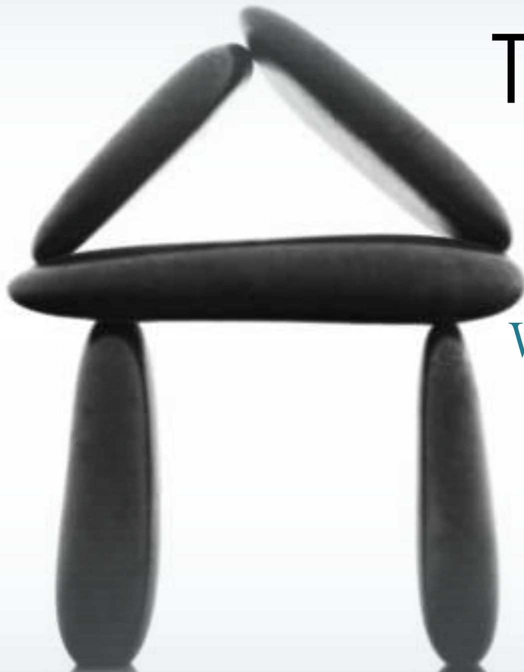
Parity: A Call to Action for Mental Health & Addiction Treatment Providers



Provider Impact Statement - The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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For more information:
Neal Shifman, President and CEO
Advocates for Human Potential, Inc.
(978) 443-0055
nshifman@ahpnet.com

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Prepared by:

Patrick Gauthier, Senior Consultant
Carol Bianco, Director of Mental Health
Neal Shifman, President and CEO

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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.

To inform the development of regulations governing the 2008 Parity Act, and assist both payers and providers in their response, Advocates for Human Potential (AHP), Inc., has produced a series of planning and implementation tools dedicated to Behavioral Health Parity. The following White Paper is the third in the series, and is dedicated to the addressing challenges and fulfilling opportunities that Parity will offer providers and their patients.

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 level of care guidelines. Most will require greater emphasis on diagnosis and many will require comprehensive case management.	Administrative personnel will require training in UM protocols if it is new for them. Staff will need to control authorization numbers to facilitate billing, and understand how to collaborate efficiently with UM professionals. Common UM tools and phone numbers should be accessible.	The UM process may be expanded significantly for some providers and practices. The process should be efficient, involve as few steps as possible, 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.	UM is supported best by phone contact, fax, and secure Internet access to plans and UM departments. Also helpful are decision support tools and support 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	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	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	Electronic billing requires HIPAA-compliant billing software as is common in a practice management system. HIPAA requires electronic data

	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.	authorization codes to a greater degree than providers use today.	accurate billing practices in advance of parity. Electronic billing processes are highly encouraged.	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 remain in treatment.	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 considerably by instituting new processes designed to keep people engaged and compliant with treatment.	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 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.

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	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	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

	as person-centered planning and shared decision-making.	consultants and refer to your trade group or association for guidance. Specialized TA is available.		field.
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	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	At a process level, estimating staffing needs with a business plan and managing human resource/personnel processes will allow	Meeting human resource needs can be facilitated by technology. Web-based recruiting tools and services attract candidates and human

	Policy	People	Process	Technology
	as expansions into new markets and services for new populations. Parity will affect decisions about necessary qualifications, recruiting, hiring, training, and retention.	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.	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.	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 with peers, and meeting with local plans' provider relations staffs.	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 making projections is also an important step in the process.	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 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	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	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	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

	Policy	People	Process	Technology
	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.	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.	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.	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

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.

Patrick Gauthier works with AHP's eHealth and Organizational Development practice. He specializes in business process and workflow management, and has served in a variety of leadership positions in the healthcare, mental health, insurance, consulting, governmental, and nonprofit fields, as well as consulting with healthcare clients throughout the country. His expertise in operations is related to quality improvement, health utilization management, technology adoption, building healthcare provider 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.

490-B Boston Post Road
Sudbury, MA 01776-3365
Phone: 978.443.0055
Fax: 978.443.4722
www.ahpnet.com
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