Health Plan Guide to Parity Implementation

Strategic and Tactical Approaches to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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Purpose

The passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act (MHPAEA) late in 2008 will continue to give rise to much change in the coverage of mental health and substance use disorders among health plans. The outcome of a successful implementation for consumers and their families will be equitable coverage for the treatment of their disorders and improved quality of life. Implementation will be a rigorous and involved process for health plans but important benefits accrue to them as well. Primarily, properly screened, diagnosed, and treated mental health and substance use disorders relieve financial pressures on health plans that result from co-morbidity, repeated attempts at inappropriate treatment, and misuse of the emergency room for mental health concerns. This June 2009 White Paper focusing on Payers is the second produced by Advocates for Human Potential, Inc. for its new Behavioral Health Parity series. AHP hopes that this paper, as well as the others in the series, will help you prepare to implement the 2008 Parity Act, which goes into effect on January 1, 2010.

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

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

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

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

this paper is to provide information and assistance to those tasked with this implementation.

The 2008 Parity Act

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

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

Critical provisions of the Act include the following:

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

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

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

- **Covered Services and Providers** — Payers and employers will need to decide (subject to stipulations in the October 2009 Federal regulations) which MH and SUD services, levels of care, and providers will be covered.
- **Treatment Plans and Best Practices** — The treatment of people with mental illnesses and/or substance use disorders is most cost effective, as measured in positive clinical and quality of life outcomes, when scientifically validated practices are employed in a comprehensive treatment plan. Ongoing research is consistently providing new and reliable evidence concerning such practices, and payers are encouraged to stay abreast of their costs and benefits for specific populations in the same way that they review pharmaceutical, medical, and surgical advances.
- **Out-of-Network Benefits** — Where allowed for other conditions, out-of-network benefits for mental health and addictions treatment must be provided and must be equal to those provided for other medical and surgical benefits.
- **Utilization Management (UM) and Level of Care Guidelines** — Plans can continue to engage in healthcare UM, as well as utilization review and other types of assessments, and determine coverage on a case-by-case basis. Plans are required to provide members, consumers, and providers with their medical necessity criteria and reasons for benefits/coverage or claims denial.
- **Compliance** — The Department of Labor, Health and Human Services, and the Treasury will almost certainly be responsible for enforcement of the Act. These departments are expected to produce guidelines and regulations later this year.
- **General Exemptions** — More than 40 states have some form of mandated mental health and/or addiction treatment parity and those whose coverage is more limited than that provided by the Act will be required to address the discrepancy. The lack of parity for addiction services will be the biggest gap for approximately 30 states to fill. A list of states and their status appears on page 6.
- **Employer Exemptions** — The Act exempts employers with fewer than 50 employees and plans whose total premium costs increase more than two percent in the first year or one percent in any subsequent year, subject to an annual application and review process.
- **Medicaid and Medicare** — Medicaid managed care plans are affected by the Act; Medicare is not.

Implications for Health Plans

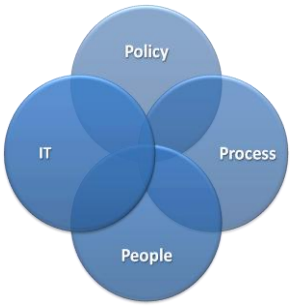


Figure 1- Interrelationship of Basic Business Zones

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

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

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

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

Zone 3: People — The implementation of the Act will require review of staffing levels, training, performance standards, and evaluation. It will also require thoughtful communication to promote provider integration and collaboration,

Children suffering from SEDs require services more commonly associated with schools, juvenile justice programs, and other social service agencies. They also require specially trained child psychiatrists and psychologists to make appropriate diagnoses and manage complex treatment plans and medications.

Some also require special services such as non-hospital residential care for short periods.

and to ensure that plan members understand their rights and responsibilities under parity. In addition, the Act will influence relationships with partners, providers, suppliers, and, most importantly, consumers. For example, payers will need to consider coverage for expanded levels and types of service for SUD treatment. Some payers currently offer medical detoxification and outpatient counseling for SUDs and will want to explore the addition of residential, partial, and intensive outpatient levels of care in the near future.

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

Situation Analysis

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

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

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

Chart 1. State Parity Status

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

SOURCE: MENTAL HEALTH AMERICA, JULY 2008

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

Good = Good parity coverage (few exceptions or limitations)

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

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

Effective, timely, and accurate communications to subscribers and plan members is critical.

One plan failed to notify its subscribers, members, and providers of a change in MBHO vendors and patients and providers were in limbo for weeks.

Providers that continued serving patients after the transition had to go through a difficult grievance process to recapture monies owed them.

The episode disrupted hundreds of therapeutic relationships and tarnished the reputations of several corporations.

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

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

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

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

  Implementing the law will present opportunities for:

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

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

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

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

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

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

- **Carve-Outs and Carve-Ins** — Payers and employers who currently have their MH andSUD benefits managed by an MBHO will likely continue to do so; however, they will need to ensure that their vendor is compliant with the Act, particularly as it relates to disclosing guidelines for levels of care and for equity between medical utilization management practices for primary care and for MH and SUD treatments. Payers who do not currently have their MH and SUD benefits managed by an MBHO vendor will want to explore that option as well as the option of a carve-in. The latter involves contracting with and integrating MH/SUD experts, case managers, and reviewers with existing medical management teams and departments.
- **Population Management —** Health plans and purchasers will want to consider population management programs that address disease prevention and management throughout an entire population. By developing programs that address needs at any point along the disease continuum, payers can

expect improved rates of early identification and treatment. This approach – including strategies such as early and periodic screening, patient education, self-care, and support for family members – is linked with lower overall healthcare costs.

Implementation

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

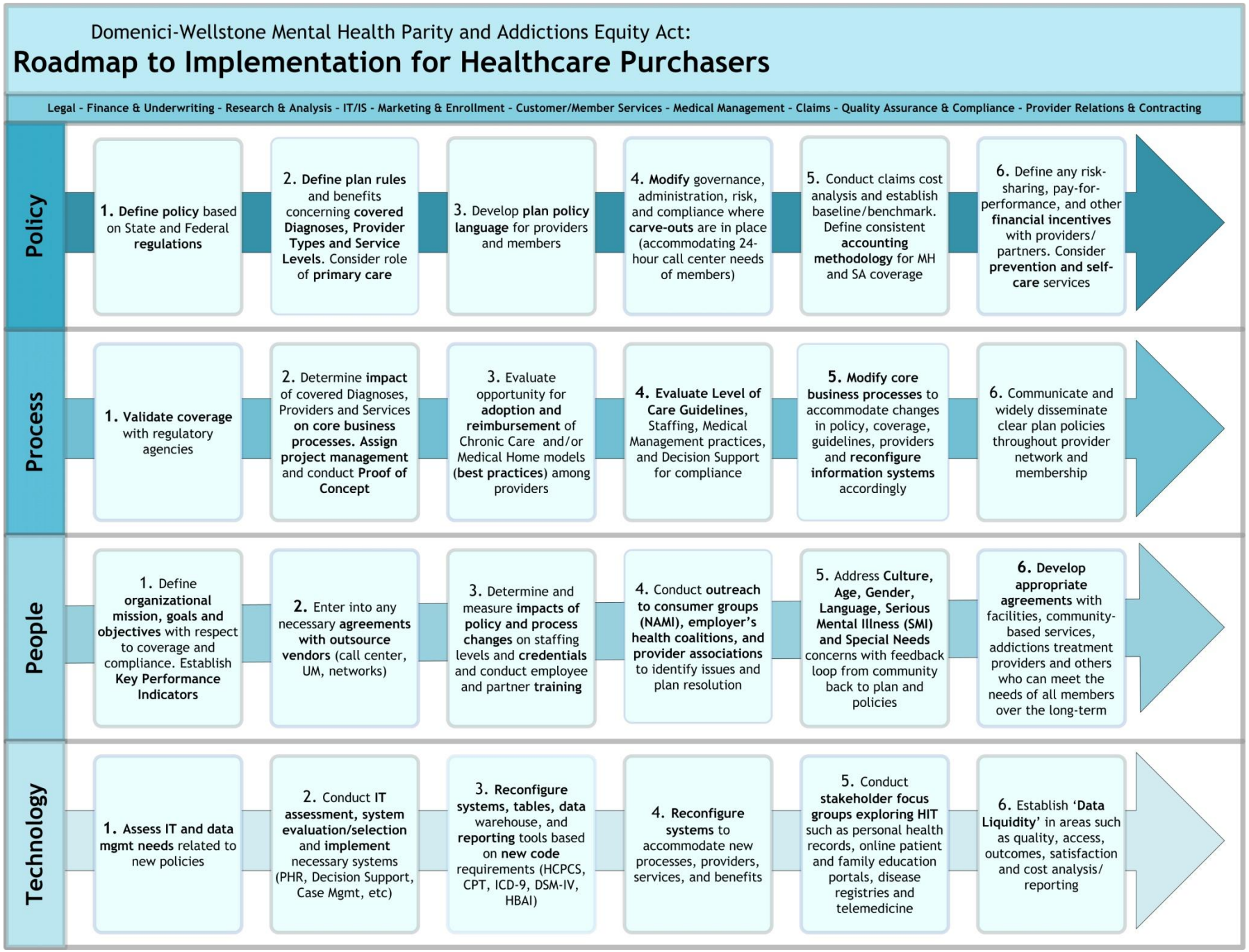
- **Functional Implementation** – This will require health plans and purchasers to assess the Act's impact throughout their organizations. Organizations should meet early to begin outlining how the Act will impact:
  - Legal Interpretation of the Act and related regulations
  - Plan policies and benefit design
  - Covered diagnoses, providers, and services
  - Benefit carve-out to an MBHO
  - Provider networks and incentives
  - Level of care guidelines, decision support protocols, and member communications
  - Fiscal impact and data analysis

- Payers also have to consider the Act's implications across other functional areas. These include possibly managing a single deductible and out-of-pocket maximum, customer service, existing disease and case management programs, and medical and utilization management. Other functional areas are subrogation and coordination of benefits, marketing and managing multiple plan designs and lines of business across states, prevention initiatives, and business partnerships.
- **Tactical Implementation** – Parity requires a great deal of tactical planning and execution. Inter-departmental, multi-disciplinary teams within payer organizations are encouraged to consider their entire change management arsenal. Tactical approaches to implementation should include:
  - Assessment of current benefits and legal review

- Strategic planning
- Business process and workflow reengineering with particular
- attention to gap analysis and employee training
- Expert consultation
- Business process outsourcing options
- Implementation oversight and project management
- Data management strategy (system reconfiguration and
- reporting)

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

Figure 2. Comprehensive Roadmap for Healthcare Purchasers



Implementation Outline

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

Impact Zone 1 – Policy

Steps plans can take with respect to statutory compliance, policies, and plan rules.

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

Impact Zone 2 – Process Steps plans can take to establish new and modify existing processes and workflow to properly implement policies and rules.
Validate policies and plan rules with regulatory agencies. This may be a particular challenge if the regulations are not published on or prior to October 3, 2009, when they are expected.
Determine the impact of plan rules, covered diagnoses, provider types, and services on core processes and any out-sourced processes. Examples include impacts on Provider Contracting and Marketing. It is recommended that a Parity Project Manager be assigned for the duration of the implementation. In addition, some plans may benefit from conducting proof of concept simulations that estimate utilization patterns and cost impacts.
Evaluate the opportunity for adoption and reimbursement of services and providers that enable care for the chronically SMI and SED children. Approaches include primary care and behavioral health integration, collaborative care, patient-centered medical home care and case management.
Evaluate Level of Care Guidelines where MH and SA are concerned, assess staffing levels, medical management practices, and decision support.
Modify core business processes and workflow to accommodate changes in policy, coverage, guidelines, and providers. Review and modify policies and procedures as well as any templates or forms involved in workflow. Communicate need for any information system reconfiguration requirements to IT personnel, analysts, and developers.
Communicate and disseminate clear plan policies and other pertinent documentation to all providers and members throughout the entire implementation process.

Impact Zone 3 – People

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

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

Impact Zone 4 – Technology

Impacts on enterprise-wide information technology and systems

Immediately evaluate IT and data management needs associated with new policies.
Conduct IT assessment, system/vendor evaluations, and selection relative to any new applications required by plan to manage policies. Prepare and deploy implementation plans. Consider claims accumulators, decision support systems, case management systems, and personal health records systems, for example.
Reconfigure systems, tables, data warehouse, and reporting tools based on new requirements and codes (HCPCS, CPT, ICD-9, DSM-IV, HBAI, etc.)

Impact Zone 4 – Technology Impacts on enterprise-wide information technology and systems
Reconfigure systems to accommodate new processes, workflow, forms, and templates. Reconfigure based on new provider type, service and benefit parameters and requirements.
Conduct stakeholder focus groups to explore health IT options such as personal health records, online patient and family education, portals, disease registries, and telemedicine (telepsychiatry)
Establish "Data Liquidity" targets and mechanisms to facilitate research, quality assurance/improvement, access, outcomes, satisfaction, and cost analysis/reporting.

Conclusion

Parity represents a sea-change for consumers, behavioral healthcare providers and health plans of all kinds. The timing is unfortunately complicated by sweeping changes to COBRA, an uncertain economy and a monumental Healthcare Reform effort. Despite the pressures, regulations will be issued and health plans will be forced to comply and press on with implementation. Many plans and payers are ahead of the curve, however, a significant number are only beginning to explore the full extent of Parity.

Next Steps—There are numerous examples to learn from and the steps needed to complete implementation are identifiable. No matter where plans and payers find themselves on the implementation curve, success is a perfectly reasonable expectation assuming plan administrators, managers and leaders apply some fundamentals. Several critical success factors stand out and should be addressed first and foremost:

- New levels of coverage will mean that more people will eventually seek services from qualified behavioral health professionals over longer courses of time (longer episodes of care). **Plans should consult best practices to establish the service and provider mix they want to offer in order to produce positive outcomes at a reasonable price.**
- Parity can entail: changes in managed care; integration between the behavioral health and primary care systems; and some degree of integration between mental health and addictions treatment providers. **Plans can act now to secure agreements with MBHOs, specialty networks, and providers in their**

communities that can meet special needs. The result will be stronger reputations for cooperation and increased opportunities to collaborate.

- Enhancements to coverage and expanded services may necessitate changes to organizational structure, staffing levels, and infrastructure. **Payers should begin strategic discussions and change management at the policy, staffing, process and technology levels.** The implementation of change at these levels is difficult to motivate and manage in the course of day-to-day business. Those who do not have adequate resources but recognize the opportunity for change are advised to consider the involvement of experts, peers, partners, and consultants. Infrastructure and staffing change may be required in UM, customer service, and provider contracting departments.
- Successful change involves accurate assessment of the current state of operations as well as an evaluation of internal resources and capabilities to manage change over time. **Payers are encouraged to:**
  - **Seek support** in assessing where they stand today in relation to where they could be or where they envision being in 1, 3, and 5 years.
  - **Invest in technical assistance** that will ensure effective adoption of best practices.
  - **Seek expert advice** when designing and re-engineering business processes and adopting health information technology

About AHP

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

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

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

AHP's passionate and committed staff members, many of whom are nationally recognized, are known for their intimate knowledge of "what happens on the streets" as well as in the offices of policymakers, and they are equally comfortable in both settings. The insights they bring to large national projects are informed by diverse experience in the field. AHP is especially known for connecting the dots across

disciplines, service systems, funders, and populations to develop comprehensive real-world solutions that meet the needs of consumers and providers. AHP has primary offices in Sudbury, MA (near Boston); Albany, NY; and Germantown, MD (near Washington, D.C.) and staff located nationwide.

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

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

and community psychiatric rehabilitation programs for adults with serious mental illnesses.

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

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