Congressional Budget Office (CBO) estimating a 4 percent increase.

The second generation of research in the late 1990s studied parity for mental health coverage in the context of managed care. These studies incorporated managed care effects into actuarial models using cost data from the FEHB, State parity experiences, the managed behavioral health care industry, and private employers. Barry et al. (2006) report, "After updating its estimation methods to incorporate managed care effects, the CBO scored comprehensive parity as raising group health insurance premiums by an average of 0.9 percent." An increase of 1 percent or less as a result of implementing parity is a fairly consistent finding across the FEHB, State statutes, and private employers. Other findings include:

- Few, if any, plans leave a program to avoid parity and employers do not drop coverage (HHS, 2004; Rosenbach et al., 2003; Sing, Hill, Smolkin, and Heiser, 1998). A recent survey by the Partnership for Workplace Mental Health (2009) found that the majority of employers surveyed do not plan to drop coverage for mental health or substance abuse treatment.
- Access to and use of mental health and substance abuse services may increase consistent with long-term trends (HHS, 2004).
- Health plans are likely to enter into carve-out arrangements to manage care (HHS, 2004).
- Managed care controls costs; spending on mental health and substance abuse may fall under parity in plans not previously subject to managed care controls (Zuvekas, Regier, Rae, Rupp, and Narrow, 2002; Varmus, 1998).
- Managed care also may reduce access and use for some services and beneficiaries; parity increases offerings while managed care limits usage (Barry et al., 2006; Goldman et al., 2006; Wood, 2005; Rosenbach et al., 2003).
- Costs do not shift from the public to the private sector (Sing and Hill, 2001).
- Consumers' out-of-pocket spending may decline substantially (for example, in Vermont, among people with serious mental disorders, the proportion of individuals spending more than $1,000 out of pocket annually was reduced by more than 50 percent) (HHS, 2004; Rosenbach et al., 2003).
- Quality of mental health and substance abuse services is unchanged (HHS, 2004).
- Parity in substance abuse treatment benefits may ease pressure on State budgets by reducing health, corrections, and welfare costs and increasing the number of people entering treatment (Gillo, Goplerud, and Williams, 2003).
- Providers and consumers often are unaware of new parity regulations and their impact (HHS, 2004; Rosenbach et al., 2003; Lake, Sasser, Young, and Quinn, 2002).

Lessons Learned

Evaluations of parity at the State and Federal level reveal some important lessons for those who are implementing changes to comply with the 2008 Parity Act. As Lake et al. (2002) note about California's experience, "The results highlight the regulatory complexity of what appears to be a relatively straightforward mandate to expand coverage for mental health services."

One of the primary conclusions was the need for ***better communication***. In many cases, evaluators found limited knowledge of parity regulations among consumers, employers, and providers. In California, inadequate communication may have contributed to disruptions in care for consumers during a transition to managed behavioral health organizations by some health plans (Lake et al., 2002).

Vermont stakeholders suggested the need to mount a proactive education campaign during the first year of parity implementation (Rosenbach et al., 2003). This may involve assigning a responsible party,

assessing information needs, choosing appropriate methods of communication, and determining when education efforts should take place (Lake et al., 2002).

After passage of parity legislation in Oregon, the State Insurance Division held several trainings and discussion groups to work on transition and implementation with consumer groups and other stakeholders. In addition, the Insurance Division hosted multi-stakeholder advisory meetings to seek input on the development of administrative rules to help implement the law (State of Oregon, 2009).

California evaluators noted that communication among health plans, providers, and employers should include clarification of critical implementation issues. These include when and how referrals should be made for mental health services, which diagnoses are covered, and how cost-sharing and benefit limits should be applied to individuals with different diagnoses or at different stages of treatment (Lake et al., 2002).

Researchers and evaluators also expressed concerns about cost containment under managed care. Barry et al. (2006) note, "it is important to remember that under parity, the traditional incentives to avoid enrolling people with high expected costs remain at least as strong as in the past, while the mechanisms available to health plans for affecting selection have expanded with managed care." They caution that expanding benefits under parity does not solve the problem of unmet need or ensure use of evidence-based practices in mental health care. As Shern et al. (2009) point out, development of regulations that ensure a meaningful range of evidence-based interventions, including psychosocial services, is a critical implementation task.

Additional findings include:

- In California, the implementation of "partial parity" for a limited set of serious mental illnesses and serious emotional disturbances created administrative challenges and caused confusion for some stakeholders (Lake et al., 2002). Evaluators cautioned that States need to weigh the potential administrative costs of covering limited diagnoses, versus the potentially increased health care costs associated with expanding parity to all mental health diagnoses.
- Also, in California, evaluators noted that stakeholders should attempt to identify strategies for addressing shortages in certain provider specialties or programs viewed as important for meeting increased service demand, such as child psychiatry and eating disorder programs (Lake et al., 2002).
- An evaluation of parity for State employees in Ohio found that the impact of parity is likely to differ across health plans depending on the pre-parity benefits and the organization of the health plan (HHS, 2004).
- Because all of the existing State parity and mandated coverage laws were written and applied prior to passage of the 2008 Parity Act, coordination and interpretation of how State and Federal laws combine or potentially conflict is an important task for 2009 (NCSL, 2009).

Some specific implementation issues for 2009 are featured below in the responses to interviews we conducted with stakeholders in the private and public sectors. Though individuals and organizations have concerns about effective implementation of the 2008 Parity Act, they remain optimistic that the legislation signals increasing recognition of the fact that *there is no health without mental health*. Ongoing collaboration among key players, which was critical to passage of parity legislation, can aid its successful implementation (Dixon, 2009).

In 2006, Barry et al. (2006) concluded, "Passage of comprehensive parity would allow policymakers, health care managers, and clinicians to shift attention away from benefit design and toward figuring out how to get effective treatment for people who would benefit." In 2009, consumers, providers, payers, and advocates believe this time has arrived.

Interview Format and Key Stakeholders

Due to the gracious participation of key stakeholders and thought leaders, AHP was able to collect information through the interview portion of the environmental scan that was both broad in scope and in many cases highly detailed. AHP interviewed 22 individuals from across the behavioral health field representing both public and private sectors. The intent was to gather and disseminate their understanding of the implications of parity and to assess whether or not parity would enhance access to behavioral health coverage and treatment in the United States, thus supporting the original authors' intention in crafting the legislation.

Participants included market leaders and thought leaders in the behavioral health field as well as subject matter experts and individuals responsible for the implementation of Parity within their own organizations. Private sector respondents collectively represent a cross –section of commercial payers including Medicaid managed care plans, traditional insurance companies, managed behavioral health organizations, third-party administrators, and EAP administrators. Thought leaders from the public sector included Single State Authorities, leaders in professional organizations, advocates for and leaders of consumer groups. Their responses reflect national, regional and state-level perspectives."

Each interview lasted between 30-45 minutes. The format was composed of open-ended questions regarding the scope of implementation, resources required in the behavioral health system, perceived impacts on consumers, and the major challenges to implementing parity.

Unlike a typical opinion survey that provides answer categories and counts responses, these questionnaires were designed to provide more in-depth, qualitative information. From the wealth of information gathered in this way, researchers at AHP conducted a "thematic analysis," grouping answers into topics and identifying how frequently respondents reported answers within those thematic categories. Because certain topics were addressed under multiple questions, responses were then organized according to the overarching issues of access, quality, and cost. The topics outlined below were those endorsed most frequently by respondents.

While the information gathered in this portion of the document is by no means exhaustive, it does provide readers with a wide variety of perspectives and a valuable array of tactical as well as strategic considerations, lessons learned, and insights into successful implementation and compliance with the law. Of equal importance, it provides innovative solutions proposed by individuals with considerable first-hand experience. A synthesis of the input follows.

Key Stakeholder Interviews

Access

Access is conventionally defined as the degree to which consumers can readily seek treatment services for their disorders and that adequate coverage and sufficient numbers and types of providers and services exist to meet their needs within acceptable timeframes. Access also refers to the availability of accurate information, advocacy, screening, diagnosis, treatment planning, and referrals. Access issues concerning diversity, language, gender, faith, sexual orientation, or other sociocultural variables were not within the scope of this study.

In general, public sector respondents tended toward cautionary feedback and did not appear to believe that parity will enhance access to services or make it easier for consumers to navigate the continuum of care. Because the legislation does not specify covered conditions or address the specifics of "medical necessity," these participants consider parity to be primarily a change in payment methodology. Of primary concern was whether commercial health plans, employers, and other purchasers would continue to offer behavioral health coverage in the absence of a mandate. They believe there is a legitimate risk of consumers losing access to coverage. Regarding access to information and records, the

public sector is also very sensitive to the unique privacy issues inherent in behavioral health care. Private sector responses concerning access emphasized adequate and high-quality provider networks and the shortage of several key types of providers.

The themes most often mentioned regarding access include the following:

Provider networks are insufficient. The vast majority of respondents stated that provider networks suffer from shortages in several practice/specialty areas, particularly child psychiatrists, child psychologists, primary care physicians with appropriate behavioral health training, and "prescribers" in general. There is a shared sense of concern for the aging of the behavioral health workforce and the tendency for new physicians to choose specialties as opposed to primary care. There is a risk that individuals with moderate behavioral health issues will receive inadequate treatment if primary care physicians (PCPs) have difficulty making referrals to behavioral health specialists. A second challenge is posed by out-of-network benefits and the risk that providers will opt to drop their network participation in favor of balance-billing out-of-network consumers at higher rates. The majority of respondents agreed that creating financial incentives such as enhancing reimbursement rates is one logical remedy to provider network and access concerns (notwithstanding medically underserved areas). Public sector respondents also note that numerous providers who are not conversant in the managed care system may be forced out of the field, further exacerbating the shortage.

The human resources needed for implementation are in short supply. In addition to specialty providers required by networks, respondents believed that clinical resources such as psychiatrist medical directors, certified case managers, psych-certified RNs, and specialist support for PCPs are insufficient to meet the expanding role health plans need to play. Plans and payers require access to consultants and subject matter experts with experience in the areas of provider contracting, implementation, benefit design, and utilization/case management in order to provide operational expertise and training.

Providing access to education for payers, providers, and consumers is considered key to implementing parity successfully and achieving access goals. The challenge of properly educating health plan members, providers, and other key stakeholders is viewed as one of the highest priorities. Plan members need to understand what their benefits are, what is covered, and how best to navigate the system of care and plan policies. Providers require a similar education in terms of plan benefits, rules, and policies. In addition, they need to understand how to work within a managed care system, market themselves to utilization and case managers as well as plan members, and navigate insurance company practices, including the utilization review and authorization process. Employers in particular need to be educated in terms of the real costs of providing parity. Employers and plans will also need to understand the differences between various approaches to managing parity, including behavioral health carve-outs, carve-ins, and employee assistance program (EAP) gatekeeping.

Communication between and within stakeholder groups and access to accurate information is crucial. Respondents believe that regulatory agencies should develop a repository of frequently asked questions (FAQs) for both payers and providers; operate a hotline to provide payers and providers with timely answers to implementation questions; and convene collaborative meetings with both payers and providers. Additionally, a number of respondents noted that plan members and providers should have easy access to a clear appeals process.

Perceptions of mental health and substance use disorder treatment may be enhanced and improved. Participants note that parity is likely to reduce the stigma surrounding treatment, thereby opening the door to consumers who would not have sought help in the past. Several participants also reported that parity serves to elevate issues of behavioral health care, which is especially important given the current push for health care reform.

Parity will increase access for many consumers as restrictions on services are lifted, though risks and obstacles remain. While a majority of respondents view the nondiscriminatory nature of parity as cause for celebration and a significant gain for consumers, several added the caveat that realization of these benefits depends greatly upon implementation and regulatory guidance. Respondents also note there remain many barriers to treatment beyond the issue of coverage.

The absence of a mandate invites the risk that employers will eliminate behavioral health benefits. While the public sector may see this as a more serious threat, a number of private sector respondents also see this as a valid concern that should be addressed by educating employers, their brokers, and plan administrators.

All stakeholders require access to standardized medical necessity criteria. The private sector response calls for access to guidance and clarity regarding covered disorders, providers, and levels/types of service covered. Those from managed care backgrounds are fluent in accreditation requirements for research-based level of care guidelines or patient placement criteria; they require specificity from regulators as to how and when to apply them. Public sector responses tend toward a desire to see the use of standards-based tools, oversight, and accountability. There is also a desire to address patient placement criteria for substance abuse treatment in particular. The majority of respondents across sectors addressed the need to provide plan members and their providers with these criteria in a manner consistent with the law.

There is a need to provide access to an appropriate service mix or continuum of services and care providers. Responses in this area varied somewhat between public and private respondents though there was consensus on the need for a service mix commensurate with what regulators determine coverage should entail. While respondents from the public sector agree it would be a positive development if regulations required all appropriate types of service that support mental health and substance abuse treatment, respondents understand that parity is no guarantee of access to this extent. Public sector respondents understand the unique and complex needs associated with substance use disorders, for example, and point to the need for community-based, recovery-focused, wraparound services. Their private sector counterparts do not disagree but believe it is prudent to await direction from Federal and State regulators concerning coverage prior to addressing continuum of care issues.

The patient-centered medical home model and primary care physicians will enhance access. There was general consensus among private sector respondents that PCPs fulfill an important function in the behavioral health care system. There was also agreement that emerging medical home models may prove beneficial to the behavioral health needs of plan members, particularly those who require case management/care coordination services.

Enhancements to information technology will facilitate improved access. Improved integration of data is needed to allow for the sharing of information across organizational boundaries. Use of personal health records and the development of health information exchanges will support this aim.

Quality

Throughout the interview process, themes related to quality were addressed by both public and private respondents repeatedly and thoroughly. Quality was viewed through a wide lens encompassing quality assurance in provider networks, quality in treatment planning, quality in authorizing medical necessity, and quality as indicated by consumer safety and outcomes.

The most significant area of difference between public and private sector responses relating to quality center around the proposition that parity will accelerate the integration of primary care and behavioral health. The majority of participants from the public sector do not believe parity will have an impact on the integration of care. Several public sector respondents stated that health plans will tend toward behavioral health carve-outs, making integration difficult. One respondent noted that integration of substance abuse treatment in particular does not happen easily, nor is funding for treatment a

guarantee. In contrast, the majority of private sector respondents believe that integration is already taking place; they state that parity will either accelerate this process or be a neutral factor.

Participants cited the following quality-related themes most often:

Regulations need to clarify service level expectations and address coverage of specific conditions. A majority of respondents from the private sector note the difficulty of designing a benefit to meet the intent of such broad legislation and request specificity around covered conditions. This issue applies to coverage of disorders such as autism and ADHD.

Established evidence-based practices should be identified and implemented. Respondents agree that best practices are vital to effective treatment and positive clinical outcomes at every level of care. The public sector is particularly interested in the establishment of scientifically validated medical necessity and patient placement criteria.

Provider credentialing and monitoring must be improved and standardized to ensure quality care. A majority of private sector respondents recommend national standards for education, licensure, malpractice, and liability insurance, as well as health plan credentialing activities.

Medical necessity criteria and level of care guidelines should be clearly defined and transparent. While plans can continue to manage care, participants note the parity law has yet to fully address how medical necessity is defined, what appeals processes are acceptable, and what types of medical necessity/level of care guidelines are sufficient and valid. Respondents are hopeful that regulations will answer many of these questions.

Quality will be enhanced through improved diagnostic capabilities and standardized tools. Public sector respondents in particular believe that the use of standardized and evidence-based tools to screen, diagnose and plan treatment is integral to ensure quality care and outcomes. Use of the American Society of Addiction Medicine (ASAM) patient placement criteria for substance use disorders is a prime example.

Training and clinical support for primary care physicians should be emphasized. PCPs currently treat the vast majority of mild to moderate behavioral health care conditions in their clinics or offices and are likely to bear an increasing burden where behavioral health care provider networks are inadequate. Private sector responses note that PCPs require support in making appropriate diagnosis, referrals, and coordinating care.

The treatment of serious mental illnesses in adults and serious emotional disturbances in children will pose unique challenges. The majority of respondents agreed that these types of illnesses have primarily been the purview of the public health and public school systems and will pose a challenge in some parts of the country depending on how regulations are interpreted and enforced. Some private sector participants reported that they believe this issue also represents a good opportunity to explore "blending" or "braiding" private and public sector benefits and services.

The use of health information technology is necessary to manage quality assurance. Technology such as electronic medical records and health information exchanges are seen as central to meeting interoperability, data exchange, and integration goals, as well as to the efficient coordination of care. All of these objectives are perceived to be necessary to manage quality and achieve superior outcomes in the modern health care system. Organizations are likely to use case management systems that meet the needs of both medical/surgical and mental health/substance use conditions. As much as health information technology is viewed positively from all sides, public sector respondents remain very alert to the importance of privacy constraints, such as CFR 42, for individuals with mental health and substance use conditions.

Cost

For the purposes of this environmental scan, cost refers to the myriad financial considerations imposed by the 2008 Parity Act and its implementation. Costs include the cost of services or claims costs, as well as the administrative costs borne by health plans and providers. Costs also include consumer and plan member premium and out-of-pocket costs, as well as premium costs borne by employers.

While consumers, employers, health plans, and managed behavioral health organizations (MBHOs) have a vested interest in constraining costs, respondents from the private sector did not address this as frequently as might be expected. This may be because most plans and managed care organizations are familiar with the actual cost increases associated with State parity laws and many have studied reports published since 1996 demonstrating cost increases well within the 2 percent range. When the issue of general cost increases is noted, the focus is on ERISA employers, third party administrators, and MBHOs, entities our respondents agree will be impacted most.

There is also general agreement among private sector respondents that out-of-pocket costs will decrease for plan members. Public sector responses indicate a serious and abiding concern that employers and their payers will eliminate behavioral health coverage entirely in order to avoid higher expenses. Several respondents in the private sector echo their concern, with one individual predicting parity will inadvertently increase the number of uninsured with each "up tick" in premium costs. A number of respondents note a pressing need for education and advocacy directed at payers who may otherwise be inclined to truncate coverage because they do not fully understand the actual cost models.

Additional cost related considerations include:

Clear guidance through the timely release of regulations is essential to efficient implementation, compliance, and cost controls. Respondents call for Federal guidance around the following: the definition of "predominant" benefits that form the basis for equity and parity; whether or not a separate deductible is allowed; and clarity concerning diagnosis, provider types, and levels of service covered by the law. Costs will be higher for plans that do not accurately estimate the content of forthcoming regulations and need to make adjustments in subsequent plan years. One participant notes that regulations should not be punitive while another states that a phasing in of penalties would be appropriate for plans acting in good faith and making every effort to comply. Some respondents express doubt as to whether full compliance is possible within the given timeframe.

Out-of-network benefits present payers with a challenge. Payers will bear the additional burden and expense of handling out-of-network providers and managing deductible accumulators. Many plans and carve-outs do not provide for out-of-network coverage and will be required to reconfigure claims processing systems accordingly. Out-of-network costs will be greater to the consumer, and reimbursement combined with balance billing may in fact create incentives for providers to abandon their in-network status.

The decision to carve-in behavioral health benefits or carve-out to an MBHO will have a significant impact on cost. Responses are varied on this issue due to the disparate interests represented by participants. Several respondents strongly recommend a deeply integrated carve-in approach that they believe allows for holistic treatment of behavioral health and general health conditions. Their responses emphasized plans' ability to coordinate care seamlessly within a single, multidisciplinary team under the same roof. A similar number of respondents are proponents of some form of carve-out, with one recommending that purchasers contract with large national managed care organizations that have the capability to very quickly manage the entire implementation. They also propose that well established and experienced MBHOs have proven they can manage claims accumulators. The challenge, many admitted, is that predictive models and pricing estimations are difficult in the first year with so many unanswered questions.

The administrative burden on providers will increase their costs. A large number of participants noted the need for process efficiency and automation in various areas including eligibility determination, patient registration, scheduling, service authorization, charting, and billing.

Case management is essential to manage costs associated with serious mental illnesses. There is general consensus that complex cases involving chronic conditions will benefit from case management services. The addition of case management may be new for some plans and employers and they will require education in order to understand medical cost-offset models and long-term financial implications.

Plans need to be prepared for the financial ramifications of increased utilization. Many individuals will increasingly maintain their private coverage, which will eventually impact the numbers of adults with serious mental illnesses and children with serious emotional disturbances receiving treatment in the private sector. Several participants noted the need for new predictive models and are conducting actuarial analyses to anticipate both near and long-term costs, which may increase within 3 to 5 years. They attribute potential and unexpected increases in utilization to the long-term effects of member education, evolving social norms, and "population shifting" into private sector coverage and treatment.

Implementation can involve costs associated with changes to provider contracts and reimbursement. Provider contracts are cited with some frequency and respondents believe that reimbursement levels may be impacted when the need arises to modify them and align them with parity regulations and new plan rules/benefits. The single most cited impact concerned PCPs and their ability to bill appropriately for mental health services involving more than one service in a given day.

Claims accumulators will be necessary to manage a single deductible. In instances where regulations and plan policies involve a single deductible and out-of-pocket maximum, plans and their MBHO partners will require sophisticated claims accumulator exchanges that will enable claims generated for medical as well as behavioral health services to be tracked simultaneously and risk assigned accordingly. This process is complicated when two organizations—the plan and its MBHO—are responsible for claims processing and handling claims that can involve "mixed" medical and mental health services and codes.

Technology systems will need to be reconfigured to adjust to new plan rules and benefits. Health plans and payers of all kinds will be required to modify the configuration of claims processing systems, data warehouse and reporting systems, and claims accumulator systems.

General

Since parity must be implemented rapidly, numerous responses to the interview questions addressed strategic considerations, the release of regulations, and tactical implementation issues that transcend or fall outside cost, quality, and access categories. These comments merit mention as they are rich with insight and will have high utility for organizations charged with implementation, particularly those undertaking parity for the first time.

Issues of compliance and regulatory guidance not mentioned elsewhere included:

The provision of timely and consistent regulatory guidance is of primary importance to the private sector. Health plans will be obligated to design, publish, and file benefit plans with State departments of insurance well in advance of the release of regulations. A Web portal, telephone hotline, and a list of FAQs will greatly facilitate timely compliance.

Regulations must incorporate meaningful provider input. Participants from both the public and private sectors note that behavioral health care providers and particularly substance abuse providers have historically been marginalized when it comes to the development of behavioral health policy. Payers of all kinds are encouraged to include behavioral health providers, experts, and consumers in their planning and implementation.

Federal agencies may need to play an expanded role. The three departments responsible for parity can act as an arbiter to enhance public/private partnerships, convene a summit of stakeholder groups, provide education and advocacy for consumers and their families, provide direct oversight, and enforce accountability. The Federal government can also assist stakeholders by continuing to involve behavioral health in the health care reform process, maintaining open communication.

Other strategic considerations our respondents noted include the following:

- Two respondents note significant interest in exploring public/private partnerships that "braid, blend," and otherwise leverage the expertise and capacity of both sectors. Several States have begun innovative collaborative approaches, which may be helpful as health care reform models emerge.
- The benefits and value of carve-in and carve-out approaches need to be understood by those who lack experience with either.
- Committed leadership is believed to be essential to timely, comprehensive implementation.

It is clear that Federal agencies have, in fact, begun to respond to concerns about implementation of the 2008 Parity Act. The Center for Substance Abuse Treatment in the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, gathered a group of 12 leaders representing States, professional organizations, and advocates to discuss the impact that parity will have on access to substance abuse treatment. Many of the comments respondents made at that meeting reflect those in our environmental scan. This group noted in particular the need for Single State Agencies to work collaboratively with other State agencies—including Medicaid, insurance commissioners, and departments of labor—to help ensure a full continuum of services for individuals with substance use disorders.

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Behavioral Health Parity: Mental Health and Addiction Providers Impact Statement & Call to Action

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Introduction to Parity

On October 3, 2008, the United States Congress passed the $700 billion Emergency Economic Stabilization Act, which included a few other pieces of legislation looking for safe passage. One of those was HR 1424 - the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008 (2008 Parity Act), more commonly and simply referred to as "Parity" since the 1990s. The passage of HR 1424 is one of the most important developments in the mental health and addictions treatment fields in the past half century.

Passage of this law is a triumph for all those who sustained the momentum for change in the face of often strong resistance: the Substance Abuse and Mental Health Services Administration (SAMHSA), the State Association of Addiction Services (SAAS), the National Council for Community Behavioral Health Care (NCCBH), many national and state provider and consumer organizations, Sen. Paul Wellstone (D-MN.), Sen. Pete Domenici (R-NM), Sen. Edward Kennedy (D-Ma.), Sen. Christopher Dodd (D-CT), Rep., Patrick Kennedy (D-RI), Rep. Jim Ramstad (R-MN.), Rep. Marge Roukema (R-NJ), First Ladies Betty Ford and Rosalyn Carter, Tipper Gore, and many others over the years. Because of their efforts, the 2008 Parity Act provides enhanced, equitable coverage for more than 110 million Americans. It also builds upon the success of Parity coverage President Bill Clinton extended to Federal Employees nearly a decade ago and the experience more than 40 states have had with their own versions of Parity. Ultimately, the Parity Act should put an end to discriminatory coverage of mental health and addictions treatment in the vast majority of health plans in America.

Health plans that provide mental health or addiction treatment benefits now must provide the same financial terms, conditions, and requirements as well as treatment limitations for mental health and addictions as they do for other medical and surgical conditions. Here is a brief summary of the Act:

- Mental health and addiction treatment cost-sharing, deductibles, co-pays, and other forms of co-insurance as well as annual limits and lifetime limits must be equal to those covering medical and surgical conditions.
- Limitations on the scope of treatment and treatment frequency and duration cannot be more restrictive than those limiting medical conditions and care.
- Where allowed for other conditions, out-of-network benefits for mental health and addictions treatment must be provided and must be equal to those provided for medical and surgical benefits.
- State Parity laws are protected by the current HIPAA standard. Stronger state laws are not preempted by the Act.
- Plans can continue to engage in healthcare utilization management (UM, UR, and other forms of review) and determine coverage on a case-by-case basis. They are, however, required to provide members, consumers, and providers with their medical necessity criteria and with reasons for benefits/coverage or claims denial.

- The Government Accountability Office (GAO) will study the manner in which plans comply with the Act on an annual basis in order to determine how coverage is defined, what diagnoses are covered, and how total costs are being calculated.
- The Act exempts employers with fewer than 50 employees and plans whose total premium costs increase more than 2% in the first year or 1% in any subsequent year, subject to an annual application and review process.
- Medicaid and Children's Health Insurance Programs are affected by Parity; Medicare is not.

Situation Analysis

The 2008 Parity Act takes effect for the majority of plans on January 1, 2010. Some plans that are maintained by collective bargaining will be allowed to start later if their current contract term ends later. This means that many hundreds of health plans – including those of self-insured employers – have just over a year to implement Parity. More than 113 million Americans will be affected, and more than 80 million of those are covered by an ERISA plan where their employer is self-insured.

More than 40 states have some form of mandated parity but only those whose coverage is weaker than the Parity Act will be required to address the discrepancy. This will be applicable especially to states and plans that currently offer very low levels of addictions treatment coverage.

Implementing Parity

Parity will be implemented by states, Medicaid agencies and Medicaid health plans, commercial (traditional) health plans, HMOs, and Managed Behavioral Health Organizations (MBHOs) around the country. However, consumers and providers will co-exist with those plans and benefits in many new ways. Preparing for parity will require a perspective that sees opportunity more than threat in the coming changes. Providers are in a position to:

- Advocate for safe, high-quality, effective care
- Advocate for access to providers in underserved areas
- Use parity as an opportunity to accelerate the transformation of mental health system and implement recovery-oriented, trauma-informed, and culturally appropriate services
- Advocate for consumer rights, education and the elimination of discrimination and stigma
- Associate provider training for parity-associated changes with more general efforts to expand and develop the behavioral health workforce

Working in a Managed Behavioral Healthcare Environment

Providers who already have a strong presence and reputation among MBHOs likely will see their business opportunities expand naturally as a consequence of their position in the market. Providers who already know how to navigate a robust utilization management program will have the tools and processes in place to expand their business operations and serve more people. Providers who are new to managed care contracting, credentialing, policies, systems, and processes will be challenged to play by new rules and will need to ramp up now.

Opportunity: Expanding Behavioral Healthcare

Parity can mean "business as usual" for behavioral healthcare providers or it can provide some measure of opportunity. Managed care tools such as utilization management will make it difficult for anyone to exploit benefits; however, some providers will see parity as an opportunity to expand their service areas, scopes of service, service integration, adoption of best and evidence-based practices, and investments in information technology.

Opportunity: Integration of Behavioral and Primary Healthcare

The push for the integration of behavioral healthcare and primary care likely will see more emphasis as a result of parity. The majority of mental health care already is provided by primary care (particularly when the cost of psychotropic prescription drugs is factored) so enhanced benefits will lead to more – not less – primary care involvement. This will present opportunities for co-location of behavioral and primary health facilities, and accelerate the need to address cross-training challenges for both clinical and administrative services.

As the Parity Act is implemented and its consequences are fully integrated, the behavioral health field also will have to address whether a separate, free-standing behavioral health system with its often segregated disciplines makes sense and, if so, in what roles the field not only can survive but thrive.

Impacts on Behavioral Health Providers

In the broadest sense, behavioral healthcare providers can expect the following impacts in their practices:

1. Requirements to enter into agreements with MBHOs or other forms of managed care.
2. Requirements to participate in more rigorous professional credentialing.
3. Requirements to participate in utilization management (pre-certification or service and benefit authorization).
4. Increased use of diagnostic and screening tools to substantiate diagnoses.
5. Increased use of decision-support and treatment planning tools that help plan and track treatment across longer episodes of care.
6. Expanded communication and collaboration with other healthcare providers such as primary care physicians.
7. Requirements to demonstrate that care is consistent with evidence-based (scientifically-validated) best and promising practices.
8. Incentives to take advantage of enhanced insurance coverage by developing new levels of services, new services for co-morbid or co-occurring disorders, expanded geographic coverage, and relationships with primary care clinics.
9. Incentives to develop disease management programs and services for those with serious mental illness and various chronic conditions.

10. Incentives to ensure timely, accurate, and efficient health information. Consideration of electronic medical records systems for the purpose of care coordination, safety (especially in medications), and billing will come to the fore in practices that previously have only contemplated systems and technology adoption.
11. Increased need for expanded billing capacity and revenue generation, bearing in mind that ICD-9 is giving way to ICD-10 and that plans will differ in terms of what diagnoses are covered. For providers in some markets the result may be an array of coverage and contracts of even greater complexity than exists today.
12. Increased need for data management that generates outcomes data and enables quality improvement and financial analysis.
13. Increased collaboration with utilization management (usually Masters-level behavioral healthcare professionals) in treatment planning.
14. Expanded awareness that new funding will stimulate competition for new resources.

The Coverage Landscape: What to Expect

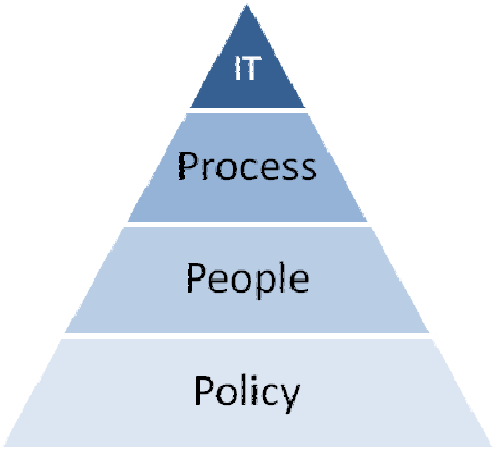
It is likely that a slow shift will occur in the treatment options available to populations commonly associated with publicly-financed mental health and addictions treatment on the one hand, and those associated with commercial, employer-sponsored plans on the other. Currently, people with serious mental illnesses and/or addictions do not trend toward voluntary treatment through employer plans, largely because the coverage has been inadequate and the fear of stigma and employer retaliation is great. As a result, the majority of consumers have sought mental health care in primary care settings. However, people with serious mental illnesses and addictions typically do not receive early and adequate treatment in primary care settings that are insured by discriminatory commercial, employer-based health plans. Sadly, many such consumers become un-employable and/or uninsured or underinsured, and then become Medicaid-eligible and reliant on treatment provided by the public sector. Due to disability or age, they may wind up covered by Medicare. Tragically, a third population receives treatment through the criminal justice system – a reminder that the system truly has failed.

If one assumes that people with mental health disorders, including those with serious mental illnesses, will receive adequate and appropriate treatment without exhausting or losing their employer-sponsored coverage, it is conceivable that fewer people will be treated in the public behavioral health clinics, jails and penitentiaries. This shift is expected to be very slow, as evidenced by the relatively small changes and impacts that have resulted from the various forms of parity in place today. However slow it may be, in time parity may result in earlier and more comprehensive treatment and maintenance for people with insurance, obviating the need for some (if not all) of the publicly-funded care they otherwise would have received.

Impact Zones

Behavioral health providers can expect four broad-based zones to be impacted by parity: Policy, People, Process, and Information Technology (IT). The four zones constitute the basic business infrastructure.

Policy is the broadest zone as it applies to everyone and everything within an organization, including its customers (consumers, members, providers, etc.). From the ground up, policy affects decisions regarding staffing, service offerings and products, strategy, authority, budgeting, training, and investments. Laws such as parity, State and Federal regulations, as well as agreements between providers and plans are all examples of external policies that shape a behavioral healthcare organization. Policy and procedure manuals are examples of internal policies that govern the way things are done in an organization.



People – the second zone – reflects leadership, staffing, human resources and personnel, hiring, recognition and retention, levels of professionalism, discipline, and areas of expertise as well as the manner in which an organization manages and supervises people. It also accounts for impacts felt by partners, providers, suppliers, and, most importantly, consumers. It includes communication among people, integration and teamwork, rights and responsibilities, and compliance with standards. Lastly, it involves specific qualifications, credentials, traits, experience, and education (including continuing education) required of people in healthcare professions.

Process – the third impact zone – refers to workflow and business processes. A process is a distinct series or sequence of steps or tasks that accomplish a core business or clinical objective. Workflow models or business process diagrams visually depict how a process begins, all of the people involved in accomplishing tasks, the tasks themselves, and the flow of work product from one person to another until the process is complete. Behavioral healthcare providers have a wide array of common core processes such as eligibility determination, assessment and treatment planning, appointment scheduling, and claiming or billing. Importantly, processes reflect policies and business rules and tell people what is expected of them. Significant change in policy results unequivocally in process change. Similarly, changes in process for the sake of discovering and instituting efficiency or quality improvements need to be reflected in policy, human resource management, and any technology in play.

Information Technology (IT) - the fourth zone – includes hardware (desktop PCs, modems, servers, routers, printers, scanners, cabling, etc.); networking (LAN, WAN, and other approaches); and software (often referred to as information systems or IS). IT also refers to data management; that is, data formats (XML, HTML, JAVA, etc.), data entry, collection, storage, retrieval, sharing or exchange, analysis, quality assurance, security, back-up, interchange, and reporting. IT impacts include database utilization,

adoption of new technology, interface between systems and users, design of systems, as well as investments in systems, hardware, and training. IT impacts will be experienced in any existing systems such as practice management and electronic medical records (EMR). Impacts also will be reflected in the desire to adopt new systems such as case management systems or tools such as data warehousing and business intelligence (BI) that help measure performance.

The following pages examine the impact of Parity in the three core divisions of most provider organizations: administration, clinical operations, and executive teams, with consideration for how the impacts will manifest in each of the four zones described above.

Impact Statement 1: Administration

Behavioral health providers such as clinics, multi-specialty practices, acute facilities, residential treatment facilities, and psychiatric rehabilitation programs share some common challenges. By virtue of their size, complexity, staffing levels, and the sheer volume of work involved, they are particularly susceptible to major policy changes such as those engendered by parity. Many more people require training, many more processes are repeated hundreds of times per day, and many more system changes may be required to adapt to change. The following administrative areas may be affected by parity:

	Policy	People	Process	Technology
Eligibility and Benefit Determination	More people will be eligible for more treatment, and new consumers likely will seek services as a result of the expanded coverage.	Front-end staff will review new benefits with more plans. Training and staffing levels likely will be affected.	The eligibility determination process should be streamlined, leveraging Internet access to capture new benefit information.	Providers should consider access to Web-based eligibility tools provided by most plans and review practice management system functionality to assess impact.
Chart-Build and Records Management	Plans may require more detailed records, including diagnostic information, assessment results, and outcomes measures. Policies may require treatment plans and evidence of best practices, such as person-centered plans or shared decision-making.	Records and filing staff may be affected by new record formats and by decisions to transition to "paperless" offices. Clinicians will be affected by requirements for more detailed record-keeping and documentation of best treatment practices.	Since consumer and service mix as well as length of treatment episodes for more serious illnesses are subject to change, staff may be need better access to charts and sharing of health information across organizational boundaries. EMR systems will require significant attention to process analysis and improvement.	Paper may give way to practice management systems (PMS) and PMS may give way to EMR systems. Some providers may be affected by a need for case management systems when caring for people with serious and complex needs in highly integrated care settings.
Utilization Management (UM)	Most people will belong to some form of MBHO. The majority will require "medically-necessary care" authorization and most plans will institute stricter	Administrative personnel will require training in UM protocols if it is new for them. Staff will need to control authorization numbers to facilitate billing,	The UM process may be expanded significantly for some providers and practices. The process should be efficient, involve as few steps as possible,	UM is supported best by phone contact, fax, and secure Internet access to plans and UM departments. Also helpful are decision support tools and

	Policy	People	Process	Technology
	level of care guidelines. Most will require greater emphasis on diagnosis and many will require comprehensive case management.	and understand how to collaborate efficiently with UM professionals. Common UM tools and phone numbers should be accessible.	and have assurances of high integrity in order to avoid payment denials. The process can be enhanced by information systems, access to the Internet and decision support guidelines.	technology as well as electronic level of care and treatment planning tools commonly found in EMR systems. Systems must track authorization numbers for billing purposes.
Billing	Billing policies will be affected by the variety of service codes (CPT) that are covered and diagnosis code (DSM-IV and ICD-9 and 10) requirements of various plans. Plans will place particular emphasis on paying for pre-authorized services. The law will change coverage, limits and financial arrangements providers have with many of those they serve.	Billing staff will require additional planning and training to manage the variety of diagnoses and services that are or are not covered. Benefits will vary and billing will require authorization codes to a greater degree than providers use today.	The billing process may change in terms of required information and clinical practices. If an organization or practice is growing, it may seek more efficient, timely and accurate billing practices in advance of parity. Electronic billing processes are highly encouraged.	Electronic billing requires HIPAA-compliant billing software as is common in a practice management system. HIPAA requires electronic data interchange (EDI) standards and formats between systems. The decision to bill electronically will be affected by the wide array of plans that offer a variety of billing options.
Contracting	Many providers soon will find themselves part of special behavioral health networks for MBHOs and the populations they serve. Contracts will require compliance with UM, greater scrutiny in credentialing, and more standardized treatment plans and record keeping in some cases. Contracting also will involve accepting new consumer referrals and agreeing not to balance bill. Expect competition in some parts of the country to drive rates down.	The proliferation of plans seeking behavioral health providers for their networks may require additional staffing among providers who want to be considered in-network wherever possible. Contracting will require subject matter expertise in reimbursement, usual and customary fees, capitation, service levels, and related codes. There may be opportunities to hire different types of professionals and to maintain different credentials. Continuing education may be affected as well if providers implement best practices.	Contracting processes involve documented credentials (degree, license, DEA license, etc.) as well as proof of clinical supervision in some cases. An efficient process involves rapid response to inquiries from plans, ready access to documentation, and proof of professional insurance as well as better use of plan-specific provider hotlines and manuals. Making internal financial decisions regarding reimbursement prior to contracting is also helpful.	Many providers will want to pursue database solutions to the challenge of keeping contracts and fee schedules current and accessible. Document management, knowledge management, and practice management systems can help resolve the issues that confound providers with many different contracts.
Scheduling and Retention	Providing prompt assessments and engaging people in treatment will be more important than ever. Not only is this a best practice area that often needs closer attention, it will be a contract requirement of many plans.	Scheduling and retaining existing consumers requires coordination between clinical and administrative staff. Retention may require training for both staff categories if people are going to be contacted by phone and encouraged to	Good practice management and EMR systems can significantly improve scheduling; however, clinicians must keep schedules up-to-date and communicate regularly with front-end staff. Retention can be enhanced	Practice management and EMR systems can enhance performance in these areas. However, front-end administrative staff and clinicians must have access to and use these systems effectively, which often involves training provided

	Policy	People	Process	Technology
		remain in treatment.	considerably by instituting new processes designed to keep people engaged and compliant with treatment.	by technology vendors. Measuring performance in this area may require a data warehouse and an analytical/reporting tool.

Impact Statement 2: Clinical Operations

The following clinical areas may be affected in organizations and practices. The full impact of parity will reflect, to some degree, an organization's strategic plan, and those that want to expand service offerings or move into new geographic markets will need to consider the impact of those decisions on clinical operations versus the impacts that result from attempting to maintain business as usual.

	Policy	People	Process	Technology
Service Mix and Consumer Mix	Parity may result in providers evaluating their particular markets for opportunities to expand geographically, offer new service levels, and/or to serve a new or more diverse consumer base. Partnerships with other providers, including primary care providers, may be expanded.	Market expansion, new service levels, and new consumer mixes involve recruiting and training additional clinical and support staff, new positions for peer counselors and specialists, and training and education for existing clinicians. Some clients should not be mixed in the same treatment setting. Credentialing and qualification requirements for new services and populations may differ from those that currently exist.	Opening new facilities and offering new service levels involve significant design and/or replication of business processes. For instance, service levels such as intensive outpatient or assertive community treatment programs involve clinical processes and operations that differ from conventional outpatient treatment.	New facilities that obviously require new hardware and a new consumer/service mix may be a strong catalyst for pursuing an EMR system to track the multitude of treatment planning and decision support tools on the market.
Screening, Assessment, and Diagnosis	Many plans may require evidence of a screening, assessment, and/or diagnostic instrument and will certainly require a diagnosis. Integrated screening and assessment for co-occurring disorders will be a priority. Assessment policies should be recovery-oriented, trauma-informed, culturally appropriate, and strengths-based.	Information collected at initial screening may be determinative of level of care. Organizations may need to expand training and supervision for "gatekeepers" – the staff who conduct initial screening and intake. Providers are encouraged to identify and employ additional screening and diagnostic tools to support gatekeepers.	Where survey tools are in use, the process may involve front-end administrative staff. These tools, however, should be reviewed by clinicians. Developing a thorough yet efficient assessment process will be crucial to effective treatment planning and a diagnosis will be absolutely essential for reimbursement.	Many tools exist in paper form; however, providers are strongly encouraged to invest in tools that allow individuals to answer questions on a computer. Some clinicians will prefer to assist consumers with computer-based assessments. It is important to integrate screening and assessment data with clinical records.

	Policy	People	Process	Technology
Level of Care Guidelines	Plans will use guidelines of their own and will be required to share level of care and medical necessity guidelines with consumers and providers. Most provider manuals include these guidelines. Providers may be motivated to develop guidelines of their own and to adopt decision guidelines that are consistent with the majority of plans.	There may be training issues for people who have not used level of care or decision support guidelines in the past. Application of these guidelines requires training and adequate non-billable time. Determining level of care should be a collaborative process involving consumers and UM staff.	Many decision support systems involve a process that moves the clinician through the level of care determination process. Without the help of a system, clinicians will need training and, in some cases, supervision as they navigate the determination process and make a decision. The process should include collaboration with consumers and involve review with UM professionals.	Providers may opt to invest in decision support systems that accelerate the process and provide evidence-based justification for clinical decisions.
Utilization Management (UM)	Most care will require prior authorization. UM professionals will review each treatment plan for medical necessity and level of care guidelines. Plans will differ in terms of coverage and the list of diagnoses and conditions covered.	Some clinicians will be very experienced in terms of navigating UM while others will be doing so for the first time. Clinicians may require some training and it is always beneficial to communicate regularly with UM staff. Some providers, by virtue of their volume, will decide to hire clinical staff for the purpose of UM.	The process is much more efficient when it is designed around adequate documentation and data. UM can be slowed by missing information. Some providers struggle with the requirement to obtain authorization before providing services which results in most of the denied claims. Clinical operations must become more disciplined in this area.	Some practice management and EMR systems can (and should be) be tailored to require a UM process and/or authorization number. The cost of denied claims can outweigh the cost of technology that supports this process. Some plans will enable electronic authorization so secure access to the Internet is also a must for clinicians.
Treatment Planning and Clinical Practices	Parity will be consistent with other policies, regulations, and provider contracts that call for the use of best practices in treatment planning and clinical practice. Providers will be pressed to adopt policies of their own that reflect this trend and be able to demonstrate that they are practicing accordingly. Policies can encourage or require practices such as person-centered planning and shared decision-making.	Treatment planning should focus on individual wellness and recovery while still addressing level-of-care criteria. Some clinicians will need training in specific treatment protocols, particularly for new services and populations. Expanded clinical supervision may be necessary and may require additional staffing. Consider trainers and consultants and refer to your trade group or association for guidance. Specialized TA is available.	The treatment planning process varies by tool or approach in use. However, it builds upon the processes preceding it and can be streamlined by leveraging behavioral health EMR systems. Clinical practices in treatment vary considerably across all of the service levels and the wide variety of best practices.	Contemporary EMR systems developed specifically for behavioral health providers will facilitate the treatment planning process and provide robust documentation. Decision support systems often can include treatment protocols to guide day-to-day clinical practices and decisions. Efficient use of the Internet can keep providers abreast of developments in the field.

	Policy	People	Process	Technology
Case Management	Expanded coverage for people with serious mental illnesses will provide an opportunity to offer case management to more consumers. Case management is a sophisticated and complex field that may involve certification and licensure. Some plans provide coverage for case management services. Opportunities for using peer specialists in these roles should be explored.	Providers who want to provide case management services will want either to hire qualified case managers or receive technical assistance and education for their existing clinical staff. Managing and coordinating the care of people with serious mental illnesses involves building collaborative relations with other professionals and services in the community. Case management also requires significant involvement of and communication with consumers and families.	Case management involves the adoption of comprehensive processes and the management of a great deal of information. It involves numerous opportunities for transition and communication among people which increases the incidence of process error. Case management processes require constant attention to quality assurance and efficiency.	Some behavioral health EMR systems facilitate case management while some vendors have developed very specialized case management systems. Systems can be tailored for specific populations such as children, people with co-occurring disorders, or those who are involved with the criminal justice system.
Care Coordination	Plans may encourage the practice of coordinating integrated care and, in fact, many plans around the country are pursuing the integration of primary care and behavioral healthcare. Managed care plans may apply level of care guidelines to assist with the determination of whether a particular consumer with co-morbid and/or complex care needs to be seen by additional providers.	Care coordination such as case management often involves training clinicians to work collaboratively with consumers to assess the need for additional services and to cultivate sufficient knowledge of a community's resources to make and track referrals.	Care coordination is a process that involves efficient handling of clinical information and community resources. Care coordination is successful when processes are thorough, follow conventional business rules in such areas as privacy, and involve accurate and timely exchange of critical information. The quality of care coordination can easily be compromised by a failure to follow through or to document appropriately.	Care coordination is often supported by systems and technology that facilitate secure information exchange and care tracking. Care coordination is enabled by databases of community providers that allow consumers and providers to find appropriate, need-based resources. Similarly, UM and case management staff within a health plan can assist in making referrals and provide online access to provider databases.

Impact Statement 3: Executive Management

The Parity Act will produce two significant conditions in the marketplace. First, it will make treatment of mental health and addiction disorders a more attractive business opportunity. Second, it will lead to greater integration of services and providers, particularly among behavioral health and primary care providers. The net effect for behavioral health providers is increased competition. Competition can be good for consumers but it introduces the need for change among established providers. Organizations will be pressed by market conditions to examine their strategic plans, to innovate, expand, improve quality and customer service, and begin pursuing vertical integration with other systems and providers of care. This will be true not only for behavioral health and primary care providers, but also between

mental health and addictions treatment providers. The next twelve months will allow every provider to consider their place in the market, their bottom line, and their vision.

	Policy	People	Process	Technology
Strategic Planning	Parity offers unprecedented opportunities to review organizational visions, missions, goals, and policies. Decisions to offer services, provide greater access, and appeal to new markets and consumers will provide direction to staff and establish mandates for change. Parity offers an opportunity to strengthen commitments to person-centered, recovery-oriented services.	Leadership teams can include the voices of consumers, clinical and administrative staff, and other community partners in making strategic decisions. Virtually every staff member, clinician, shareholder, stakeholder, contractor, supplier, and consumer will be impacted by decisions.	A strategic planning process that includes the traditional SWOT (strengths, weaknesses, opportunities, and threats) and PEST (political, economic, social, and technological) analyses will provide a comprehensive window into what is possible. Organizations are encouraged to employ a process that builds upon core competencies.	Providers will benefit from leveraging the Internet to research conditions in the behavioral healthcare market; by attending Webinars hosted by trade groups such as SAAS, NiTx, NCCBH, and NAADAC; and by contacting state professional associations, departments of behavioral health, Medicaid agencies, and Federal agencies like SAMHSA, NIDA, NIAAA, and NIMH to collect appropriate information.
Human Resources	Opportunities to consider additional staff resources will be generated by expanded business relations with managed care organizations as well as expansions into new markets and services for new populations. Parity will affect decisions about necessary qualifications, recruiting, hiring, training, and retention.	Providers should offer leadership in times of economic uncertainty and change, such as those generated by the Parity Act. Staff should be involved in strategic decisions, and be able to position themselves for training and growth opportunities. Changes required of provider organizations and their people will be facilitated by regular communication and inclusiveness.	At a process level, estimating staffing needs with a business plan and managing human resource/personnel processes will allow quick and effective responses to opportunities. Staffing is a challenge in rural and underserved areas and in places where language, gender, and cultural barriers exist. Recruiting people in recovery as staff may help to overcome these barriers. Developing a hiring process that addresses these issues will be an advantage.	Meeting human resource needs can be facilitated by technology. Web-based recruiting tools and services attract candidates and human resource databases and systems enable very efficient and accurate data management. Providers also can invest in systems that manage professional credentials and simplify contracting with plans.
Budget and Financial Management	As plan policies change to comply with the Parity Act, so will such financial variables as reimbursement schedules. Contracting with MBHOs will be pervasive and will involve far more financial data management and significant changes in revenue generation.	Providers that require professional guidance in the areas of business planning, financial planning, marketing, and contracting with managed care should identify resources as soon as possible. Senior people and executives in organizations can educate themselves by staying abreast of parity implementation, networking	Decisions made regarding the business opportunities associated with parity will largely determine any process changes required in financial forecasting, business planning and budgeting. Planning processes should involve projections of many factors including competition and populations served. Involving health plans in	There are many software tools that support business planning and budgeting. The degree of complexity in an organization will determine the tools that should be used in making projections and managing finances. Billing systems are easily the most important financial management tool in an organization's arsenal and

	Policy	People	Process	Technology
		with peers, and meeting with local plans' provider relations staffs.	making projections is also an important step in the process.	should be capable of managing many different fee schedules. Revenue generation and cash flow should be maximized through accurate and efficient systems prior to absorbing an increase in volume.
Performance Management	Plans will continue to require provider participation in initiatives to improve quality and clinical outcomes. The GAO will be reviewing the performance of parity on an annual basis so there will be increased pressure from payers to participate in value-based initiatives such as pay-for-performance. Providers need to institute their own quality assurance, quality improvement, clinical outcomes, consumer satisfaction, and other measures. While onerous and expensive at first, these data can help generate a competitive advantage.	Performance management –including quality, outcomes, satisfaction, efficiency, and profit – can require significant cultural change and represent new concepts and practices for people at all levels. Performance should be linked to mission and vision, and staff should be included in discussions of these issues. Establish key performance indicators and encourage organization-wide involvement in measuring and tracking performance. Providers without expertise to identify and measure their own performance can include consultants in this effort and/or seek training from the leadership team, managers, and supervisors.	Measuring and managing performance is a reflection of core business processes and increases "visibility" into how an organization works and serves people. Properly measuring quality and outcomes requires implementing new processes, and virtually everything can be measured and improved if an organization is pursuing a comprehensive program. Therefore, it is important to approach performance measurement strategically and implement what is most urgent and important for immediate growth goals.	Many technologies assist performance management, but selecting the appropriate one is a challenge for providers. The ability to analyze and report quality, outcomes, and satisfaction data is a function of the ability to collect data in a reliable database. Some EMR and practice management systems are equipped with reporting functions while others will require additional databases or "data warehouse" technology to integrate data from disparate systems and allow parsing and analysis. Reporting systems and Business Intelligence (BI) tools are an additional investment. Some IT tools can allow performance data sharing across organizational boundaries.

Call to Action

The behavioral healthcare field has advocated for fair and equal coverage and treatment on behalf of consumers for many years. Providers have had strong allies in Washington D.C. in the form of a handful of Senators and Presidents. On October 3rd of this year, support for parity and equity was nearly unanimous. Beginning January 1, 2010, nearly all Americans will have access to coverage that finally eliminates many of the most common barriers to behavioral health treatment. The last of the obstacles and barriers may fall as a result of decisions made and actions taken by behavioral healthcare providers. Despite improved coverage, consumers will continue to face access issues. As a result, parity opens the

door to providers who want to expand into new, viable markets; offer expanded service levels; and reach new target populations.

New levels of coverage will mean that more people eventually will seek services from qualified behavioral health professionals, and that they may be treated for longer time periods than was previously possible. Providers need to decide how many more consumers they want to attract, serve, and retain, as well as how they want to serve them.

Parity will entail more managed care and more integration between the behavioral health and primary care systems, as well as between the mental health and addictions treatment systems. Providers can act now to secure positions in relation to MBHOs, HMOs, and primary care providers in their communities. The result will be a stronger reputation for cooperation and an increase in opportunities to collaborate.

Expansions in markets, services, and partnerships will necessitate changes in organizational structures, staffing levels, and infrastructures. Providers must begin having strategic discussions and acting to manage change at policy, staffing, process, and technology levels in their organizations. The implementation of changes at these levels is difficult to motivate and manage in the course of day-to-day business. Those who do not have adequate resources but recognize the opportunity for change need to consider the involvement of experts, peers, partners, and consultants in their planning and execution.

Successful change involves accurate assessment of the current state of play and evaluation of resources and capabilities to manage change initiatives comprehensively. Provider organizations are encouraged to seek support in assessing where they stand today in relation to where they could be or where they envision being in one, three, and five years. Invest in technical assistance that will ensure effective adoption of best practices among clinical staff. Seek expert advice when designing and re-engineering business processes and adopting health information technology. Much the same way consumers need the help of behavioral health professionals to assess their motivation and navigate stages of change, provider organizations benefit from the perspective, resources, and expertise of qualified professionals who can help them achieve their business goals and realize their visions.

About AHP

Real World Solutions for Systems Change

Advocates for Human Potential, Inc. (AHP), is a research and consulting firm that specializes in changing and improving the organizational systems that help individuals create full and productive lives. Founded in 1980, AHP's comprehensive range of services helps clients identify and define challenges and potential solutions, engage stakeholders, design or modify programs and organizational practices, provide training, and develop new resources. AHP also conducts research on difficult issues, evaluates programs and service system, and helps clients translate research into practice.

Our services are organized in the following areas: *research and evaluation; technical assistance and training; system and program development, including strategic planning and information management;* and *resource development and dissemination,* in core content areas. Those areas include mental health policy and services, substance abuse treatment and prevention, co-occurring disorders, workforce development, electronic medical records, trauma, homelessness, housing, employment program development, domestic violence, and criminal justice.

AHP provides extensive consultation to healthcare provider organizations; health plans; and Federal, state, local, and international governments. The company manages Federal contracts of all sizes for several U.S. agencies in the areas of mental health, substance abuse, co-occurring disorders, workforce development, homelessness, domestic violence, elder abuse, rural elder health, and performance review and improvement. These projects enhance understanding of critical issues, help agencies and their stakeholders improve performance, and provide the most current information to the field about effective programs and system development to better serve vulnerable populations.

AHP's passionate and committed staff members, many of whom are nationally recognized, are known for their intimate knowledge of "what happens on the streets" as well as in the offices of policymakers, and they are equally comfortable in both settings. The insights they bring to large national projects are informed by diverse experience in the field. AHP is especially known for connecting the dots across disciplines, service systems, funders, and populations to develop comprehensive real-world solutions that meet the needs of consumers and providers.

The authors of this report together bring more than 75 years of experience helping to improve the performance of behavioral healthcare systems.

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networks, reaching underserved populations, and building successful public-private partnerships. For 10 years, he served as Chief Marketing Officer and Chief Operations Officer for a national insurer dedicated to mental health and addiction. He was responsible for nationwide crisis-call center operations, customer service, eligibility and enrollment, utilization management, case management, and provider contracting. Previously he served in management roles in adolescent residential treatment settings, acute psychiatric hospital settings, and a drug and alcohol detoxification center.

Carol Bianco leads the Mental Health practice at AHP and has provided consultation and training to community-based organizations and state and local mental health departments throughout the states and territories. Her expertise includes mental health policy and financing, organizational development, supportive housing development and financing, supported employment, and job creation for people with disabilities. At AHP, she has directed several contracts for the Substance Abuse and Mental Health Services Administration (SAMHSA) that assist states and territories in implementing the recommendations of the President's New Freedom Commission on Mental Health and provide resources and technical assistance to the mental health community regarding best practices to promote community integration for children and adults with mental disorders. Currently, she also serves as a Technical Assistance Consultant/Advisor for the SAMHSA Center for Mental Health Service's Mental Health Transformation State Incentive Grant Program. She was formerly Director of Program Development for New York State's largest provider of supportive housing and community psychiatric rehabilitation programs for adults with serious mental illnesses.

Neal Shifman, AHP's founder, President, and CEO, is a nationally and internationally known consultant and facilitator in service system redesign, with special expertise in mental health, substance abuse, criminal justice, and a variety of at-risk populations and their interface with social service systems. He was an early pioneer in the development of continuum of care designs for substance abuse prevention and treatment, was a founder and first president of the State Association of Addiction Services (SAAS), and has worked extensively with Federal and state systems on a large number of substance abuse and behavioral health projects. For the past 12 years he has led a number of strategic initiatives as well as planning and facilitative processes involving governments (both civil servants and political ministries), the judicial systems, non-government organizations, and the private sector. Examples of his work include the design of the substance abuse delivery system in St. Maarten; the coordination, development, and implementation of a WHO-sponsored Caribbean Initiative and subsequent conference on substance abuse; policy, facilitative, and writing support for United Nations Drug Control Program's (UNDCP) International Drug Court Project; a three-year redesign of the criminal justice system in Bermuda known as Alternatives to Incarceration and a similar effort currently underway in St. Maarten; and numerous strategic planning, program design, and needs assessments for NGOs ranging from HIV/AIDS, to child and adolescent services, women and violence, substance abuse prevention and treatment, labor and training, and welfare and social services.

AHP has primary offices in Sudbury, MA (near Boston); Albany, NY; and Germantown, MD (near Washington, D.C.) and staff located nationwide.

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Behavioral Health Parity:
Health Plan & Healthcare Purchaser's Strategic & Tactical Guide to Implementation

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Purpose

The passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act (MHPAEA) late in 2008 will continue to give rise to much change in the coverage of mental health and substance use disorders among health plans. The outcome of a successful implementation for consumers and their families will be equitable coverage for the treatment of their disorders and improved quality of life. Implementation will be a rigorous and involved process for health plans but important benefits accrue to them as well. Primarily, properly screened, diagnosed, and treated mental health and substance use disorders relieve financial pressures on health plans that result from co-morbidity, repeated attempts at inappropriate treatment, and misuse of the emergency room for mental health concerns. Advocates for Human Potential, Inc. (AHP) hopes that this paper, as well as the others in the series, will help you prepare to implement the 2008 Parity Act, which goes into effect on January 1, 2010.

Hundreds of payers – including self-insured employers – have fewer than six months to bring themselves into line with the Parity Act. As regulations are not expected to be released until October 2009, implementation will be rapid.

This paper will introduce and summarize the Mental Health Parity and Addiction Equity Act of 2008, providing an overview of issues that are particularly salient for healthcare providers. It will then present a situation analysis of state by state parity regulations and explain many of the implementation issues payers can expect, particularly those new to mental health (MH) and substance use disorder (SUD) treatment. Finally, it will offer a roadmap, an implementation outline, and next steps to assist healthcare purchasers in navigating the path to full implementation of the requirements of the Parity Act.

Throughout the paper you will see lessons learned set off from the main text. By sharing the experiences of those who have already implemented parity regulations, we hope that you can gain insight into the challenges and solutions that lay ahead. The Implementation Outline is a practical guide to implementation activities and tasks that you can begin using immediately.

This paper is not intended to establish a rationale for expanding coverage; this has been accomplished through the Act and the research supporting it. The purpose of this paper is to provide information and assistance to those tasked with this implementation.

The 2008 Parity Act

On October 3, 2008, the United States Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The passage of the Parity Act is one of the most important developments in the mental health (MH) and substance use disorders (SUDs) treatment fields in the past half century. The Parity Act provides enhanced, equitable coverage for more than 110 million Americans (including more than 80 million individuals covered by Employee Retirement Income Security Act [ERISA] plans) and ends differential coverage of MH and SUDs treatment for this population.

The Act takes effect for the majority of plans on January 1, 2010 and regulations are scheduled for issuance in October 2009. It builds upon the success of parity coverage President Bill Clinton extended to Federal employees and the experience more than 40 states have had with their own versions of parity coverage. With some exceptions, health plans that provide mental health or addiction treatment benefits now must provide the same financial terms, conditions, requirements, and treatment

limitations for mental health and addictions as they do in providing "predominant" coverage for medical and surgical conditions.

Critical provisions of the Act include the following:

- **Cost-Sharing and Limitations** — Mental health and addiction treatment cost-sharing, deductibles, co-pays, and other forms of co-insurance as well as annual limits and lifetime limits must be equal to "predominant" coverage for "substantially all" of the covered medical and surgical conditions. In addition, limitations on the scope of treatment and treatment frequency and duration cannot be more restrictive than those limiting other medical conditions and care.
- **Conditions/Diagnoses Covered** —The Federal government appears to be leaving decisions about which conditions to cover to states, payers, and employers. Several approaches have been taken over the past decade for covering various mental illnesses.
- **Parties Responsible for Implementation** — The Act will be implemented by states, Medicaid agencies and Medicaid managed care plans, employer-based plans, third-party administrators (TPAs), managed care organizations, and managed behavioral health organizations (MBHOs).
- **Covered Services and Providers** — Payers and employers will need to decide (subject to stipulations in the October 2009 Federal regulations) which MH and SUD services, levels of care, and providers will be covered.

It is not enough to maintain long lists of MH and SUD providers. To be of real value, the providers must be at their published addresses, accepting new patients, and providing the services described in your provider manual. Perform random sample calls to audit the list and determine the value it truly represents for you and your subscribers.

- **Treatment Plans and Best Practices** — The treatment of people with mental illnesses and/or substance use disorders is most cost effective, as measured in positive clinical and quality of life outcomes, when scientifically validated practices are employed in a comprehensive treatment plan. Ongoing research is consistently providing new and reliable evidence concerning such practices, and payers are encouraged to stay abreast of their costs and benefits for specific populations in the same way that they review pharmaceutical, medical, and surgical advances.
- **Out-of-Network Benefits** — Where allowed for other conditions, out-of-network benefits for mental health and addictions treatment must be provided and must be equal to those provided for other medical and surgical benefits.
- **Utilization Management (UM) and Level of Care Guidelines** — Plans can continue to engage in healthcare UM, as well as utilization review and other types of assessments, and determine coverage on a case-by-case basis. Plans are required to provide members, consumers, and providers with their medical necessity criteria and reasons for benefits/coverage or claims denial.
- **Compliance** — The Department of Labor, Health and Human Services, and the Treasury will almost certainly be responsible for enforcement of the Act. These departments are expected to produce guidelines and regulations later this year.
- **General Exemptions** — More than 40 states have some form of mandated mental health and/or addiction treatment parity and those whose coverage is more limited than that provided by the Act will be required to address the discrepancy. The lack of parity for addiction services will be the biggest gap for approximately 30 states to fill. A list of states and their status appears on page 5.
- **Employer Exemptions** — The Act exempts employers with fewer than 50 employees and plans whose total premium costs increase more than two percent in the first year or one percent in any subsequent year, subject to an annual application and review process.
- **Medicaid and Medicare** — Medicaid managed care plans are affected by the Act; Medicare is not.

Implications for Health Plans

The Parity Act will affect health plans' basic business infrastructure in four distinct dimensions or zones: policy, process, people, and information technology (IT). As planning and implementation progresses within health plans, each zone should inform the others in an interdependent fashion and all will require review and possible adjustments and offer areas for development.

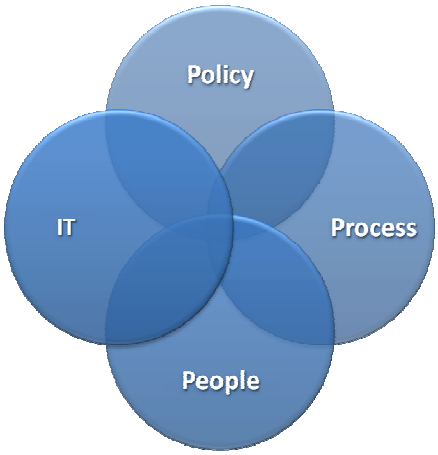


Figure 1. Interrelationship of Basic Business Zones

> Most mental health emergencies occur after hours. If you're considering in-sourcing tasks that are now a function of your MBHO partner, plan to have mental health professionals available to answer calls 24/7/365. One payer overlooked this only to have a subscriber commit suicide after their answering service referred him to an urgent care clinic that had closed hours before he arrived at their doorstep. After-hours crisis call center operators can be contracted to perform this service at a low cost.

Zone 1: Policy — This is the first and broadest area requiring review. Policy interpretation will help guide plan design and coverage decision-making as well as member and provider communications concerning benefits, policies, and plan rules. Payers are encouraged to consult with experts (policy experts, brokers, and consultants) as well as state Department of Insurance officials for any early interpretation of the Act. In-house legal counsel also can be very helpful in beginning to interpret the Act. Policy and legal interpretation will be considerably easier following the issuance of Federal guidelines and regulations later in the year. Until then, however, payers will have to do their best to study state regulations and base their approach on the most likely path forward, given other states' experiences with parity.

> Payers are strongly encouraged to conduct peer reviews to better understand how level of care decisions are made and to require rigorous documentation. This will help avoid problems such as the shifting of medical costs to the medical plan by MBHOs that make inappropriate coverage decisions and referrals. Level of care guidelines and decision support tools are available from software developers with expertise in these areas. Seek support from UM vendors and MBHOs that can demonstrate superior quality, member satisfaction ratings, and up-to-date evidence-based level of care guidelines, process, and tools.

Zone 2: Process — Operational workflow and business processes must be reviewed to ensure that policy changes are implemented efficiently and to be certain that the desired impacts are optimized for plan members as well as staff. Particular attention should be paid to core processes such as marketing, enrollment, customer service, utilization and medical management, provider contracting, claims processing, and quality improvement. For example, deductibles represent a tremendous opportunity for this kind of business process management. Many plans will have to decide how they will calculate deductible(s) if and when coverage and benefits are managed in a carve-out scenario that includes MH/SUD claims processing outsourced to the MBHO.

Zone 3: People — The implementation of the Act will require review of staffing levels, training, performance standards, and evaluation. It will also require thoughtful communication to promote provider integration and collaboration, and to ensure that plan members understand their rights and responsibilities under parity. In addition, the Act will influence relationships with partners, providers, suppliers, and, most importantly, consumers. For example, payers will need to consider coverage for

expanded levels and types of service for SUD treatment. Some payers currently offer medical detoxification and outpatient counseling for SUDs and will want to explore the addition of residential, partial, and intensive outpatient levels of care in the near future.

Zone 4: IT — This zone includes hardware, networking, software, and data management. The Act will likely affect database configuration, new system requirements and procurement, and the potential for interface between systems in order to support new policies and processes. Decision-support systems, for example, may be required if a payer desires to manage MH and SUD treatment internally. Information exchange between payers and their MBHO partners is especially pertinent to authorizing treatment plans and claims processing.

Situation Analysis

In order to understand the changes that will be effected by implementation of parity regulations, we must first survey where states currently stand with regard to parity.

The following chart illustrates each state's parity status. However, until Federal Parity Act regulations become available, it will be difficult to precisely determine what will be required of payers in each state. Plans in states with mandates or limited versions of parity will have more to change and implement than states considered to have the "best" coverage.

Chart 1. State Parity Status

State	Status	State	Status	State	Status	State	Status
Connecticut	Best	**California**	Limited	**New Jersey**	Limited	**Michigan**	Mandate
Maryland	Best	**Colorado**	Limited	**New York**	Limited	**Pennsylvania**	Mandate
Minnesota	Best	**Delaware**	Limited	**Ohio**	Limited	**Alaska**	Mandate
Vermont	Best	**Hawaii**	Limited	**Oklahoma**	Limited	**Georgia**	Mandate
Oregon	Best	**Illinois**	Limited	**S. Carolina**	Limited	**Mississippi**	Mandate
Indiana	Good	**Iowa**	Limited	**S. Dakota**	Limited	**Wisconsin**	Mandate
Kentucky	Good	**Louisiana**	Limited	**Tennessee**	Limited	**D.C.**	Mandate
Maine	Good	**Massachusetts**	Limited	**Texas**	Limited	**Kansas**	Mandate
N. Mexico	Good	**Missouri**	Limited	**Utah**	Limited	**N. Dakota**	Mandate
N. Carolina	Good	**Montana**	Limited	**Virginia**	Limited	**Wyoming**	None
Washington	Good	**Nebraska**	Limited	**W. Virginia**	Limited	**Idaho**	*State employees only*
Arizona	Limited	**Nevada**	Limited	**Alabama**	Mandate		
Arkansas	Limited	**N. Hampshire**	Limited	**Florida**	Mandate		

Source: Mental Health America, July 2008

Best = Best parity and comprehensive equity (covers MH and SA, no exemptions)

Good = Good parity coverage (few exceptions or limitations)

Limited = Mostly applicable to specific populations such as serious mental illness SMI (listing 7-10 "biologically-based" disorders such as psychosis and bi-polar disorder) and can exclude SUDs. Often exempts employers with 50 or fewer employees

Mandate = State-mandated levels of coverage or benefit expressed in terms of financial limits and/or treatment constraints. Mandated coverage is often inconsistent with Parity.

The current status of state-specific parity will have a bearing on the gap between what fully insured, commercial plans are doing today and what they will need to do in order to comply with new Federal parity regulations. TPAs administering benefits on behalf of self-insured ERISA groups and employers may have the greatest "distance to travel" in terms of closing the gap between where they are today and where they will likely need to be a year from now.

While many states already have pieces of parity enacted, other states will have a long way to go to reach full implementation. Beyond changes in regulations, the Act's impacts will be felt in the subtle shift of populations and costs, most likely in the areas of:

Credentialing providers is absolutely essential to being a good steward of coverage and care. Many tragic stories underscore the need for primary source verification of education, licensure, insurance, and other credentials. One payer failed to comprehensively validate its providers' credentials only to discover that children in one particular treatment program were camping with provider staff and exchanging their medication for staff favors.

Public to Private Sector — Experts anticipate a slow but steady shift in covered populations and costs as people with serious mental illness— and SUDs are increasingly treated through employer health plans. However slow this shift may be, the Parity Act is expected to transfer some measure of responsibility for coverage, treatment, and cost from the public to the private sector.

To address this shift, payers will increasingly consider tactics such as: coordinated case management, medical home models, decision-support systems, and specialty networks of care that include community-based sub-clinical systems of support. These require considerable planning and policy and procedure modifications, especially in contracting, reimbursement rules, medical management, and member services.

Integration of Behavioral and Primary Healthcare — The Parity Act will accelerate the need for integrated primary and behavioral healthcare. Research shows that outcomes improve when medical management and psychosocial therapies are provided in a single setting.

Implementing the law will present opportunities for:

- Bi-directional co-location of behavioral and primary health providers, thereby increasing the likelihood that behavioral services, including medication management, will be easier for clients to access; research indicates that this will result in improved outcomes. However, co-location may also accelerate the need to address cross-training issues for providers.
- Reshaping reimbursement for primary care providers who provide mental healthcare. These individuals provide the majority of mental health treatments and often are the frontline screeners for care. However, their reimbursement is frequently limited to a specific number of treatments per day.

Children suffering from SEDs require services more commonly associated with schools, juvenile justice programs, and other social service agencies. They also require specially trained child psychiatrists and psychologists to make appropriate diagnoses and manage complex treatment plans and medications. Some also require special services such as non-hospital residential care for short periods.

"Blended" Systems of Care — Parity presents opportunities to blend private and public sector approaches. The public SUD treatment system has evolved to include "recovery support services" or "wrap-around services" which will need to be factored into private health plans as viable and important adjuncts to medical detoxification, rehabilitation, and intensive outpatient treatment. During the past 30 years, researchers have found that many clinical services are less effective on a stand-alone basis than

they are when paired with these sub-clinical, community-based recovery support services. For example, recovering alcoholics or individuals suffering from schizophrenia are more successful in adhering to their treatment plans if they are provided with community-based services such as transportation to and from treatment.

The need for blended systems of care becomes even more apparent when considering children with severe emotional disturbances (SEDs). State laws often require that these children be provided with an array of services and this responsibility is usually taken on by the public schools and the public mental health system. Payers that are newly required to meet these children's needs must consider how care can best be provided.

Chronic Illness Models of Care — Payers will be confronted with the complex and pervasive treatment needs of their members who suffer from SUDs and serious mental illnesses (SMIs). These are serious, chronic conditions and require different types and levels of care over longer periods of time. Relapses are to be expected and treatment outcomes will vary depending upon complications such as co-morbidity. Payers and providers are encouraged to address collaborative treatment planning needs, especially where co-morbidity is concerned, in order to deliver high quality, cost-effective, and medically sound care. Data suggests that medical conditions (e.g., diabetes, obesity, heart disease, and chronic obstructive pulmonary disease) are complicated by mental illness as much as mental illness is complicated by other medical conditions. The expectation that the "whole" person will be treated may truly be coming of age and saving plans money over the long-run.

Carve-Outs and Carve-Ins — Payers and employers who currently have their MH and SUD benefits managed by an MBHO will likely continue to do so; however, they will need to ensure that their vendor is compliant with the Act, particularly as it relates to disclosing guidelines for levels of care and for equity between medical utilization management practices for primary care and for MH and SUD treatments. Payers who do not currently have their MH and SUD benefits managed by an MBHO vendor will want to explore that option as well as the option of a carve-in. The latter involves contracting with and integrating MH/SUD experts, case managers, and reviewers with existing medical management teams and departments.

Effective, timely, and accurate communications to subscribers and plan members is critical. One plan failed to notify its subscribers, members, and providers of a change in MBHO vendors and patients and providers were in limbo for weeks. Providers that continued serving patients after the transition had to go through a difficult grievance process to recapture monies owed them. The episode disrupted hundreds of therapeutic relationships and tarnished the reputations of several corporations.

Population Management — Health plans and purchasers will want to consider population management programs that address disease prevention and management throughout an entire population. By developing programs that address needs at any point along the disease continuum, payers can expect improved rates of early identification and treatment. This approach – including strategies such as early and periodic screening, patient education, self-care, and support for family members – is linked with lower overall healthcare costs.

Implementation

During the planning process, health plans and purchasers are encouraged to consider both the functional and tactical dimensions of implementation:

Functional Implementation – This will require health plans and purchasers to assess the Act's impact throughout their organizations. All departments or functional areas will be involved to some measure in implementing the Act. Organizations should meet early to begin outlining how the Act will impact:

1. Legal Interpretation of the Act and related regulations
2. Plan policies and benefit design
3. Covered diagnoses, providers, and services
4. Benefit carve-out to an MBHO
5. Provider networks and incentives
6. Level of care guidelines, decision support protocols, and member communications
7. Fiscal impact and data analysis

Payers may contemplate excluding all but the seven to ten "biologically-based" disorders expecting that they will be better able to manage risk, provider services, and costs. However, some providers may shift patients into covered conditions to provide them with better care. In addition, patients whose diagnoses are not covered may use services that cost much more over time (e.g. emergency room visits).

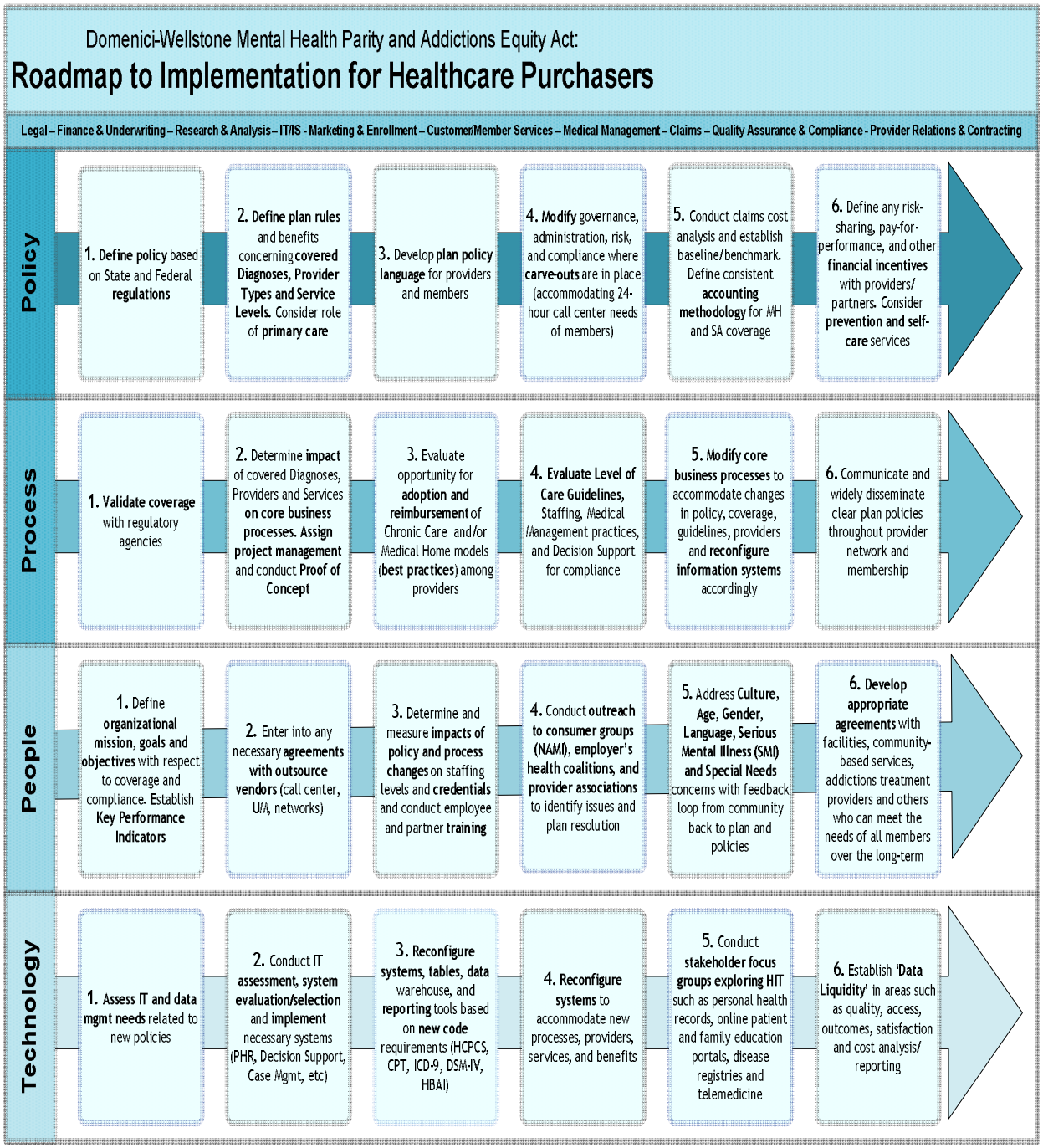
Payers also have to consider the Act's implications across other functional areas. These include possibly managing a single deductible and out-of-pocket maximum, customer service, existing disease and case management programs, and medical and utilization management. Other functional areas are subrogation and coordination of benefits, marketing and managing multiple plan designs and lines of business across states, prevention initiatives, and business partnerships.

Tactical Implementation – Parity requires a great deal of tactical planning and execution. Inter-departmental, multi-disciplinary teams within payer organizations are encouraged to consider their entire change management arsenal. Tactical approaches to implementation should include:

1. Assessment of current benefits and legal review
2. Strategic planning
3. Business process and workflow reengineering with particular attention to gap analysis and employee training
4. Expert consultation
5. Business process outsourcing options
6. Implementation oversight and project management
7. Data management strategy (system reconfiguration and reporting)

A Roadmap for Implementation provides general steps within each of the four zones that can be implemented and supplemented. Payers have much to learn from the implementation of other parity laws. Vermont implemented a comprehensive form of parity that will likely be a model for national dissemination in 2010. Similarly, the Federal Employees Health Benefits Plan (FEHBP) provided hundreds of plan administrators serving millions of enrollees the opportunity to implement parity at the beginning of the decade and to begin measuring its actual impact on costs and overall quality of care. Minnesota, Maryland, Connecticut, and Oregon have implemented parity while containing costs.

Figure 2. Comprehensive Roadmap for Healthcare Purchasers



Implementation Outline

Moving from a road map to actually "where the rubber meets the road", the following is an Implementation Outline that can be used as a guide in navigating the implementation process. Using the model described earlier in this paper we have divided the areas of business infrastructure into four zones and have provided steps for implementation for each zone. By using this same model in our other white paper: *Mental Health and Addiction Providers Impact Statement & Call to Action,* we were able to highlight steps providers can take as Parity rolls out. We used the same format in our discussion of payers/purchases, and encourage the reader to compare and contrast the steps of implementation to better collaborate and anticipate the needs of partnering organizations. Please avail yourself to these high level project management tools.

Impact Zone 1 – Steps plans can take with respect to statutory compliance, policies, and plan rules.

Policy
☑ Plan seeks guidance from State Insurance Commissioner and/or Federal regulators with respect to regulations and policy direction.
☑ Plan establishes its rules concerning benefits, limitations, restrictions, out-of-pocket expenses as well as covered diagnoses, provider types and services. Plan considers how new rules apply to primary care and hospital settings.
☑ Plan develops marketing, communications, certificates of coverage, and Summary Plan Descriptions to reflect new rules and policies. Plan also develops provider communications strategy for mental health, substance abuse, and primary care providers.
☑ Plan addresses need for 24/7/365 hotline. Plan addresses MBHO contracts and modifies administration, governance, risk sharing, performance standards, and guarantees.
☑ Plan conducts claims cost analysis and establishes consistent methodology for comparing premium impacts year over year. Various research and analysis models can be established.
☑ Plan explores and defines any risk sharing, pay-for-performance, and other incentives with providers. Plan considers addition of prevention and self-care providers.

Impact Zone 2 – Steps plans can take to establish new and modify existing processes and workflow to properly implement policies and rules.

Process
☑ Validate policies and plan rules with regulatory agencies. This may be a particular challenge if the regulations are not published on or prior to October 3, 2009, when they are expected.
☑ Determine the impact of plan rules, covered diagnoses, provider types, and services on core processes and any out-sourced processes. Examples include impacts on Provider Contracting and Marketing. It is recommended that a Parity Project Manager be assigned for the duration of the implementation. In addition, some plans may benefit from conducting proof of concept simulations that estimate utilization patterns and cost impacts.
☑ Evaluate the opportunity for adoption and reimbursement of services and providers that enable care for the chronically SMI and SED children. Approaches include primary care and behavioral health integration, collaborative care, patient-centered medical home care and case management.
☑ Evaluate Level of Care Guidelines where MH and SA are concerned, assess staffing levels, medical management practices, and decision support.
☑ Modify core business processes and workflow to accommodate changes in policy, coverage, guidelines, and providers. Review and modify policies and procedures as well as any templates or forms involved in workflow. Communicate need for any information system reconfiguration requirements to IT personnel, analysts, and developers.
☑ Communicate and disseminate clear plan policies and other pertinent documentation to all providers and members throughout the entire implementation process.

Impact Zone 3 – Impacts of change on personnel, suppliers, providers, and plan members. Many of the impacts will also be absorbed and managed at the level of organization.

People
☑ Define organizational mission, goals, and objectives concerning compliance and coverage. Establish clear Key Performance Indicators as early as possible.
☑ Establish necessary relationships and begin contract negotiations with out-source vendors such as 24-hour call centers, utilization review, and specialty provider networks. Clarify performance expectations, standards, and incentives for performance guarantees.
☑ Determine impact of new processes on staffing levels, qualification requirements, and conduct any necessary training.
☑ Conduct outreach with consumer groups such as your local chapter of NAMI, employers' health coalitions, and provider associations to identify issues early and develop plans of action to resolve concerns effectively.
☑ Address culture, language, gender, and special needs (among SMI and SED, especially). Develop communication and feedback loops between parties.
☑ Develop appropriate agreements with facilities, community-based services (including any public sector providers), substance abuse providers, and others. Address need for competitive, discounted rates early in the process.

Impact Zone 4 – Impacts on enterprise-wide information technology and systems.

Technology
☑ Immediately evaluate IT and data management needs associated with new policies.
☑ Conduct IT assessment, system/vendor evaluations, and selection relative to any new applications required by plan to manage policies. Prepare and deploy implementation plans. Consider claims accumulators, decision support systems, case management systems, and personal health records systems, for example.
☑ Reconfigure systems, tables, data warehouse, and reporting tools based on new requirements and codes (HCPCS, CPT, ICD-9, DSM-IV, HBAI, etc.)
☑ Reconfigure systems to accommodate new processes, workflow, forms, and templates. Reconfigure based on new provider type, service and benefit parameters and requirements.
☑ Conduct stakeholder focus groups to explore health IT options such as personal health records, online patient and family education, portals, disease registries, and telemedicine (telepsychiatry)
☑ Establish "Data Liquidity" targets and mechanisms to facilitate research, quality assurance/improvement, access, outcomes, satisfaction, and cost analysis/reporting.

Next Steps

Beginning January 1, 2010, nearly all Americans will have access to coverage that finally eliminates many of the most common barriers to behavioral health treatment. This will have a lasting impact on and ramifications extending into all facets of the healthcare field. While the full consequences of enactment of the MHPAEA cannot be anticipated, a few outcomes are to be expected and the natural question is what can we do in order to be successful?

- New levels of coverage will mean that more people will eventually seek services from qualified behavioral health professionals over longer courses of time (longer episodes of care). **Plans should consult best practices to establish the service and provider mix they want to offer in order to produce positive outcomes at a reasonable price.**
- Parity can entail: changes in managed care; integration between the behavioral health and primary care systems; and some degree of integration between mental health and addictions treatment providers. **Plans can act now to secure agreements with MBHOs, specialty networks, and providers in their communities that can meet special needs.** The result will be stronger reputations for cooperation and increased opportunities to collaborate.
- Enhancements to coverage and expanded services may necessitate changes to organizational structure, staffing levels, and infrastructure. **Payers should begin strategic discussions and change management at the policy, staffing, process and technology levels.** The implementation of change at these levels is difficult to motivate and manage in the course of day-to-day business. Those who do not have adequate resources but recognize the opportunity for change need to consider the involvement of experts, peers, partners, and consultants. Infrastructure and staffing change may be important in UM, customer service, and provider contracting.
- Successful change involves accurate assessment of the current state of operations as well as an evaluation of internal resources and capabilities to manage change over time. **Payers are encouraged to:**

- **Seek support** in assessing where they stand today in relation to where they could be or where they envision being in 1, 3, and 5 years.
- **Invest in technical assistance** that will ensure effective adoption of best practices.
- **Seek expert advice** when designing and re-engineering business processes and adopting health information technology.

The advent of full Federal Parity is an opportunity for a comprehensive and thoughtful implementation. Anyone who has endured an incomplete implementation in the past and had to deal with the negative consequences and re-work will attest to the need to get it right the first time.

About the Authors

AHP

Real-World Solutions for Systems Change

Advocates for Human Potential (AHP), Inc., is a research and consulting firm that enhances and improves organizational systems so individuals may have fuller and more productive lives. Since its founding in 1980, AHP has worked with clients including healthcare provider organizations, health plans, and all levels of government. The company manages contracts of all sizes in the areas of mental health, substance abuse, co-occurring disorders, workforce development, homelessness, domestic violence, elder abuse, rural elder health, and performance review and improvement.

AHP's passionate and committed staff members, many of whom are nationally recognized, are known for their intimate knowledge of "what happens on the streets" as well as well as in the offices of policymakers, and they are equally comfortable in both settings. The insights they bring to projects are informed by diverse experience in the field. AHP is especially known for connecting the dots across disciplines, service systems, funders and populations to develop comprehensive real-world solutions that meet the needs of consumers and providers. The company has a nationwide network of staff and offices in Sudbury, MA (near Boston); Albany, NY; and Germantown, MD (near Washington, D.C.).

The authors of this report together bring more than 75 years experience helping to improve the performance of behavioral healthcare systems.

Patrick Gauthier is a senior consultant working with AHP's eHealth and Organizational Development practice. He specializes in mental health service system design and in financing, strategic planning and business process management. Mr. Gauthier has served in a variety of leadership positions in the healthcare, mental health, health insurance, MBHO and EAP, consulting, governmental and nonprofit fields. His expertise in operations is related to quality improvement, health utilization management, technology adoption, building specialty provider networks, reaching underserved populations, and creating successful public-private partnerships with private, employer-based, state and county MH/SA systems. For 10 years, he served as Chief Marketing Officer and Chief Operations Officer for a national insurer dedicated to mental health and addiction. He was responsible for nationwide crisis-call center operations, customer service, eligibility and enrollment, utilization management, case management, and provider contracting. Early in his 20-year career he served in management roles in adolescent residential treatment and family preservation programs, and in acute psychiatric hospital and drug and alcohol treatment settings.

Carol Bianco leads the Mental Health practice at AHP and has provided consultation and training to community-based organizations and state and local mental health departments throughout the states and territories. Her expertise includes mental health policy and financing, organizational development, supportive housing development and financing, supported employment, and job creation for people with disabilities.

At AHP, Ms. Bianco has directed several contracts for the Substance Abuse and Mental Health Services Administration (SAMHSA) that assist states and territories in implementing the recommendations of the President's New Freedom Commission on Mental Health. In addition, she leads teams providing resources and technical assistance to the mental health community regarding best practices to promote community integration for children and adults with mental disorders. Currently, she also serves as a Technical Assistance Consultant/Advisor for the SAMHSA Center for Mental Health Service's Mental Health Transformation State Incentive Grant Program. Ms. Bianco formerly was the director of program

development for New York State's largest provider of supportive housing and community psychiatric rehabilitation programs for adults with serious mental illnesses.

Neal Shifman, AHP's founder and CEO, is a nationally and internationally known consultant and facilitator in service system redesign, with special expertise in mental health, substance abuse, criminal justice issues. His work enhancing the interface between at-risk populations and social service systems has received accolades from multiple state agencies.

Mr. Shifman was an early pioneer in the development of continuum of care designs for substance abuse prevention and treatment, was a founder and first president of the State Association of Addiction Services (SAAS), and has worked extensively with federal and state systems on a large number of substance abuse and behavioral health projects. For the past 12 years he has led a number of strategic initiatives involving government agencies, nongovernment organizations, and the private sector. Examples of his work include the design of the substance abuse delivery system in St. Maarten; the coordination, development, and implementation of a Caribbean Initiative and subsequent conference on substance abuse sponsored by the World Health Organization; and policy, facilitative and writing support for United Nations Drug Control Program's International Drug Court Project. He also conducted a 3-year redesign of the criminal justice system in Bermuda known as Alternatives to Incarceration and is engaged in a similar effort underway in St. Maarten. In addition, Mr. Shifman has led numerous strategic planning, program design, and needs assessments for nongovernment organizations focused on HIV/AIDS treatment, child and adolescent services, support for women facing violence, substance abuse prevention and treatment, labor and training, and welfare and social services.