AHP HEALTHCARE SOLUTIONS

Health and Behavioral Health Consulting

Special Report: MHPAEA Regulations

Preliminary Operational Analysis of the Mental Health Parity and Addiction Equity Act Interim Final Rule

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Introduction

This *Special Report* provides a preliminary analysis of the Mental Health Parity and Addiction Equity Act (MHPAEA) Interim Final Rule and regulations. Readers can expect regular updates to this *Report* based upon ongoing analysis, exchange of findings and opinions between experts, and material changes in understanding that arise from implementation. In addition, this document will be updated in response to any supplemental clarification provided by the Departments following the open comment period ending May 3rd 2010.

The *Report* is written for the benefit of diverse audiences including public and private health plans and insurers, payers, state and federal agencies, legislators, consumer advocates, mental health and substance use disorder providers, the medical community and business. In marked contrast to the highly polarized debate on health care reform currently in process, the MHPAEA was sponsored in a bi-partisan fashion and signed into law by then President George W. Bush. It evolved from more than a decade of earlier state and federal legislation and large-scale research, as well as impassioned advocacy, negotiation and compromise between stakeholders. The IFR ushers Parity into effect, and this *Report*, drawing upon the same spirit of cooperation and mutual interest that produced the law, aspires to make the implementation process more informed and effective for all who are involved.

The IFR addresses some, but not all of the tensions that have long existed between the financial stewards of healthcare resources and consumers and providers of services. Some payers express concern that the key elements of the IFR range far afield of expectations developed during MHPAEA negotiations, impinging on their capacity to control costs and requiring extensive data collection and complex financial calculations to ensure compliance. Ongoing consultation with experts in the field reveals the dissonant interests of key stakeholders and underscores the complexity and confusion inherent in the legislative process, public policy, health insurance, and health care. At the heart of much of the confusion lies what is involved in “scope of services”.

Scope of Services
Questions linger on all sides of the equation concerning the actual scope of the IFR; the boundaries between State and Federal regulations and plan/issuer policies, and the degree to which further regulatory guidance will resolve ambiguous elements of the IFR. Some of the views and interpretations of the IFR include:

- Consumers and providers who would prefer that the IFR offer greater specific protections with respect to scope of services and continuum of care. They are eager to know that more – not fewer – conditions will be covered and that a comprehensive continuum of care (types of services and providers) will be allowable.

- Some plans and issuers operating in states where comprehensive or partial parity benefits are mandated are taking a “business as usual” stance. These plans and issuers have grown accustomed to many of the rigors embodied in the IFR, expect few challenges and report little in the way of change ahead.

- Similarly, health plans and issuers with vast resources and expertise will be able to comply with classification of benefits, financial limitations and non-quantitative treatment limitations (NQTL), as well as other aspects of the IFR. They can readily envision how it is that they will define MH and/or SUD conditions – perhaps covering 7 or 8 of the most serious diagnoses – and have clear ideas what services levels and types of providers they will cover. They believe they can readily modify their medical management and other NQTL practices without controversy. Perhaps their biggest hurdle, however temporary, will be the elimination of separate but equal deductibles.

- Some experts call for a broad interpretation of the scope of services provisions, arguing that they include most if not all conditions, services and providers These experts believe that the IFR's provisions establish that most if not all services delivered in a qualified facility constitute Inpatient services; all services delivered on an ambulatory basis constitute Outpatient services; that MH and SUD conditions are to be defined by the entirety of the DSM-IV and/or the ICD-9; and that all qualified providers of services within each of the IFR's six classifications are entitled to participate as contracted providers in plan networks, bill for services rendered and receive compensation.

- Other experts read and interpret the IFR more literally and expect that the actual definition of the scope of services – beyond the IFR's classification of benefits, financial limits and NQTLs - is at the sole discretion of plans according to state laws and regulations. They would argue that what constitutes covered conditions, services and providers – the prerequisites for processing and paying a claim - are theirs to define. This position is based on the fact that a diagnosis, CPT code and allowable provider are essential to benefits management.

Medical Necessity

The role and function of standards like medical necessity criteria and level of care guidelines as well as the practices employed by plans and issuers in the process of managing benefits has a tremendous bearing on scope of services experienced on a day-to-day basis by providers and plan participants. Readers can expect a wide variety of approaches to these aspects of benefit management.

- Some plans can align tools and practices rapidly while others will struggle to translate practices across disciplines and inter-organizational boundaries.
- Some stakeholders fully expect to apply rigorous medical model standards and practices to all medical, MH and SUD as well as surgical benefits;
- Others are planning to continue managing MH and SUD benefits with as much fidelity to their current practices as possible and believe they are at or close to the cutting-edge of best practices in behavioral health;
- Yet another stakeholder group is concerned that the medical guidelines and practices called for in the IFR will be too narrowly defined at the exclusion of many of the levels of care, types of services and types of providers that make up a contemporary continuum of care. This group points to the necessity for plans to build capacity to meet the needs of those with chronic conditions. This stakeholder group would expect, for instance, that people with serious and persistent mental illness, serious emotional disturbances or substance use disorders would be able to avail themselves of psycho-social supports and community-based wrap-around services, evidence-based practices that have clinical necessity and extend beyond narrow definitions of medically necessity that often are limited to the stabilization of an individual associated with an acute episode but not his or her longer term rehabilitation.

The decision-making process moving forward will continue to require attention to the merits of the competing views of key stakeholders.

The *Report* is organized to provide the reader with a detailed summary of the regulations; an in-depth review of the operational and strategic implications of the Interim Final Rule and regulations from the viewpoint of Plans, Payers and Providers; a review of the challenges and unanswered questions that remain as the MHPAEA is implemented; and the opportunities that are available to stakeholders in the field. The goal is to provide readers with the preliminary analysis necessary to determine their immediate next steps in their respective roles. Collectively, the team of authors that prepared this *Report* represents a wide range of expertise and experience in all domains of the health care and coverage arena. They have endeavored to provide suggestions that are objective, reliable and timely.

Highlights of Federal Parity Regulations

Background and Purpose of the Parity Regulations:

- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) became Public Law 110-343 in October 2008
- The MHPAEA prohibits group health plans that currently offer coverage for drug and alcohol addiction and mental illness from providing those benefits in a more restrictive way than other medical and surgical procedures covered by the plan
- The MHPAEA rule and accompanying guidance, issued by the Departments of Health and Human Services, Labor and Treasury (the Departments), is intended to provide greater clarity and guide implementation of the MHPAEA
- In addition to the specific language of the rule, the Departments released guidance including a preamble discussion that defines certain terms and explains how the rule was formulated; the rule also includes numerous specific examples of practices that would and would not meet the requirements of the MHPAEA statute and regulations
- The Departments state that they expect the MHPAEA to affect approximately:
  - 111 million participants in 446,400 ERISA-covered group health plans
  - 29 million participants in the estimated 20,300 public, non-federal employer group health plans sponsored by State and local governments
  - 460 health insurance issuers providing substance use disorder (SUD) or mental health (MH) benefits in the group health insurance market
  - 120 Managed Behavioral Healthcare Organizations (MBHOs) providing SUD or MH benefits to group health plans

Status of and Process for the MHPAEA Rule:

- The MHPAEA rule was published in the Federal Register Tuesday, February 2, 2010
- The rule was issued as "interim final"; this includes a 90-day public comment period which closes May 3rd; the Departments identify specific areas on which they would like public comment (listed below)
  Despite being issued as "interim final," Group health plans and issuers with plan years beginning on or after July 1, 2010 will be required to comply with the MHPAEA and accompanying regulations
- The rule does not address every area of the MHPAEA and the accompanying guidance makes clear that additional rules will be issued on specific topics; for example, while acknowledging that Medicaid managed care plans offering SUD or MH services must comply with the MHPAEA, the Departments state that this rule does not yet apply to those plans and that additional guidance will later be given by the Centers for Medicare and Medicaid Services (CMS)
- The citations for the MHPAEA regulations are:
  - 26 CFR Part 54 (Department of Treasury's Internal Revenue Service regulations)
  - 29 CFR Part 2590 (Department of Labor's Employee Benefits Security Administration regulations)
  - 45 CFR Part 146 (Department of Health and Human Services Center for Medicare and Medicaid Services regulatory code)

Discussion of the Intersection of State Laws with the MHPAEA:

- The regulations affirm that the MHPAEA does not preempt any State laws except those that would prevent the application of the MHPAEA
- The guidance states that the Departments have tried to "balance the States' interests in regulating health insurance issuers, and Congress's intent to provide uniform minimum protections to consumers in every State."
- The regulations also state that, "State insurance laws that are more stringent than the federal requirements are unlikely to 'prevent the application of the MHPAEA,' and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law."

Scope of Services/Categories of Care Not Defined by the Regulations:

- The regulations do not define a scope of services or continuum of care for SUD or MH benefits; the regulations state that group health plans can define which services are covered in MH and SUD benefit packages; those definitions must be consistent with "generally recognized independent standards of current medical practice" which include the Diagnostic and Statistical Manual of Mental Disorders, the International Classification of Diseases, and State guidelines
- The regulations do not define what constitutes inpatient, outpatient or emergency care but leave it up to health plans and State health insurance laws to define those terms; the regulations do require group health plans to apply these terms uniformly for medical/surgical benefits and SUD and/or MH benefits

Rule Defines How to Determine whether Financial Requirements and Treatment Limitations Imposed on SUD or MH Benefits Comply with the MHPAEA:

- The MHPAEA statute prohibits group health plans/health insurers offering SUD or MH benefits from applying financial requirements or treatment limitations to SUD or MH benefits that are more restrictive than the *predominant* financial requirements or treatment limitations applied to *substantially all* medical/surgical benefits
- The rule defines the terms "*predominant*" and "*substantially all*" and gives guidance about how to determine whether financial requirements and treatment limitations imposed on SUD or MH benefits comply with the MHPAEA

Classifications of Benefits are Defined; Parity Analysis Must Compare Financial Requirements/Treatment Limitations Imposed on SUD or MH Benefits with Same Type Imposed on Medical/Surgical Benefits in the Same Classification:

- The rule first identifies six categories of classification of benefits. These six classifications are:
  - Inpatient, in-network
  - Inpatient, out-of-network
  - Outpatient, in-network
  - Outpatient, out-of-network
  - Emergency care
  - Prescription drugs
- The rule specifies that, when examining whether SUD or MH benefits are being offered at parity with other medical/surgical benefits, a financial requirement or treatment limitation must be compared only to financial requirements or treatment limitations of the same type within the same classification
- This review must take place separately (i.e. copayments must be compared with copayments, annual visit limits with annual visit limits) within each above-listed classification
  - Example: The copayment amount charged for an outpatient session of care provided by an in-network SUD service provider must be compared with copayment amounts for sessions of outpatient care provided by other medical/surgical in-network providers
- The rule establishes standards to measure plan benefits so that medical/surgical benefits can be compared with SUD or MH benefits

Rule Discusses Financial Requirements and Treatment Limitations, Including Medical Management Tools, and How They Must Comply with the Parity Requirements:

- Financial requirements are defined as including deductibles, copayments, coinsurance and out-of-pocket maximums
- The rule makes the distinction between quantitative treatment limitations and non-quantitative treatment limitations
  - Quantitative treatment limitations include day or visit limits or frequency of treatment limits
  - Non-quantitative treatment limitations are medical management tools. The regulations include a non-exhaustive list of types of non-quantitative treatment limitations that includes:
    - Medical management standards
    - Prescription drug formulary design
    - Fail-first policies/step therapy protocols
    - Standards for provider admission to participate in a network

    - Determination of usual, customary and reasonable amounts
    - Conditioning benefits on completion of a course of treatment
- The regulations state that group health plans offering benefits for an SU or MH condition or disorder must provide those benefits in each classification for which any medical/surgical benefits are provided; if the plan provides medical/surgical benefits in one of the classifications but does not provide SUD or MH benefits in that classification, that would constitute a treatment limitation
- The regulations state that the processes, strategies, evidentiary standards and other factors used to apply non-quantitative treatment limitations to SUD or MH benefits in a classification have to be comparable to and applied no more stringently than the processes, strategies, evidentiary standards and other factors used to apply to medical/surgical benefits in the same classification. The regulations acknowledge that there may be different clinical standards used in making these determinations.

Discussion of Implications of the MHPAEA on Employee Assistance Programs (EAP):

- The regulations acknowledge that the Departments received a number of questions about whether the MHPAEA requirements apply to the practice of requiring an individual, in order to access his/her MH or SUD benefits, to first exhaust a set number of MH or SUD counseling sessions offered through an employee assistance program (EAP)
- The regulations state that, generally, an EAP providing MH or SUD counseling services in addition to the MH or SUD benefits offered by a major medical program that otherwise complies with parity would not violate the MHPAEA requirements
- However, the regulations also explicitly state that "requiring participants to exhaust the EAP benefits—making the EAP a gatekeeper—before an individual is eligible for the program's MH or SUD benefits would be considered to be a non-quantitative treatment limitation" that would be subject to the above-discussed parity analysis to determine compliance with the MHPAEA
- The regulations further state that if other gatekeeping processes with similar exhaustion requirements, whether offered through an EAP or not, are not applied to medical/surgical benefits, the exhaustion requirement related to EAPs would violate the rule that non-quantitative treatment limitations be applied comparably and not more stringently to MH and SUD benefits

Rule Defines a "Predominant" Financial Requirement or Treatment Limitation for Purposes of Parity Analysis:

- The rule states that a financial requirement or treatment limitation is predominant if it is the most common or frequent of a type of limit or requirement
- A predominant level (amount) of a type of financial requirement or quantitative treatment limitation is defined as the level that applies to more than one-half of the medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in that classification
- If there is no one level that applies to more than one-half of the medical/surgical benefits that are subject to financial requirements or quantitative treatment limitations in a certain classification, the regulations provide guidance about how this should be determined

Rule Defines What Constitutes "Substantially All" Medical/Surgical Benefits for Purposes of Parity Analysis:

- The rule states that when a financial requirement or quantitative treatment limitation on a medical/surgical benefit applies to at least two-thirds of the benefits in that classification, this is considered to be "substantially all" of those benefits. For example, if a coinsurance requirement of 20% applies to at least two-thirds of the medical/surgical benefits in a classification, the same 20% coinsurance must be applied to SUD or MH benefits in that classification.

Additional Regulatory Provisions Aimed at Providing Parity for SUD and MH Benefits:

- The regulations restate the MHPAEA requirement that, for group health plans/issuers that offer SUD or MH benefits, where out-of-network benefits are provided for medical/surgical benefits they must also be provided for SUD and MH benefits
- The regulations prohibit separate cost-sharing requirements or treatment limitations that apply only to SUD or MH benefits
- The regulations provide guidance on the two MHPAEA disclosure provisions requiring:
    - Criteria for medical necessity determinations for SUD or MH benefits be made available to participants and beneficiaries, and

  - Reasons for denial of reimbursement or payment for SUD or MH services be made available to participants and beneficiaries
- The preamble to the rule acknowledges that some group health plans have lower co-payments for primary care providers than for specialists and that often SUD and MH providers are defined as specialists; the Departments chose not to create distinct classifications for generalists vs. specialists relying instead on the calculation of "substantially all" and "predominant" to determine co-pay or coinsurance.
- The guidance prohibits insurers from setting up separate plans or benefit packages to try to avoid complying with the MHPAEA requirements; the guidance states that separately administered benefit packages should be considered as a single plan
- The rule prohibits plans from applying cumulative financial requirements (such as deductibles) or cumulative quantitative treatment limitations for SUD or MH benefits in a classification that accumulates separately from any cumulative financial requirements or cumulative quantitative treatment limitations established for medical/surgical benefits in the same classification

Application of the Parity Requirements to Prescription Drugs:

- The regulations state that the MHPAEA parity requirements apply to prescription drug benefits
- To determine whether a group health plan/issuer is imposing improper financial requirements on certain drugs prescribed for SUD or MH conditions, the regulations state that financial requirements imposed on drugs prescribed for the treatment of an SUD or MH condition must be compared with those imposed on other prescription drugs in the same tier in which the prescription drug is classified
- The regulations state that if a plan imposes different levels of financial requirements on different tiers of prescription drugs based on "reasonable factors" and without regard to whether a drug is generally prescribed for medical/surgical benefits or SUD or MH benefits, the parity requirement is satisfied

Areas Identified as Subject to Future Regulatory Action:

- The regulations acknowledge that Medicaid managed care plans offering SUD or MH services must comply with the MHPAEA, however, additional guidance will be given by the Centers for Medicare and Medicaid Services (CMS)
- The regulations state that additional guidance will be issued "in the near future" concerning the provisions that allow group health plans that experience certain increased costs to be exempt from the MHPAEA requirements

Solicitation for Public Comments:

- In addition to seeking general comments in response to the MHPAEA regulations, the Departments identify a number of areas where they would like public comment including:
  - Additional examples of non-quantitative treatment limitations and how the parity analysis would be applied to these medical management tools
  - Whether and how the MHPAEA addresses the issue of scope of services/continuum of care
  - Which clarifications would help to ensure compliance with disclosure requirements for medical necessity criteria and denials of SUD or MH benefits
- The 90-day public comment period closes on May 3, 2010

Operational Considerations and Implications of the Interim Final Rules

This *Report* has identified fourteen (14) aspects of the Interim Final Rule (IFR) as most significant to the stakeholder community and explored each from the practical standpoint of health plans, payers and providers of mental health and substance use disorder treatment. Each table in this section begins with a brief selection of regulatory language from the IFR and follows it with comments from our experts and a discussion of the tactical and practical implications for each of the two stakeholders primarily responsible for or impacted by the regulations.

In general, the IFR has an immediate impact on American health insurers, managed care organizations, managed behavioral health organizations, third-party administrators and self-insured employer plan-sponsors. While the IFR does not directly apply to Medicaid managed care plans, additional regulatory guidance is forthcoming on how these plans should comply with the MHPAEA. There are others, such as pharmacy benefit managers, utilization management, disease management and case management outsource firms that will be affected as well. In essence, the MHPAEA constitutes insurance reform, therefore, the following sections will underscore that the first and foremost responsibility for implementation falls on those who insure and manage benefits. The impacts on providers are secondary only in terms of timing. Providers of MH and SUD treatment will need to adapt to the conditions created by insurers and those who manage benefits. For the reader's convenience, a summary of actions steps that plans, payers and providers may want to consider appears below. A more detailed exploration of some of the operational implications of the IFR appears in the tables that follow.

Plan and Payer	Provider
1. Conduct strategic planning and assess availability of resources and expertise for change effort. Allocate sufficient resources. 2. Collect data and conduct cost analysis to determine how all existing policies and benefit designs will need to be revised for compliance with IFR 3. Modify deductibles, out-of-pocket maximums, co-pays and other coinsurance accordingly 4. Review care and medical management practices 5. Define scope of services in alignment with State law subject to any additional direction from the Departments 6. Review network of providers. 7. Review prescription drug formulary design for compliance 8. Conduct underwriting analysis 9. Conduct information system reconfiguration analysis 10. Develop plan participant and provider communications strategy including amendment of Plan documents, certificates of insurance, and summary plan descriptions (SPDs) 11. Modify all affected agreements and contracts with vendors, suppliers, agents, and customers	1. Conduct strategic planning and assess market conditions, existing network contracts, and resources required for compliance with IFR's impacts on care management and billing as well as expansion into new payer markets and geographic or service areas 2. Assess credentials, certifications and accreditation requirements 3. Convene meetings where possible with plans, payers and provider relations personnel 4. Position services relative to classification of benefits and scope of services with State definitions in full view 5. Apply for in-network status where appropriate 6. Negotiate Usual, Customary and Reasonable reimbursement 7. Assess and evaluate business processes, workflow, forms, information systems and staff capabilities 8. Assess and modify care management capabilities in order to comply with new plan/payer medical management standards and guidelines including the ability to document and communicate diagnosis, treatment plans, referrals and care coordination, progress notes and discharge plans 9. Assess and modify billing procedures and systems to optimize electronic billing

Table 1: Effective Date

"These interim final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010"

Comments

- Plans that already made their best faith effort to comply effective January 1, 2010 can continue as-is through the end of year or can make mid-year corrections. Insured plans will need to make amendments within their State, filing new plans with their Department of Insurance that come into greater alignment with these regulations. Plans that begin anytime after July 1, 2010 will need to abide by these regulations immediately.
- The window of opportunity for compliance has only recently opened with the release of the regulations. Individual plans and payers have between 6 and 17 months to reconfigure plan policies, processes and systems, depending on the type of plan and its effective date. Some plans and payers may find that aspects of this effort are challenging in terms of systems change and adoption of new business processes. Whether a managed behavioral health carve-out is in effect or not, some plans may find that they require additional subject matter expertise and interim staffing.

Plan & Payer Implications	Provider Implications
1. Plans and payers need to consider both the strategic and near term implications of full implementation 2. Plans are encouraged to make as much progress as possible toward implementation within this first year; fines for non-compliance are prohibitively expensive at $100 /member/day 3. Plans concerned about medical management and professional standards should seek the advice of experts 4. Plans should communicate implementation plans as soon as possible with members and providers. Facilitating communication early among differing provider types (mental health, medical, pharmacy) and functions (administrative vs. clinical) overcomes resistance and builds necessary collaboration. 5. Plans should consider how they will develop organizational leadership capacity for full deployment.	1. Participating providers can expect that claiming will require keeping pace with plans and payers in terms of acceptable code sets and electronic data interchange (EDI). Additionally, medical and utilization management processes are subject to considerable change depending upon the current practices of plan partners so providers will find it beneficial to keep track of operational changes. 2. Providers seeking to join networks will want to take this opportunity to update their credentials, understand how Usual, Customary and Reasonable rates are determined locally, contact plans and payers and request applications.

Table 2: Addition of Substance Use Disorders (SUD)

"Among the changes enacted by MHPAEA is an expansion of the parity requirements for aggregate lifetime and annual dollar limits to include protections for substance use disorder benefits. Prior law specifically excluded substance abuse or chemical dependency benefits from those requirements. Consequently, these regulations amend the meanings of medical/surgical benefits and mental health benefits (and add a definition for substance use disorder benefits). Mental health benefits and substance use disorder benefits are benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. These regulations further provide that the plan terms defining whether the benefits are mental health or substance use disorder benefits must be consistent with generally recognized independent standards of current medical practice.
This requirement is included to ensure that a plan does not misclassify a benefit in order to avoid complying with the parity requirements."

Comments

- This language expands the former working definition of parity to include substance use disorders (SUD). Because SUD conditions and treatment are not well understood by many non-clinicians, plans are urged to consult with experts. Doing so will help avoid plan design decisions that may prove more costly in terms of medical cost-offset in

the long-term. There is certainly ample scientific evidence confirming that SUDs are in fact diagnosable and treatable conditions. SUD treatment is not prohibitively expensive if and when it is appropriate to the needs of the individual.

- Plans will also need to review relevant State law in order to accurately define benefits.

Plan & Payer Implications	Provider Implications
1. Plans are encouraged to consult with experts in order to more fully understand the current medical practice where SUD is concerned. ASAM Certified Addictionologists (physicians with specialized training) can be especially helpful in this regard and in the case of co-occurring disorders. 2. Plans are encouraged to meet with their State's agency or department dedicated to mental health and/or alcohol and drug abuse/substance abuse in order to understand how the public sector has managed best practices, services, and providers in the recent past. These agencies can be very helpful in building the capacity to treat SUD. 3. Plans can review State law regarding benefits for SUD as a function of their overall compliance effort.	1. Non-participating SUD treatment providers are encouraged to update their credentials and contact local plans and payers in order to become familiar with their expectations and to review service offerings. 2. SUD providers are encouraged to re-examine notions of usual, customary and reasonable (UCR) with revenue management experts and to enter into network contracting where advantageous. 3. Providers can benefit by collaborating and integrating with mental health and primary care wherever feasible. 4. SUD providers – particularly those whose business interests have largely been tied to public sector funding – are encouraged to implement practice management and billing systems capable of electronic data interchange (EDI) at the earliest possible opportunity.

Table 3: Generally Recognized Independent Standards of Current Medical Practice

"The word "generally" in the requirement "to be consistent with generally recognized independent standards of current medical practice" is not meant to imply that the standard must be a national standard; it simply means that a standard must be generally accepted in the relevant medical community. There are many different sources that would meet this requirement. For example, a plan may follow the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Diseases (ICD), or a State guideline. All of these would be considered acceptable resources to determine whether benefits for a particular condition are classified as medical/surgical, mental health, or substance use disorder benefits."

Comments

- Plans and payers are at liberty to make these kinds of determinations locally with the understanding that their plan policies will be consistent with *generally recognized independent standards of current medical practice.* Plans and payers may instinctively gravitate to the American Medical Association (AMA) and the American Psychiatric Association as resources. Plans, payers and employers are encouraged to seek broader input from various MH and SUD organizations and experts prior to finalizing standards. Selecting a set of standards that excludes MH and SUD services may produce undesirable medical cost offsets.
- Many providers – particularly new entrants - will find that certain specific credentialing and accreditation standards will be enforced in the commercial health plan sector and that their participation in this market will require strengthening credentials and capabilities.
- HHS/SAMHSA can provide direction to further the cause of national standards for the treatment of MH and SUD by preparing employer-friendly materials describing best practices and standards.

Plan & Payer Implications	Provider Implications
1. Plans must decide which MH and SUD conditions they will cover. 2. Plans will need to assess and evaluate their various non-quantitative medical management tools to assure alignment with recognized standards. Many plans and payers – relatively new	1. *"Accepted in the relevant medical community"* language can be both a positive development and a potential roadblock for some SUD providers in particular. The field will need to advocate for the inclusion of their own relevant standards in discussions with commercial and employer based plans though some providers will need

to expanded behavioral health coverage – may not be equipped and others may have relied on their EAP to serve as a gatekeeper, an arrangement that is no longer permitted. 3. Fully considering the pros and cons of buying or building such capacity is probably in the best interest of many plans at this juncture.	to accept that certain credentials and accreditations must apply in the commercial sector. Some providers will be faced with difficult business decisions regarding whether to pursue specific credentials and accreditation. 2. Providers are urged to familiarize plans and payers with their treatment, services, methodologies and tools. Many times, the underpinnings of effective MH and SUD treatment are better known to the community behavioral health sector and need to be shared openly with payers who may be less familiar with standards such as ASAM Patient Placement Criteria or the importance of Child Psychiatrists in the treatment of Serious Emotional Disturbance (SED).

Table 4: Non-Quantitative Treatment Limitations

"These regulations provide that the parity requirements in the statute apply to both quantitative and non-quantitative treatment limitations. A quantitative treatment limitation is a limitation that is expressed numerically, such as an annual limit of 50 outpatient visits. A non-quantitative treatment limitation is a limitation that is not expressed numerically, but otherwise limits the scope or duration of benefits for treatment…Such non-quantitative provisions are also treatment limitations affecting the scope or duration of benefits under the plan. These regulations provide an illustrative list of non-quantitative treatment limitations, including:

- *medical management standards;*
- *prescription drug formulary design;*
- *standards for provider admission to participate in a network;*
- *determination of usual, customary, and reasonable amounts;*
- *requirements for using lower-cost therapies before the plan will cover more expensive therapies (also known as fail-first policies or step therapy protocols);*
- *conditioning benefits on completion of a course of treatment...*

…The phrase, "applied no more stringently" was included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face are applied in the same manner to medical/surgical benefits and to mental health or substance use disorder benefits… A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation"

Comments

- The regulations devote a considerable amount of attention to non-quantitative limitations in order to assure that plans and payers do not arbitrarily limit MH and SUD benefits. The regulations identify six general categories of such restrictions and state that practices in each of the six categories cannot be any more stringent where MH and SUD are concerned than they are for medical and surgical concerns.
- The definition of non-quantitative treatment limitations impacts health plan operations across the board and will require considerable review, planning, design and implementation. The appearance of this language is somewhat surprising to plans and issuers who believed they had negotiated greater autonomy in the management of behavioral health benefits.
- A review of what constitutes Usual, Customary and Reasonable (UCR) may prove to be very beneficial to some providers and facilities though it may require developing expertise in this area.
- To the extent that plan members can be admitted directly to the level of care they require, plan members and providers will require education concerning a plan's medical management processes and continuity of care while level of care guidelines will become very important to both providers and payers. Plan members who have grown accustomed to requirements that they utilize EAP benefits first, for instance, will require some communication and clarification as a result of this change.
- Some plans and issuers – particularly those with less experience managing MH and SUD benefits on a parity basis - may be inclined to gravitate toward strictly medical definitions and standards in determining medical management standards and processes. This approach may prove to be short-sighted as it overlooks the fact that successful

resolution of many MH and SUD conditions requires a thoughtful blend of medical stabilization and clinical attention to the behavioral aspects of the condition being treated. The inclination to cover only those services that are strictly medically necessary and exclude clinical services and treatments that modify a plan member's behavior can result in the frustrating and expensive "revolving door" outside the emergency room.

- Mental health disorders and related unhealthy behaviors are commonly co-morbid with medical conditions and can hinder treatment compliance for chronic conditions such as diabetes, obesity, and heart disease. Successful and cost-effective treatment for such conditions requires individual behavioral modification that may be difficult to achieve without concurrent treatment of co-occurring MH/SUD conditions. For example, for a plan subscriber with Cardio-Pulmonary Disease, behavior modification that addresses underlying anxiety and supports smoking cessation may be as important as respiratory therapy. Tightly limiting scope of service may produce unintended consequences as untreated behavioral health disorders manifest in medical cost-offset in more expensive and intensive settings. The distinction between what is "clinical" and "medical" necessity can become the source for contention and debate; appeals and grievances should be considered carefully as medical management criteria must be disclosed upon request.
- One segment of the rule reminds consumers and providers to appreciate that all people and circumstances are unique and that some medical management decisions – while not agreeable to the consumer or provider – will be in accord with medical guidelines and hence in compliance with regulations. Disagreement and adverse determinations do not and will not always involve discriminatory practices.
- Regulatory oversight, in light of the remaining ambiguity and subjectivity, may prove difficult depending upon the State and any existing MH and/or SUD coverage mandates.
- The last statement in the section above - *A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation* – provides very clear direction that plans and payers can exercise their discretion when establishing their list of covered conditions and disorders.
- Some plans may be better able to assure themselves of consistency and alignment by in-sourcing or carving-in some of the medical management processes performed by MBHOs though this determination should be evaluated very carefully with vendors. Plans and payers will want to enlist the guidance of experts in reviewing and evaluating their various practices and standards and may want to explore the adoption of more contemporary or comprehensive tools.

Plan & Payer Implications	Provider Implications
1. Payers are encouraged to take advantage of the opportunity to comment on non-quantitative treatment limitations as they relate to plan design. 2. Health plans and payers should consider evaluating the non-quantitative treatment limitation practices of their MBHO carve-out vendors in all of the six "classifications of benefits" to ensure they are no more stringent than the plan's practices for medical benefits. 3. The review of MH and SUD conditions, providers and coverage may have a direct impact on staffing levels and types of staff 4. Modifications to Medical Management practices must be reflected in technology and systems 5. Plans and their PBM administrators need to evaluate the equity and parity of formulary design and make adjustments accordingly. Changes need to be reflected in everything from underwriting to marketing and claims reporting. 6. Plans are strongly encouraged to open networks and re-examine standards for credentials and accreditation. Plans and payers should meet with State agencies and community behavioral health (MH and SUD) providers in order to discover the value they can deliver in the treatment of Serious Mental Illness and SUD. The vast majority of treatment for the seriously mentally ill and children suffering from Serious Emotional Disturbance has thus far been delivered by community or public providers. While standards and criteria	1. Providers are encouraged to take advantage of the opportunity to comment on the non-quantitative treatment limitations as they relate to their professional standards and the medical necessity of their services 2. Providers are urged to familiarize plans and payers with their treatment, services, methodologies and tools. 3. Providers are encouraged to carefully evaluate the risks and rewards of joining local and regional networks. 4. Prepare for Utilization Management and develop streamlined processes and forms to accelerate turn-around time 5. Consider developing the capacity to serve children and families, co-morbid medical conditions, co-locating with primary care and joining a local Patient-Centered Medical Home initiative 6. Obtain adequate revenue management expertise in order to effectively negotiate and set rates with payers and plans and develop the capabilities and systems to submit EDI-compliant billings to multiple payers

they utilize may be a departure from the norm for some plans, their experience and expertise in the efficient treatment of MH and SUDs can be an invaluable resource. 7. Meet with non-traditional providers as well as existing providers to openly review UCR. Plan sponsors should review rate-setting with their third-party administrators; insurance issuers should review rate-setting with Compliance and Finance Changes need to be reflected in underwriting, contracts, and claims processing systems. 8. Review Medical Management practices for the application of "Fail-First" or Step Therapy protocols as well as references to making coverage contingent upon completion of a course of treatment and contrast each against its medical counterpart. Make changes in policy, process and systems accordingly. Make any remaining plan certificate or SPD modifications accordingly. 9. Plan sponsors typically rely on their plan administrator to perform medical management practices such as determining UCR and crafting provider networks, designing formularies, etc. As such, plan sponsors may wish to include new language in contracts with TPAs requiring mental health parity compliance with regard to all medical management practices performed by the administrator.	

Table 5: Classification of Benefits

"Classification of benefits. Paragraph (c)(1) cross-references the term "classification of benefits" in paragraph (c)(2)(ii). Paragraph (c)(2)(ii) describes the six benefit classifications and their application, which are discussed later in this preamble. These regulations provide that the parity requirements for financial requirements and treatment limitations are applied on a classification-by-classification basis…These regulations specify, in paragraph (c)(2)(ii), six classifications of benefits: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs…… If a plan does not have a network of providers for inpatient or outpatient benefits, all benefits in the classification are characterized as out-of network… … If a plan provides benefits for a mental health condition or substance use disorder in one or more classifications but excludes benefits for that condition or disorder in a classification (such as outpatient, in-network) in which it provides medical/surgical benefits, the exclusion of benefits in that classification for a mental health condition or substance use disorder otherwise covered under the plan is a treatment limitation. It is a limit, at a minimum, on the type of setting or context in which treatment is offered… … These regulations do not define inpatient, outpatient, or emergency care. These terms are subject to plan design and their meanings may differ from plan to plan. Additionally, State health insurance laws may define these terms. A plan must apply these terms uniformly for both medical/surgical benefits and mental health or substance use disorder benefits. However, the manner in which they apply may differ from plan to plan…"

Comments

- This section of the preamble attempts to assure parity between medical and MH/SUD benefits across different classifications of benefits. It ensures, for example, that inpatient medical co-pays or limits are not imposed on outpatient mental health services. Unfortunately, the notable absence of definition around scope of services will complicate matters for health plan managers.
- This and other sections of the IFR complicate matters for plans and issuers who made a good faith effort prior to the start of the most recent plan year (as of the effective date of the law). Their plan designs and corresponding systems infrastructure may require modifications in order to comply.
- Managed Behavioral Health Organizations (MBHOs) will be required to modify plans and business rules in their systems accordingly, normalizing plan designs with their health plan counterparts.
- MH and SUD providers may find that the resulting variability in benefits is overwhelming to keep track of and to integrate with their practice management and billing systems. The potential for complexity will require greater expertise in revenue management and greater capability in terms of billing.
- Leaving the precise definition of classification of benefits to States and plans may result in complexity for providers and plan members. For instance, two people residing in two states suffering from the same acuity of an identical

disorder or diagnosis may have benefits approved for very different types of treatment services despite what evidence based practices would recommend. This section of the IFR, for example, enables plans to define Inpatient only in such a way as to cover medically-necessary stays in a JCAHO accredited facility for conditions that could have more efficiently and effectively been treated in a residential treatment facility. Practically-speaking, the cost of 5 nights of detoxification for SUD – while presumably medically-necessary - may be greater than a 30-day residential treatment program or 90-day sober living/day treatment program and no more effective in managing the addiction that produced the need for treatment. Plans and issuers may find it advantageous to review the definitions of these classifications with behavioral health experts and consider their options closely.

- The regulations do not define how treatment services that are not easily categorized according to the six classifications of benefits should be addressed. For the sake of discussion, the preamble describes Inpatient as a classification that can cover facility services received after midnight. While that establishes Inpatient benefits for Inpatient services, the "partial hospitalization" level of treatment would not qualify any longer nor would it meet generally accepted standards for Outpatient unless a plan/issuer knew to include it in its policy and benefit design. The same can be said of one of the most effective treatments for SUD, Intensive Outpatient Programs. If plans and issuers do not carefully consider their plan design in light of services that do not fit neatly in a medical model, they may inadvertently disqualify them, costing themselves more in the long-run.

Plan & Payer Implications	Provider Implications
1. Whereas many MH/SUD benefits in the past have been relatively simple to administer, plan and system configuration, medical management, and day-to-day claiming/processing will—for the foreseeable future—involve more complexity. 2. Some plans are capable of clearly stating what is covered and what is not but many will require direction. Plans are advised to consider that the medical cost-off-set that results from a too-narrow definition of coverage is not in their best interest, and are encouraged to seek guidance in defining classifications of benefits for MH/SUD conditions and services. 3. Plans are also urged to meet and discuss openly the classification of benefits related to the care of Serious and Persistent Mental Illness (SPMI), SED and SUD with the experts that have long been responsible for those services. They can be found within the community of providers and within State agencies responsible for MH and SUD. This is an excellent opportunity to integrate, "braid" and "blend" providers, services and potentially the funding that exists for these chronic and complex conditions. Coverage for halfway housing is an example of a service at least one state has required in order to effectively support recovery.	1. Bearing in mind that a single health plan or employer can offer many different plan designs, providers should anticipate a great deal of complexity and should plan to make investments in revenue management and information systems that will allow them to navigate that complexity successfully. 2. Providers that can begin advocating for their services with the State Department of Insurance and local plans' Provider Relations staff/Medical Director are encouraged to do so. This language and this effort to normalize classifications of care will require openness and willingness in discussions between stakeholders. 3. Providers are similarly encouraged to explore horizontal and vertical alliances that deliver greater strength in terms of representation, operations and administration. Other providers may use this opportunity to entertain strategic joint ventures as well as mergers and acquisitions.

Table 6: Scope of Services (Continuum of Care)

"The Departments recognize that not all treatments or treatment settings for mental health conditions or substance use disorders correspond to those for medical/surgical conditions. These regulations do not address the scope of services issue. The Departments invite comments on whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage."

Comments

- The Departments acknowledge that they are not clarifying Scope of Services at this point in time, leaving decisions surrounding service types, levels and definitions to plans and states. The additional comment period allows time for questions and comments though any clarification could lead to time constraints and communication issues for plans and payers in coming months.
- Smaller regional and local plans as well as some ERISA groups may find it difficult to establish and define scope of

services specific to covered conditions/diagnoses without recommendations from experts. Selecting a limited sample from a list of biologically-based disorders, for example, can lead some plans to omit some very important disorders and run the risk that those diagnoses will manifest in other forms of medical cost-offset. This is especially true in states without any mandated or parity in benefits.

- It is of primary importance to understand the difference of opinions related to scope of services and continuum of care. While stakeholders such as providers and consumers may seek greater specificity and clarity, plans and issuers seek more flexibility and autonomy in making decisions. There are and will be conflicting views related to scope of service.
- The coordination of care between medical and MH/SUD systems has been proven effective. However, restrictive plan designs may create unintended barriers to coordinated treatment, unnecessarily limiting the treatment of co-morbid conditions.
- Plans that are required to provide coverage for chronic and complex conditions like Serious and Persistent Mental Illness (SPMI) in adults and Serious Emotional Disturbance (SED) in children should consider collaborating with public sector experts in determining how best to efficiently serve these populations.
- It is critical that providers and plans/issuers take advantage of the open comment period in order to clarify their positions and expectations.

Plan & Payer Implications	Provider Implications
1. Plans and issuers may want to meet with experts in order to consider their options and develop comments regarding scope of services for the Departments. 2. It is important to review covered conditions (disorders, diagnoses) in light of the treatment services and providers that best meet the needs of plan participants. For example, Major Depression is a relatively pervasive condition that responds favorably to psychotherapy. Accordingly, the plan could include Masters and Doctoral level counselors who are trained to provide psychotherapy.	1. Providers are strongly urged to review their services with the State Department of Insurance and local plans and payers, advocating for inclusion at this critical point in time. 2. Providers are also encouraged to submit their comments to the Departments in a timely manner.

Table 7: Gatekeeper Role of EAP

"Requiring participants to exhaust the EAP benefits – making the EAP a gatekeeper –before an individual is eligible for the major medical program's mental health or substance use disorder benefits is a non-quantitative treatment limitation subject to the parity requirements. Consequently, if similar gatekeeping processes with a similar exhaustion requirement (whether or not through the EAP) are not applied to medical/surgical benefits, the requirement to exhaust mental health or substance use disorder benefits available under the EAP would violate the rule that non-quantitative treatment limitations be applied comparably and not more stringently to mental health and substance use disorder benefits."

Comments

- Plans and payers (employers and MBHOs included) cannot use an EAP as the gatekeeper to MH/SUD benefits since the EAP does not serve in that capacity for medical and surgical conditions. An EAP may still provide such benefits, which often supplement those available through the health plan; it is only the gatekeeping function that will need to be eliminated.
- This rule will be a challenge for EAP vendors, many of which have evolved to serve a gatekeeping function. EAP benefit design, agreements, and scope of service will necessarily have to change and EAP vendors will wish to solidify their position as an important service for Human Resource and Personnel concerns – their original form and function. EAP plays a vital role in the identification and remediation of workplace concerns including violence in the workplace, conflict management, responding to substance abuse, and critical incident debriefing and related services. EAP also provides employees and their family members with important access to services that are non-clinical in nature yet have a direct and positive impact on morale, absenteeism, presenteeism and other workplace dynamics.
- EAPs have absorbed much of the costs related to people seeking basic outpatient counseling so underwriters will want to estimate the impact in health plan utilization as a result of this change. It may also be possible to incentivize employees to continue using EAP benefits first. For example, if employees have access to three free counseling sessions through the EAP, they may still choose to utilize those benefits before turning to the health plan, which likely

imposes cost-sharing requirements and requires medical necessity.

- The largest MBHOs will recognize the opportunity this creates in the market. Small and regional standalone EAP vendors that rely on gatekeeper contracts have more risk and may need to consider consolidation or to explore mergers and acquisitions.

Plan & Payer Implications	Provider Implications
1. Plans and payers that use an EAP as a gatekeeper will need to address their agreements and either in-source that process or find a capable MBHO. This may prove to be a cost-savings opportunity for some plans and payers. 2. Plan documents, benefit summaries, and SPDs will likely need to be amended. 3. This change will require communication with plan members who will have grown accustomed to contacting their EAP for service authorization and referrals. Continuity of services will be important to maintain during any transitions. 4. Plans and payers are reminded that the EAP often provides a 24-hour hotline to screen, assess and refer callers. That important capability – handling crisis calls on weekends and after-hours - will need to be addressed if and when plans decide to in-source the gatekeeping function. MBHOs have this capability. 5. MBHOs will be required to align their medical management processes with those of the broader health plan as described earlier.	1. This may represent an operational change for some providers who have grown accustomed to seeking prior authorization and referrals from local and regional EAPs. 2. Providers will want to communicate directly with plan and payer provider relations and network administrators to better understand new processes.

Table 8: Scope of the Regulations

"Scope. Paragraph (e)(3) of these regulations provides that nothing in these regulations requires a plan or issuer to provide any mental health or substance use disorder benefits. Moreover, the provision of benefits for one or more mental health conditions or substance use disorders does not require the provision of benefits for any other condition or disorder."

Comments

- The MHPAEA does not mandate MH and SUD coverage. Plans and issuers can decline to provide any coverage. Public plans (City, County, State employee plans) are exempt from covering MH/SUD – like ERISA plans – if they choose to eliminate coverage altogether.
- This language also specifies that coverage for one condition (where many plans have identified 7-10 conditions and disorders they will cover) does not compel or commit plans to the coverage of any other disorders. This final point may become complicated as plans attempt to identify the appropriate mix of conditions and disorders to cover.

Plan & Payer Implications	Provider Implications
1. Plans and payers are encouraged to work closely with clinical experts and their State to adopt services and a continuum of care that is commensurate with the medical and clinical needs of their members and avoids cost-offsets. 2. The exception from the parity requirements for a plan that does not offer any MH or SUD benefits is still available and some employers may consider eliminating such benefits. However, it is possible to implement a streamlined approach to effectively managing benefits and costs. The consequences of such a decision will likely manifest in medical	1. As always, it will be critical that providers review eligibility at the point of patient registration in order to properly establish the coverage they have. The fact that a patient has health insurance does not guarantee that they have MH and SUD coverage nor does it assure coverage for all conditions and disorders (or for all treatment settings or recommended services that could be available to treat such conditions and disorders). 2. Providers are encouraged to consider electronic patient registration and eligibility verification processes and documentation/information management.

cost-offset as people with MH and SUD treatment needs seek care in more expensive settings for related co-morbid conditions. The elimination of MH and SUD benefits can be financially devastating to families and potentially very dangerous in terms of mortality. Therefore, employers may want to consider continuing to provide these benefits.	

Table 9: Single Plan

"The new combined rule in these regulations does not use the term benefit package. Instead, it provides that (1) the parity requirements apply to a group health plan offering both medical/surgical benefits and mental health or substance use disorder benefits, (2) the parity requirements apply separately with respect to each combination of medical/surgical coverage and mental health or substance use disorder coverage that any participant (or beneficiary) can simultaneously receive from an employer's or employee organization's arrangement or arrangements to provide medical care benefits, and (3) all such combinations constitute a single group health plan for purposes of the parity requirements. This new combined rule clearly prohibits what might have been formerly viewed as a potential evasion of the parity requirements by allocating mental health or substance use disorder benefits to a plan or benefit package without medical/surgical benefits (when medical/surgical benefits are also otherwise available)..

…Health insurance issuers. These regulations make a change regarding applicability with respect to health insurance issuers. Both the MHPA 1996 regulations and these regulations apply to an issuer offering health insurance coverage. The MHPA 1996 regulations provide that the health insurance coverage must be for both medical/surgical and mental health benefits in connection with a group health plan; the rule in these regulations provides that the health insurance coverage must be for mental health or substance use disorder benefits in connection with a group health plan subject to MHPAEA under paragraph (e)(1). Thus, under these regulations, an issuer offering health insurance coverage without any medical/surgical benefits is nonetheless subject to the parity requirements if it offers health insurance coverage with mental health or substance use disorder benefits in connection with a group health plan subject to the parity requirements. In addition, under these regulations, the parity requirements do not apply to an issuer offering health insurance coverage to a group health plan not subject to the parity requirements…

Comments

- The Departments have made this rule clear: all medical care benefits provided by an employer or employee organization constitute a single health plan. That health plan will need to comply with the full extent of the rules and regulations if MH and/or SUD benefits are provided.
- This rule speaks to the approach some employers were attempting which would have seen their MH/SUD carve-out treated as a distinct benefit, separate from the health plan and, therefore, not subject to the MHPAEA. Employers who have taken this approach will need to review and modify their plans accordingly as well as any agreements they may have in place with carve-out vendors.
- To clarify, the Departments included this helpful language in the regulations:
  For example, if an employer with a single benefit package for medical/surgical benefits also has a separately administered benefit package for mental health and substance use disorder benefits, the parity requirements apply to the combined benefit package and the combined benefit package is considered a single plan for purposes of the parity requirements.
  Similarly, if an employer offered three medical/surgical benefit packages, A, B, and C, and a mental health and substance use disorder benefit package, D, that could be combined with each of A, B , and C, then the parity requirements must be satisfied with respect to each of AD, BD, and CD. If the A benefit package had a standard option and a high option, A1 and A2, then the parity requirements would have to be satisfied with respect to each of A1D and A2D.

Plan & Payer Implications	Provider Implications
1. Employers who have assumed that a carve-out would obviate them from compliance will need to review and amend their plans and MBHO carve-out agreements accordingly. Implications of this change will reverberate through various functional areas. Plans, payers and issuers may want to seek external guidance and legal counsel. 2. As discussed above, plan sponsors may want to consider	This language has little to no effect on providers.

whether a carved out approach is advisable. Elimination of MH/SUD coverage often manifests in medical cost-offset as individuals with MH and SUD treatment needs seek care in more expensive settings for related co-morbid conditions. 3. Regional and local MBHOs may find it useful to review their capacity to deliver services in full compliance with the rules and regulations. Agreements may be modified around a different scope of services. Vendors may want to take this opportunity to develop strategic joint ventures with larger, more capable vendors.	

Table 10: Defining Mental Health and Substance Use Disorder Benefits

"Mental health benefits means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines)…(82 and 106)
…Substance use disorder benefits means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines)."

Comments

- Plans and issuers can exercise their discretion when defining the terms of benefits with respect to disorders and conditions. However, plans and issuers will need to do so in accordance with generally-recognized independent standards of current medical practice such as the most current version of the DSM, the most current version of the ICD, or State guidelines in order to establish and define their terms.
- The mention of the DSM is one of many departures from what plans and issuers expected in light of past negotiations related to passage of the MHPAEA, and has the potential to complicate matters. This language has been interpreted by some to mean that in order for a plan or issuer to define "any disorder…as *not being* a MH or SUD disorder" it must do so using the very standards that would define said disorder as a disorder.

Plan & Payer Implications	Provider Implications
1. Plans and payers should consult with experts and legal counsel in order to define their terms for benefits and coverage with regards to certain disorders and conditions. Most employers are not accustomed to requirements to consult external standards or state requirements when defining plan terms and benefit categories.	1. This language has no immediate bearing on providers except to the extent that it may be helpful to discuss the importance of covering certain conditions and disorders. 2. As discussed above, it will be very important for providers to understand that patients will present with a wide array of benefits and coverage and that information will need to be tracked carefully in practice management and billing systems.

Table 11: Disclosures

"MHPAEA includes two new disclosure provisions for group health plans (and health insurance coverage offered in connection with a group health plan). First, the criteria for medical necessity determinations made under a plan (or health insurance coverage) with respect to mental health or substance use disorder benefits must be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. These regulations repeat the statutory language without substantive change. The Departments invite

comments on what additional clarifications might be helpful to facilitate compliance with this disclosure requirement for medical necessity criteria…
… MHPAEA also provides that the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available, upon request or as otherwise required, by the plan administrator (or the health insurance issuer) to the participant or beneficiary in accordance with regulations. These regulations clarify that, in order for plans subject to ERISA (and health insurance coverage offered in connection with such plans) to satisfy this requirement, disclosures must be made in a form and manner consistent with the rules for group health plans in the ERISA claims procedure regulations, which provide (among other things) that such disclosures must be provided automatically and free of charge."

Comments

- This language clarifies that the criteria used for MH and SUD medical necessity determinations made under a plan must be made available to current and prospective plan participants and contracting providers upon request.
- This language also makes it clear that reasons for denial of reimbursement or payment of MH/SUD services must also be made available upon request. These disclosures must be made automatically and free of charge to the plan member making the request.

Plan & Payer Implications	Provider Implications
1. Plans and payers will want to review their standards for medical necessity determinations to ensure they have written policies specific to, or appropriate for, MH and SUD claims. They may want to consult with experts in order to independently validate their medical necessity guidelines and criteria. 2. Plans may be interested in evaluating options and alternatives or may require the help of experts in selecting appropriate tools such as decision-support systems, case management systems and – above all – level of care/medical necessity guidelines. It is important to align classification of benefits, covered conditions, types of service, and providers. 3. For payers, any changes to criteria and guidelines of this nature will be optimized by thorough implementation and training and will necessitate some reconfiguration of systems and business processes. 4. Plan sponsors that take an active role in the appeals process may want to use this opportunity to review their appeals process. For example, many employers seek independent medical review in connection with benefits that were denied for reasons related to medical necessity (as required by ERISA). Such employers may want to confirm that the providers or agencies with which they contract have sufficient expertise to assist with medical necessity determinations in connection with MH and SUD claims. 5. ERISA plans are already required to provide the reasons for a denial of benefits for any claim or appeal. Therefore, administrators for those plans will not likely have to make any changes to their current practices with regard to that requirement. 6. In connection with non-ERISA plans, denial codes and reasons may need to be documented and configured in information systems, and the process by which plans communicate denials (EOBs) will need to be assessed for compliance.	1. Providers may want to enhance their understanding of medical necessity guidelines and the manner in which they are applied in medical management. Experts – as well as plan provider relations staff - can provide clinical staff with training that streamlines processes. 2. Providers may want to request guidelines prior to beginning to serve patients in order to familiarize themselves and make any necessary business process changes, particularly those that will impact electronic data interchange (EDI) and systems configuration.

Table 12: Single Deductible

"Some cumulative financial requirements, such as deductibles and out-of-pocket maximums, involve a threshold amount that causes the amount of a plan payment to change. These regulations clarify that, for purposes of deductibles, the dollar amount of plan payments includes all payments with respect to claims that would be subject to the deductible if it had not been satisfied. For purposes of out-of-pocket maximums, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that were taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Other threshold requirements are treated similarly… These regulations provide, in paragraph (c)(3)(v), that a plan may not apply cumulative financial requirements (deductibles) or cumulative quantitative treatment limitations to mental health or substance use disorder benefits in a classification that accumulate separately from any such cumulative financial requirements or cumulative quantitative treatment limitations established for medical/surgical benefits in the same classification…

(i) …Some group health plans and health insurance issuers "carve-out" the administration and management of mental health and substance use disorder benefits to MBHOs. These entities obtain cost savings for plan sponsors by providing focused case management and directing care to a broad network of mental and behavioral health specialists (with whom they negotiate lower fees) who ensure that appropriate care for mental health conditions and substance use disorders is provided. When a group health plan or health insurance issuer uses a carve-out arrangement, at least two entities are involved in separately managing and administering medical/surgical and mental health and substance use disorder benefits. The imposition of a single deductible requires entities providing medical/surgical and mental health and substance use disorder benefits to develop and program a communication network often referred to as an "interface" or an "accumulator" that will allow them to exchange the data necessary to make timely and accurate determinations of when participants have incurred sufficient combined medical/surgical and mental health and substance use disorder expenses to satisfy the single deductible."

Comments

- The regulations unequivocally mandate a single, integrated deductible for medical/surgical, MH and SUD. If a plan has carved out MH and SUD benefits to an MBHO, a single deductible will likely require building new interfaces or accumulators between health plans and their MBHOs.
- This rule is not likely to create a significant burden on plans that currently provide medical/surgical and MH/SUD benefits through a single vendor, although they may need to revise current plan designs.
- Providers and their patients should find that a single deductible marks a significant shift towards simplicity.

Plan & Payer Implications	Provider Implications
1. Plans and payers will need to work together to compile data, perform the necessary calculations to assess the predominant level of substantially all medical benefits within each classification, and apply the result to determine how MH/SUD benefits may need to be revised. This process will probably need to be repeated annually, depending on plan design. 2. Plan document, policies, contracts, certificates, summary plan descriptions and other member communications will need to be amended. 3. In addition to changes in plan design, these regulations will have impacts across underwriting, marketing, member communications, customer service and claims processing.	1. Providers will need to understand the changes to the benefits and coverage applicable to their existing caseload and – if they collect patient cost-sharing at the time of the visit - modify patient insurance information and front-desk processes accordingly.

Table 13: Defining "Predominant" and "Substantially All"

"The first step of these regulations in applying the general parity requirement of MHPAEA is to determine whether a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification. Regulations issued under MHPA 1996 interpreted the term "substantially all" to mean at least two-thirds (2/3). Under these regulations, a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in that classification…

… If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of the medical surgical benefits in a classification, that type of requirement or limitation cannot be applied to mental health or substance use disorder

benefits in that classification. If a single level of a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of medical/surgical benefits in a classification, then it is also the predominant level and that is the end of the analysis. However, if the financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification but has multiple levels and no single level applies to at least two-thirds of all medical/surgical benefits in the classification, then additional analysis is required. In such a case, the next step is to determine which level of the financial requirement or quantitative treatment limitation is considered predominant…

… Under these regulations, the predominant level of a type of financial requirement or quantitative treatment limitation is the level that applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in that classification. If a single level of a type of financial requirement or quantitative treatment limitation applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in a classification (based on plan costs, as discussed earlier in this preamble), the plan may not apply that particular financial requirement or quantitative treatment limitation to mental health or substance use disorder benefits at a level that is more restrictive than the level that has been determined to be predominant

If a plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

If a plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either—

(ii) Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or

(iii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. (For cumulative limits other than aggregate lifetime or annual dollar limits, see paragraph (c)(3)(v) of this section prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.)"

Comments

- The regulations unequivocally mandate a single, integrated deductible for medical/surgical, MH and SUD. If a plan has carved out MH and SUD benefits to an MBHO, a single deductible will likely require building new interfaces or accumulators between health plans and their MBHOs.
- This rule is not likely to create a significant burden on plans that currently provide medical/surgical and MH/SUD benefits through a single vendor, although they may need to revise current plan designs.
- Providers and their patients should find that a single deductible marks a significant shift towards simplicity.

Plan & Payer Implications	Provider Implications
1. Plan sponsors that already use a single vendor to provide and manage medical/surgical and MH/SUD benefits will need to review and possibly revise their plan designs to ensure that medical/surgical and MH/SUD benefits accumulate toward a single deductible. Separate deductibles are a common feature in current plan designs. 2. Plans and payers with carved out MH/SUD benefits will need to review MBHO capabilities with respect to interfaces and accumulators and some will require independent testing, verification and validation. 3. The elimination of a separate but equal deductible has an impact on the underwriting of risk-bearing agreements with MBHOs, particularly those who are entirely at risk for all MH/SUD claims. Without the financial buffer provided by a separate deductible, MBHOs are exposed to greater financial risk and are likely to seek increased per member/per month premiums. 4. Plans and their partners might begin to consider the advantages, if any, of in-sourcing claims processing and other functions in order to better manage the entire cycle of medical management and claims processing.	1. Providers will need to understand the changes to the benefits and coverage applicable to their existing caseload and – if they collect patient cost-sharing at the time of the visit - modify patient insurance information and front-desk processes accordingly. 2. Providers may wish to contact payers with whom the majority of commercial business is conducted and inquire into any changes in billing procedures.

Table 14: Prescription Drug Formulary Design
"Special rule for prescription drug benefits with multiple levels of financial requirements. These regulations include, in paragraph (c)(3)(iii), a special rule for applying the general parity requirement of MHPAEA to prescription drug benefits. Consequently, these regulations provide that if a plan imposes different levels of financial requirements on different tiers of prescription drugs based on reasonable factors (such as cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up), determined in accordance with the requirements for non-quantitative treatment limitations, and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or mental health or substance use disorder benefits, the plan satisfies the parity requirements with respect to the prescription drug classification of benefits. The special rule for prescription drugs, in effect, allows a plan or issuer to subdivide the prescription drug classification into tiers and apply the general parity requirement separately to each tier of prescription drug benefits. For any tier, the financial requirements and treatment limitations imposed with respect to the drugs prescribed for medical/surgical conditions are the same as (and thus not more restrictive than) the financial requirements and treatment limitations imposed with respect to the drugs prescribed for mental health conditions and substance use disorders in the tier."
Comments
• Recognizing that most prescription drug plans today have a tiered cost-sharing structure that does not typically distinguish between medical/surgical and MH/SUD benefits, the regulations provide a simplified method for prescription drug plans to satisfy the parity standards. So long as the prescription drug plan design is based on reasonable factors and without regard to whether a drug is generally prescribed with respect to medical/surgical or MH/SUD benefits, the plan design will satisfy the parity requirements. • The effect of this provision is that most prescription drug plan designs will not likely need to be revised.

Plan & Payer Implications	**Provider Implications**
1. Plans will need to meet with pharmacy benefit managers (PBMs) to confirm and document that reasonable factors, without regard to whether a drug is generally prescribed with respect to medical/surgical or MH/SUD benefits, were used to create their current plan designs and formularies. If not, plans should work with the PBMs to make appropriate changes. 2. Plans and payers may want to include new language in contracts with PBMs requiring the use of reasonable factors without regard to whether a drug a generally prescribed with respect to medical/surgical or MH/SUD benefits when setting plan design and formularies.	1. Prescribers and acute inpatient facilities will need to understand whether changes in formulary designs will be made and, if so, how they may impact the prescribers, facilities, and their patients. 2. Some providers may need to understand whether changes will affect any capitation agreements they have in place that include risk where MH and SUD drugs are concerned.

Challenges and Unanswered Questions

The following sections provide a brief discussion of the challenges, open issues, unanswered questions and the immediate, positive prospects related to the IFR. As challenges and opportunities are discussed, it is important to keep in mind the differing perspectives of payers, providers and consumers. What one stakeholder perceives to be a challenge, the other may perceive as an opportunity. Several other key facts are also important:

- The MHPAEA does not affect individual and small group health insurance.
- While the Departments and our legislators have enhanced coverage for many millions of people, they have not obligated self-insured public employee health plans representing State, County and local governments to provide MH and SUD benefits. This decision appears to have contributed to the recent decisions of some public employee health plans that dropped MH and SUD benefits altogether.

- Lastly, the IFR does not attend to three of the major health policy concerns of health plans, issuers and other payers, namely access, quality and cost. The National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Committee (URAC) each exist to measure performance in these areas. Nevertheless, it is noteworthy that the MHPAEA did not pursue a common, standardized approach to measuring access, quality and cost in MH and SUD care and coverage.

Scope of Services

- The regulations do not comprehensively define scope of services or covered levels of care. This is a perceived challenge for consumers and providers who were seeking clarity and specificity on this issue. For plans in states with mandated mental health or SUD parity or partial parity (applying to specific conditions and disorders), the outcome is fairly predictable and less problematic. For ERISA groups that aren't subject to State law and health plans operating in those states with no mandated mental health and/or substance benefits, one of the challenges is to decide which diagnoses, conditions, disorders, and treatment services (and, by extension, providers) to cover.

- From the perspective of plans and issuers, greater government involvement in scope of services may be viewed as an intrusion and threat to their ability to contain escalating plan costs. Some ERISA plans believe the real challenge is that the Departments have already gone much farther than expected in requiring them to define plan terms, benefits, and classifications consistent with DSM, ICD and state and federal law. Serious concern in the plan and payer stakeholder communities exists that the Departments may issue additional regulations that further infringe upon their autonomy and the capacity to control costs. The employer community, in particular, views expanding benefits and related costs as a threat to their capacity to be able to manage benefits and, therefore, continue providing health benefits to their employees.

- From the provider perspective, the regulations include a number of imprecise phrases such as "*generally accepted medical standards,"* which may preclude coverage for conditions, services, and providers that do not necessarily meet "medical" standards.

Financial

- The regulations do not accurately reflect costs related to implementation. The cost estimates for such activities as building electronic interfaces between claims processing systems in order to manage a single deductible and conducting data-intensive review of classifications of benefits across plans on an annual basis to establish "predominant" and "substantially all" appear to be understated. Many of these costs will be greatest in the first year of compliance and drop dramatically in subsequent years, particularly those related to initial communication efforts, building infrastructure, and adding systems capabilities.

- Several areas of potential intersection between the public and private systems of care and associated financial implications are not addressed in the regulations. These include court-ordered treatment, State hospital admissions and involuntary holds.

- Plans and employers have a considerable communication challenge ahead of them. Benefit design changes to financial factors such as deductibles and co-pays and the complex underwriting that may result in premium increases are difficult to explain to employees and plan participants.

Medical Management

- The regulations make it clear that medical management tools may be used to manage benefits but prohibit their more stringent application in the review of MH/SUD benefits. Without defining *"generally accepted medical criteria"*, the regulations leave room for interpretation that may result in conflicting practices and opinions. Plans need to align covered diagnoses, covered services and covered providers in order to ensure appropriate determinations and use of the benefits.

- Sometimes a practice that makes good clinical sense (for the plan and often the patient) in the MH/SUD context does not have a comparable standard on the medical/surgical side. Targeted case management is an example. This may be a good opportunity for plans to exercise the same case management techniques across medical/surgical and mental health/substance use disorders.
- Many states mandate benefits or medical management techniques in connection with certain conditions, such as autism. If the plan does not automatically impose the condition (such as a treatment plan) on the medical/surgical side, they may find themselves in a double-bind - they have to offer the treatment plan in order to comply with state law, but to offer it means they've violated MHPAEA.
- Standardized SUD assessment instruments and patient placement criteria are important tools for the provision of cost-effective and equitable treatment. The IFR could do more to help guide stakeholders toward an appropriate common ground. Because plans, payers and providers may not readily agree upon generally accepted medical criteria, the regulations provide an opportunity to bring best practices and scientifically-validated practices to the attention of stakeholders and promote the use of instruments that have been demonstrated most valid and reliable. Identifying specific SUD assessment tools and patient placement criteria would help to ensure that people receive the most appropriate treatment. Simply pointing to the DSM-IV and ICD-9 is not adequate in and of itself.

Opportunities

Integration

The advent of the MHPAEA represents a unique opportunity in time to pursue better integration in a system of care that has been defined by fragmentation for too long. Integration opportunities abound for the many stakeholders:

- *Mental health and substance use disorder service providers* who can work more closely together for the purpose of treating co-occurring disorders.
- *Behavioral health providers of all kinds* who share common missions, operations, information technology, quality and business and/or growth aspirations. These opportunities involve both "horizontal" and "vertical" integration and alliance building.
- *Health plans, managed behavioral health organizations, pharmacy benefit managers, and disease management firms* who can integrate on a number of different levels to share processes, information and raise the overall quality of care as a result.
- *Medical and behavioral health care managers* who can see to it that the "whole person" is treated. Co-morbid conditions such as diabetes respond well to integrated efforts, which produce cost savings and improved outcomes.
- *Primary care and behavioral healthcare providers* who want to treat the whole person, particularly where co-morbid conditions are concerned.
- *Publicly-funded mental health and substance abuse disorder programs and commercial health plans* who realize that the effective treatment of serious mental illness, serious emotional disturbance in children and substance use disorders require the integrated assets and efforts of the community and health economy. The opportunity to "blend" and "braid" systems of care is excellent as a result of the MHPAEA.
- *Health plans* can bring into their advisory and governance structures the perspective and consultation of organizations representing those with various mental health and substance use disorders, further legitimizing their allocation of scarce healthcare dollars to this constituency and better integrating their care.

Patient-Centered Medical Home Initiatives

The PCMH initiatives unfolding around the country are vigorously championed by healthcare professionals, managed care, researchers, employers and policymakers as having tremendous potential for the future of our healthcare system. Among other positive developments, the creation of medical and healthcare "homes" with primary care physicians at their center enable the early screening and detection of co-morbid conditions among people at high-risk for chronic illness. These models also feature tremendous advances in the tracking and monitoring of patient progress. By cooperating and collaborating in these models, all stakeholders have a great deal to gain. The coordination of care, sharing of vital health information that prevents errors and assures patient safety, and ease of navigation patients enjoy through otherwise complex systems of care produces greater clinical outcomes and bottom-line savings for payers.

Value Creation

Our healthcare system is at a juncture in its evolution that offers exciting opportunities for the creation of value. By focusing our collective efforts on continuous quality improvement, standardized health and quality of life outcomes measures such as those found in *Healthy People 2020*, and by virtue of creating rational incentives for healthcare providers such as is the case in Pay-for-Performance programs, our healthcare and insurance system can begin to close the gap that has existed between our spending on healthcare and the resulting health outcomes we produce. Plans, payers and issuers can lead new initiatives to optimize access, quality and outcomes in the private sector while governmental agencies do the same (using the same metrics) in the public health sector.

All stakeholders should agree to the implementation of national best-practice guidelines for the prescribing and monitoring of psychiatric drug interventions, for example. Similarly, all stakeholders should agree to annual assessment of their performance in relation to the nationally accepted standard best-practice guideline they have chosen or that govern their particular discipline.

Health IT Adoption

Healthcare is the biggest and the last of our major business and economic sectors to "automate the shop floor". There are many different programs, incentives and new initiatives dedicated to the advancement of electronic health records and health information exchange. As managed behavioral healthcare, State and County mental health and substance use disorder programs and all manner of behavioral health providers join their medical, hospital and health plan counterparts in a National Health Information Network linking vital information from coast-to-coast, the field will have overcome one of the greatest sources of its fragmentation.

Evidence-Based Treatment for the Seriously Mentally Ill (SMI)

Plans and payers can provide MHPAEA-compliant benefits for evidence-based treatment of the seriously mentally ill children and adults participating in their plans. To that end, MCOs and MBHOs may want to add to their networks providers who can deliver evidence-based modalities including, to name a few examples, Child Psychiatrists and Psychologists; Targeted Clinical Case Management services; Assertive Community Treatment (ACT) programs; therapeutic nursery services; and therapeutic group home services.

Behavioral Health Benefit Management

Plans, payers, employers, and issuers, as well as State, County, and Medicaid programs, can use this opportunity to assess the comparative advantages, benefits, issues and risks associated with a traditional carve-out approach, contemporary approaches to carve-in vendors and the complete absorption or in-sourcing of all roles, functions and responsibilities. This analysis does not advocate for one approach at the expense of another.

Conclusion

The MPHAEA includes a number of ambiguities, complicating the provision of clear regulatory guidance. Regardless of whether stakeholders agree with its content, the IFR has, nevertheless, answered some key questions regarding deductibles, the role of EAPs, defined “substantially all” and “predominant”, and established that non-quantitative approaches to benefit management cannot be any more stringent for MH and SUD benefits than they are for medical benefits. As this report has discussed, however, the regulations have not defined scope of services or levels and types of care, and create very complex methods for determining benefits. Some plans, issuers and payers perceive the IFR as having gone too far in defining plan terms, dictating complex methodologies to ensure compliance with the MHPAEA and precluding a number of common cost-containment strategies. Some providers on the other hand, perceive that the IFR did not go far enough to assure them and their patients of coverage for conditions and services they believe to be most appropriate. In large part due to ambiguities embedded in the statute, the gulf that separates plans and issuers from providers has not been narrowed by the MHPAEA IFR to the extent that most had hoped for.

It is important to note that the IFR is, in fact, interim and that a 90-day comment period allows stakeholders to make their concerns known to the Departments. Similarly, it is important to recognize that this analysis is preliminary. While we have consulted experts from a number of disciplines, the real test of a Rule comes through its implementation. Only when we have been able to assess and review the impact of the regulations in a most practical sense will we be able to prepare a more conclusive analysis.

The MHPAEA Interim Final Rule was not released in a vacuum or a particularly calm time in America. We have endured a year of health insurance reform debate, two years of deep recession, 10% unemployment, health plan membership losses, economic hardship for employers and households, and unparalleled State deficits that are threatening Medicaid and community behavioral healthcare budgets. These dynamics underscore how interdependent the story behind and ahead of the MHPAEA truly is.

An optimal behavioral healthcare system engages skilled care providers and stewards of finite health plan resources in a cooperative effort to improve the health and well being of individuals in as cost-effective and quality-assured a manner possible. Achieving optimal health at a reasonable cost is an honorable endeavor that distributes value equitably. Readers are strongly encouraged, therefore, to submit their comments, questions and concerns to the Departments on or before May 3, 2010.

About AHP Healthcare Solutions

AHP Healthcare Solutions is a division of AHP, Inc. and provides consulting to health plans, managed care organizations, federal, state, local and international governments as well as healthcare providers and delivery systems. Since 1980, AHP's services have evolved to help healthcare 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 systems, and helps clients translate research into practice.

AHP Healthcare Solutions builds upon AHP's tradition and success improving the delivery of effective mental health and addictions coverage and treatment. Our consulting services are designed to support health plans, payers, benefit managers and help providers enhance business and clinical operations, information management and access to person-centered services. AHP Healthcare Solutions' consultants are senior subject matter experts who have earned their "thought-leader" status over 20-30 year careers by developing and managing high-performance systems of behavioral healthcare. We leverage deep roots in the managed care, EAP, insurance, mental health and substance abuse fields, as well as our experience with federal, state and community initiatives to provide our clients with practical and measurable solutions to complex problems. We take a multi-disciplinary approach to delivering highly integrated solutions such as:

- Achieving operational compliance with rules and regulations that have a bearing on behavioral health care and coverage
- Designing more efficient systems of care that control the cost of benefits while enhancing coverage
- Adopting and implementing processes and systems that produce desired results and outcomes
- Matching behavioral health care and coverage to broader medical and employee health benefit goals to maximize overall health and productivity
- Delivering targeted and effective information to the consumer
- Developing strategic approaches to managing vendors and agreements

AHP has primary offices in Sudbury, MA, Albany, NY, Germantown, MD, and Palm Desert, CA. Staff and affiliate consultants are located nationwide.

About the Legal Action Center

The Legal Action Center is the only non-profit law and policy organization in the United States whose sole mission is to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records, and to advocate for sound public policies in these areas.

For three decades, LAC has worked to combat the stigma and prejudice that keep these individuals out of the mainstream of society. The Legal Action Center is committed to helping people reclaim their lives, maintain their dignity, and participate fully in society as productive, responsible citizens.