Mental Health Parity and Addiction Equity Act: A Watershed Moment for the Future of Behavioral Health Care

Uniting the Community with What We Know Now to Transform Our Systems of Care

The Colorado Coalition for Parity

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The Colorado Coalition for Parity is dedicated to disseminating information regarding the pursuit of equality in substance use and mental health disorder benefits in Colorado. This document is the result of Coalition members working together to create a concise review of the need for substance use and mental health parity and a vision to attain it. We hope it provides information to help further our mission toward achieving parity.

"The work begins anew, the hope rises again, the dream lives on" -Senator Edward M. Kennedy

PAR•I•TY

noun \ˈper-ə-tē, ˈpa-rə-\
1: the quality or state of being equal or equivalent

1. Introduction

The Colorado Coalition for Parity is a community based coalition that serves individuals, families and communities affected by substance use and mental health disorders.

The purpose of the Coalition is to further develop the dialogue between providers of mental health and substance use disorder treatment services, consumers and their families, insurers, and policy makers in order to improve access to appropriate and timely care.

In 2008 the Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law.[1] The final rule on the law was passed in November 2013. The final rule is critical to ensuring that MHPAEA is fully implemented and enforced so that the millions of Americans in and seeking recovery from mental health and substance use disorders can access the non-discriminatory care promised under the law.

To better understand how the law was being implemented across the country and to solidify support for the passage of the final rule, former Congressmen Patrick Kennedy (D-RI) and Jim Ramstad (R-MN) announced a series of field hearings in 2012. Nine hearings took place in 2012/13 in order to gather relevant input from constituencies nationally and to raise awareness regarding the importance of the MHPAEA and integration with the Affordable Care Act (ACA).[2] Hearings took place in Michigan, Maryland, Minnesota, Illinois, California, Florida, Connecticut, Colorado, and New Jersey.

The Colorado Coalition for Parity hosted a field hearing in Denver in January 2013. Bringing together over 40 organizations and over 300 individuals from across the state, the hearing brought to light the obstacles still facing full implementation of MHPAEA. In an effort to ensure full adoption of MHPAEA, the Coalition agreed to continue its advocacy beyond the field hearing. This White Paper is one "next step" undertaken by the Colorado Coalition for Parity toward this end.

[1] Patient Protection and Affordable Care Act, § 2001(c)(3), codified at 42 U.S.C. §1396u-7(b)(5).
[2] Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, codified at 42 U.S.C. § 300gg-26.

2. The Purpose

It is the intent of this paper to engage providers of substance use and mental health disorder services and insurance carriers in the process of assuring that appropriate care is available to individuals living with substance use and mental health disorders according to the requirements of MHPAEA and the ACA.

This paper highlights some of the prohibited practices used by managed behavioral health care organizations. This paper proposes alternatives to the current practices that are consistent with an accurate understanding of substance use and mental health disorders and their effective treatment.

3. The Need: Substance Use and Mental Health Disorders

With a population of 5.2 million, the need for substance use and mental health treatment in Colorado is significant. Key findings from a 2011 report titled "The Status of Behavioral Health Care in Colorado" found that about 1 in 12 (about 425,000) Coloradans have a severe condition; 1 in 30 (more than 170,000) are adults with severe mental illness (SMI); 1 in 100 (60,000) are adults with a severe substance use disorder without SMI; and more than 1 in 50 (90,000) are children and adolescents with serious emotional disturbance. The same report found that 3 in 10 or 1. 5 million Coloradans need treatment for substance use or mental health issues each year. Despite this need, Colorado's spending on mental health services fell to 32nd in the nation in 2007 and substance use spending in Colorado is one-third the national average.[3]

Regarding substance use treatment needs specifically, the 2010-2011 National Survey on Drug Use and Health (NSDUH) estimates that among Coloradans aged 12 and older, 559,000 used illicit drugs in the past year, 124,000 are estimated to meet criteria for illicit drug abuse or dependence, 2,562,000 used alcohol in the past year, 1,020,000 binge drank, and 356,000 are thought to meet criteria for alcohol abuse or dependence. Colorado ranked in the highest use, abuse, and dependence categories for illicit drug and alcohol use when compared to other states.[4]

Unfortunately, despite the need, many people are not receiving services. Colorado consistently ranks higher than the national average in terms of the unmet treatment need for alcohol and drug problems. According to 2010-2011 NSDUH data, Colorado ranks sixth among states nationwide in the proportion of persons aged 12 years and older needing, but not receiving, treatment for

[3] TriWest Group. (2011). The Status of Behavioral Health Care in Colorado–2011 Update. Advancing Colorado's Mental Health Care: Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust, and The Denver Foundation: Denver, CO. Available at: http://www.coloradotrust.org/attachments/0001/6934/ACMHC_2011_Full-Report.pdf.

[4] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (January 8, 2013). The NSDUH Report: State Estimates of Nonmedical Use of Prescription Pain Relievers. Rockville, MD. Available at: http://www.samhsa.gov/data/2k12/NSDUH115/sr115-nonmedical-use-pain-relievers.htm.

alcohol use in the past year, and tenth among all states in the proportion of persons 12 years and older needing, but not receiving, treatment for illicit drug use in the past year.[5]

The unmet treatment need in Colorado for substance use and mental health disorders is due to barriers including stigma, limited treatment resources, individual perception that treatment is not needed, and financial barriers**.** Many individuals with substance use and mental health disorders do not receive treatment, although many present in healthcare settings with medical conditions such as obesity, diabetes, asthma, migraines, heart disease and cancers.[6] These often co-exist with substance use and mental health disorders. A recent report indicates that 68% of adults with substance use and/or mental health disorders have at least one physical health condition.[7] Additionally, 29% of adults with a physical health condition also struggle with substance use and/or mental health disorders.[8] Furthermore, many people with physical health conditions are more likely to develop emotional disorders. For example, approximately one in five people who suffer from heart attacks become severely depressed.[9]

The Patient Protection and Affordable Care Act (ACA) is rapidly transforming Colorado's healthcare landscape. Preventing and treating chronic conditions, including substance use and mental health disorders, is critical as healthcare providers strive to achieve the "triple aim" coined by the Centers of Medicare and Medicaid Services: better care for individuals, better health for populations, and lower per-capita costs.

The integration of physical and behavioral health services is central to the success of healthcare reform in Colorado. To accomplish the goal of providing quality care and improving health outcomes, health and behavioral health providers are identifying new and innovative approaches to address substance use and mental health concerns as routinely as any other chronic health conditions. Integration is especially important as substance use and mental health disorder prevention and treatment resources in Colorado are limited.

With the implementation of the ACA in January 2014, 30 million people nationwide will gain access to health insurance benefits. In Colorado, approximately 600,000 citizens will be able to access healthcare. The Mental Health Parity and Addiction Equity Act, as incorporated in the ACA, assures access to substance use and mental health treatment for these populations. While the current system of care is ill-prepared and not adequate to meet the needs of this newly eligible population, efforts to improve and a willingness to transform systems do exist.

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[5] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (January 8, 2013). The NSDUH Report: 2010-2011 National Survey on Drug Use and Health Model-Based Estimates (50 States and the District of Columbia) Rockville, MD. Retrieved on 4/17/13 at http://www.samhsa.gov/data/NSDUH/2k11State/NSDUHsae2011/.

[6] Kessler, Ronald C. National Comorbidity Survey, 1990-1992 [Computer file]. Conducted by University of Michigan, Survey Research Center. 2nd ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [producer and distributor], 2002. Accessed at http://www.hcp.med.harvard.edu/ncs/ftpdir/Baseline%20NCS.pdf.

[7] Goddell S, Druss B, Reisinger Walker E, Mental Disorders and Medical Comorbidity, Robert Wood Johnson. Foundation, Policy Brief, 2011.

[8] Ibid.

[9] Ibid.

4. Managed Behavioral Healthcare - A Brief History

Substance Use Disorders

Federal legislation developed in the early 1970's set the stage for public policy addressing substance use disorders. This legislation decriminalized public intoxication, established and used detoxification services and coordinated and supported a continuum of community care to promote recovery. States were required to provide these services for individuals charged with public intoxication. Public funding was budgeted to provide treatment and research on the issues of alcoholism and drug addictions.[10]

During this same period progressive insurance companies saw the value of providing a medically based approach to substance use disorders and offered benefits to pay for their treatment. This led to the privatization of the treatment of substance use disorders primarily funded by third party insurance companies. Through the middle 80's an expansion of the acute care model of treatment was used primarily in detoxification and residential settings. In this evolving system, patients completed treatment in a traditional 30-day program and then were discharged back to their community without facilitated aftercare. This model of care evolved from a grassroots, self-help model. Outcomes were not routinely or systematically measured. This system was perceived to provide a revolving-door approach to treatment.

The need for increased access to treatment led to the expansion of resources from public into private sector funding sources. In a growing competitive market a more complex business environment evolved in which treatment programs operated. Lacking experience in the establishment of sound business practices, abuses occurred in the provision of substance use disorder treatment services including unethical marketing practices, financially motivated admissions, lack of admission criteria supporting length of stay, excessive fees, inappropriate re-admissions and abandonment of clients who exceeded their insurance coverage.[11]

In the private sector a managed care system evolved in response to this trend, in an effort to reduce costs and improve quality of care. The pendulum swung from an abundance of unlimited services with little oversight and accountability to limitation of services with increased oversight and mandated measurement of quality improvement. Managed care required the use of new treatment and placement guidelines and placed limits on payment for substance use disorder treatment, used capitation, placed annual and lifetime limits on services, and denied coverage for substance use and mental health disorder treatment altogether. This evolved in parallel to the general system of healthcare in what is known as Mental and Nervous or Behavioral Health Care. Publically funded programs also adopted a managed care approach. As private insurers went the way of managed care, or removed coverage for mental health and substance use disorders altogether, the burden of cost for treatment shifted increasingly to federal and state sources, including criminal justice systems.

[10] Trilogy Claims Administrative Handbook, section 4.
[11] White, William, (1998) Slaying the Dragon- A History of Addiction Treatment and Recovery in America, Chestnut Health Systems/Lighthouse Institute.

Mental Health Disorders

Mental Health treatment prior to the early 1960s consisted primarily of government-run mental institutions. Following changes in psychiatric treatment and the deregulation and privatization of the mental health industry, individuals receiving treatment in government run mental institutions were discharged to community-based mental health treatment. This shift occurred rapidly and communities were not equipped or prepared to treat the influx of individuals needing mental health disorder services. Patients left the institutions in a variety of mental states, some with no way to financially support themselves and at times unable to provide for their own basic needs. This led to an increased number of homeless individuals and swelled the facilities of the nation's criminal justice systems. As federal and state funding decreased and focused on stabilizing the individuals who were discharged from the government-run mental institutions, the variety and quality of available services decreased. Community mental health centers were developed and created new care delivery systems. Insurers labeled coverage for mental illness as "Mental and Nervous" coverage. As a result of the de-institutionalization of the government-run mental institutions, a stigma developed by which people generally believed mental illness was a choice. Most insurers covered mental and nervous conditions, but on a smaller scale than medical diseases, typically allocating about 20 outpatient sessions per year, with financial caps for inpatient care, and flatly denying coverage for some conditions or problems.

In the late 80's and early 90's as managed care organizations developed to control upward spiraling medical costs, they were tasked with improving quality and establishing accountability for service delivery and cutting financial waste. In a much slower form the costs for mental and nervous conditions began to appear on the radar of managed care organizations.

5. Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act

MHPAEA requires that if a group health plan offers coverage for mental health or substance use disorder benefits, the financial requirements and treatment limitations for those benefits can be no more restrictive than the predominant requirements and limitations applied to substantially all medical/surgical benefits. Under the Affordable Care Act (ACA), new individual and small group plans in and outside of mandated health insurance exchanges are required to offer substance use and mental health disorder coverage at parity.

The Mental Health Parity and Addiction Equity Act of 2008 is an extension of the Mental Health Parity Law (MHPA) of 1996. The 1996 law required insurers to apply the same annual and lifetime caps for mental health coverage as medical/service benefits covered by the plan. The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 extends coverage even further to include substance use issues, amends certain provisions in the 1996 law, and includes a variety of other consumer protection provisions. For example, plans are only permitted to manage the mental health and substance use benefit so long as they do not do so in a discriminatory manner. This applies to private and public sector employers with more than 50

employees, including self-insured and fully insured plans. MHPAEA currently exempts small employers (fewer than 50 employees), and an every-other-year cost exemption is granted to plans upon request if providing parity increases the cost to a plan beyond 2% the first year and 1% in subsequent years. The law also permits self-insured state and local government employee plans to actively opt out of the Parity Act's requirements for a specific plan year with option for renewal.[12]

On November 8, 2013, the final rule on MHPAEA was issued, requiring health plans to apply parity to intermediate levels of care such as residential treatment and intensive outpatient settings. It also requires plans to disclose to their members the standards they use to determine benefits and reasons for denying a claim. Regulators eliminated a provision from the interim rule that had allowed insurers to make exceptions to certain benefits based on "clinically appropriate standards of care" after hearing from clinical experts that the exception was unnecessary and had been abused by health care plans.[13]

The federal law is regulated, administered, and enforced jointly by the United States Treasury, the Departments of Labor (DOL) and Health and Human Services (HHS), and the 50 states. The Parity Act does not require employers to offer mental health or substance use disorder benefits; it states that only if these benefits are offered they must be offered on par with medical/surgical benefits.

In 2014, under the Affordable Care Act (ACA), new individual and small group plans in and outside of the mandated health insurance exchanges will be required to offer mental and substance use disorder coverage at parity.[14] In order to comply with and conform State Statutes on behavioral health care and parity to the new requirements of the Affordable Care Act, Colorado has done the following:

Prior to the passage of the Affordable Care Act at the federal level, the Colorado State Legislature passed two behavioral health and substance use disorder parity laws. The first, House Bill 1192 in 1997, identified six biologically based mental disorders that are to be on parity with biological health insurance coverages. These disorders are bipolar disorder, schizophrenia, schizo-affective disorder, obsessive/compulsive disorder, major depressive disorder, and panic attacks. This bill applied to the small and large health insurance markets. It did not apply to the individual health insurance market.

The second parity bill, Senate Bill 36 in 2007, extended parity coverage to posttraumatic stress disorder, drug and alcohol disorders, attention deficit disorder, attention deficit hyperactivity disorder, eating disorders, and anxiety disorders. This bill applied only to the large group health insurance market, not the small group nor the individual health insurance market.

To conform to the Federal Mental Health Parity and Addiction Equity Act now incorporated into the Affordable Care Act of 2010 the Colorado Division of Insurance, introduced House Bill 1226

[12] Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, codified at 42 U.S.C. § 300gg-26.
[13] "NAATP, Leading Advocate for Parity, Welcomes Final Rule On Mental Health and Addiction", National Association of Addiction Treatment Providers Press Release, November 14, 2013.
[14] Patient Protection and Affordable Care Act, § 2001(c)(3), codified at 42 U.S.C. §1396u-7(b)(5).

in the 2013 legislative session. This bill overhauled current state statutes regarding health care to bring them into compliance with the Affordable Care Act. The bill applies the two state mandates on behavioral health parity already in the law (HB 1192 and SB 36) to all individual and small group health insurance markets. This includes the marketplace established by the Affordable Care Act and plans outside the ACA marketplace. This eliminates any potential for adverse selection in the individual or small group health insurance markets. The bill was approved during the 2013 session.

In the spring of 2013, the Colorado Division of Insurance held public hearings and received comments on the proposed rules regarding the definitions of preventative care as required in the Affordable Care Act for behavioral health. The purpose of these regulations is to establish rules for the required inclusion of the essential health benefits in the individual and small group health benefit plans in accordance with the Colorado Revised Statutes and the Affordable Care Act of 2010. Entitled "Life, Accident and Health," 3 CCR 702-4, the Division defined Covered Preventative Services, as required by the Affordable Care Act. For ages 18 and older, both depression screening and alcohol misuse screening and behavioral counseling interventions are included as preventative services which are not subject to deductibles, copayments, or coinsurance. For children 3 – 12 years of age, obesity screening and comprehensive, intensive behavioral interventions are listed as preventative services, as well as screening for major depressive disorder for young people between ages 12 – 18.[15]

6. Common Types of Unfair Management in Managed Behavioral Healthcare[16]

As health care costs have increased, public and private health care plans have imposed stricter cost containment requirements on health benefits. When cost containment is used by plans to achieve quality and accountability, its impact can be beneficial to patients, communities, providers, and payers in the health system. Many plans have imposed inappropriate and/or stricter cost containment requirements on substance use and mental health disorder treatment benefits than those applied to the management of other medical benefits. This includes the use of higher co-pays and deductibles, shorter day and visit limits, and pre-approval or "prior-authorization" for services. If cost containment results in a delay or denial of medically appropriate care, it can have devastating consequences on individuals, families, communities, and the health system at large. The Mental Health Parity and Addiction Equity Act was not developed to eliminate cost containment or medical management. The law's aim is to create equality between medical benefits and substance use and mental health disorder benefits.

Some common types of inappropriate and/or unfair practices used to manage substance use and mental health disorder benefits include, but are not limited to:

[15] Colorado Department of Regulatory Agencies, Division of Insurance: 3 CCR 702-4, Life, Accident and Health, Concerning Essential Health Benefits. Regulations 4-2-42.
[16] Health Reform Toolkit. http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/healthcare-reform.

Prior authorization/Pre-approval - required to receive treatment:

In most cases, in order for a person to access substance use or mental health disorder services, using their in or out-of-network insurance benefits, a prior authorization or pre-certification is required. Prior authorization is a cost-savings feature of a benefit plan that helps ensure the appropriate use of selected treatments including prescription drugs and certain services. When used appropriately, it can indeed serve to improve quality and control costs. When used inappropriately, it delays or limits access to necessary care. While prior-authorization is not unique to behavioral health managed care and is applied to certain medical benefits, the MHPAEA requires that this management approach is "no more stringently applied" to mental health and addiction services than it is to medical services. Historically, this has not been the case. The Coalition is aware of many cases that indicate the use of prior-authorization in the behavioral health sector is applied much more stringently and across many more behavioral health service types than are applied in medical coverage. Currently, this is especially apparent in the use of prior-authorization practices to access outpatient services or to continue outpatient services after a predetermined and restrictive number of outpatient sessions. This is an example of discriminatory practice as it "more stringently" applies this cost containment strategy for outpatient behavioral health than it does for outpatient medical care.

Utilization review - (the plan must authorize how the care is going to be delivered in advance of receiving treatment)

Another cost containment mechanism in the behavioral health sector that is applied much more stringently in comparison to medical services is utilization review. Behavioral health organizations have been forced to develop entire systems dedicated to responding to insurance companies' need for intensive and proactive authorization to continue care based on their unique "medical necessity" criteria. Essentially, utilization review places a heavier burden on behavioral health providers than is does for general medical providers. This is essentially prospective prior-authorization over and over again designed to force providers to continually justify service delivery and to justify the need for a specific service versus a less expensive or "no care" option. The organizations represented and the consumers served by the Colorado Coalition for Parity have been significantly and negatively impacted by this practice. Under MHPAEA this practice is deemed discriminatory and should be brought into parity with the common practices used in the medical surgical arena to justify medical necessity. Protocols and generally accepted criteria exist in behavioral health and these should be applied in a standardized manner to guide care decisions eliminating the practice of utilization review applying "medical necessity" criteria that is unique to each benefit plan.

"Fail first" policies - (requirement to fail at one drug or treatment before another is approved. "Failure" meaning a relapse to drug and/or alcohol use, or a reoccurrence of symptoms of mental illness)

"Fail first" policies represent probably the most egregious of the discriminatory practices in behavioral healthcare which are applied "more restrictively" than in general medical care. Fail first policies are an approach to prescribing drugs or authorizing clinical services that mandates the least expensive treatment should be tried first, despite medical appropriateness and

effectiveness. In an ideal scenario, this would be an appropriate match to the patient's needs and the most effective care for a specific condition. In the worst case, this policy forces behavioral health providers to apply treatments that are not needed and may even lead to significant patient harm. Fail first is used by health insurers to control costs but it is time-consuming from a provider and patient perspective, is ultimately more expensive from a direct and indirect cost perspective, denies patients the services they need when they need them, and allows payers to practice medicine without a license. Probably the most common example of this practice exists in the practice of requiring outpatient care to treat a mental health or addiction disorder before a higher level of care is authorized. Another common practice is the denial of injectable medications until and unless a patient has failed at oral medication trials first.

Fail first policies:

- Create additional barriers leading people to forgo medically necessary and most effective services
- Cause patients' medical conditions to deteriorate, increasing the need for more expensive medical intervention in the future while forcing patients to endure unnecessary health consequences
- Increase frustrations and feelings of despair and stigmatization
- Increase the risks of non-compliance

Denials or exclusions of coverage for particular treatments or levels of care by the plan - (refers to the unequal limitation of services when compared to services allowed in general medical coverage)

Under MHPAEA if an insurance company provides coverage for mental health and addiction services, it must provide all levels of care available and be commonly accepted as effective for these conditions. Members represented in the Colorado Coalition for Parity find many cases where an insurance company will provide coverage for mental health or addiction conditions but limit the services allowed under the plan. For instance, only outpatient services are covered and residential services have no coverage. Another version of this situation is when outpatient services apply only in individual formats and Intensive Outpatient Group services are not covered. These practices are considered illegal under the MHPAEA and consumers are discriminated against in these instances. While "medical necessity" criteria and generally accepted treatment guidelines should be applied, the outright exclusion of appropriate service types provided by credentialed and licensed service providers should be one inequity that is both easily identified and rectified.

Medical necessity criteria – (denials of care because a service or treatment is not "medically necessary")

Medical necessity criteria is a commonly accepted method of assuring quality and cost efficiency in the delivery of general and specialty healthcare. However, like other methods of cost containment, when applied in a manner that is discriminatory can have adverse effects. One example of this is when "medical necessity" is determined by the plan and not by the healthcare provider working with the individual who needs care, treatment, or services. If medical necessity

criteria are applied more restrictively than it would be applied for general medical conditions, it violates MHPAEA requirements.
Historically, an insurance plan's medical necessity criteria were not easily available to providers and consumers. Under MHPAEA, when medical necessity criteria are used as a rationale for the denial or limitation of coverage, the criteria must be made available to providers and patients. Medical necessity criteria is also often unique to the plans that create them and in the worst case scenarios, lead to many of the aforementioned types of discriminatory practice.

It is the contention of the Colorado Coalition for Parity that standardization in the practice of determining coverage eligibility and applying it to the delivery of care in a manner consistent with the requirements of the MHPAEA is something on which providers, consumers, and insurance companies can come together. Changes that result in conformance with these requirements would lead to improvement in the quality and effectiveness of care to manage and reduce overall costs of behavioral health services. Additionally, these changes would simultaneously reduce the burden of these diseases on patients, families, and the community.

7. The System of Care and Health Insurance Benefits

There have been significant advancements in our understanding of substance use and mental health disorders. There exists a scientific basis for their etiology, pathophysiology, natural history, and course of development. There is also a significantly improved understanding of effective therapies and treatment protocols to treat these disorders. In the last 20 years clinical and scientific advancements have allowed practitioners and provider organizations to more effectively than ever prevent, intervene, treat, and maintain recovery for those with substance use and mental health disorders.[17] Concurrently over this time period, the evolution of our system of care has not kept pace with our understanding of the most effective methods to prevent, treat, and sustain recovery for these disorders. The current system of care is based largely on an acute care model, rather than one designed to manage a chronic illness.[18] The managed behavioral health care funding system developed in the 1990's is not designed with the current understanding of MH/SUD as chronic in nature nor does it effectively allow for the early identification, prevention, and intervention of less severe levels of substance use and mental health disorders. Therefore, the payment system and financial incentives are not aligned with the most effective system of care required to prevent and reduce the burden of illness on those individuals and families affected by substance use and mental health disorders and to reduce the long-term economic costs on our society and the healthcare system as a whole. When financial incentives are not aligned with the basic nature of the most effective care delivery system, patients, families, and communities experience less than optimal care. In this environment, costs are harder to bring into control and the system as a whole suffers.

Historically, the mental health and addiction treatment system has existed alongside and not integrated within the larger healthcare system. There are many reasons why this is the case, but

[17] McLellan A.T., Treating Addiction as a Chronic Disease – How do We Get from Here to There, Addiction Professional Magazine, July 2, 2013.
[18] McLellan, A.T., Addiction and Segregation, Join Together, April 26, 2011.

suffice it to say that this system no longer works.[19] Efforts at integrating mental health, physical health, and addiction recovery services are gaining traction and state licensing and public funding systems are beginning to align around this paradigm. Mental health and substance use disorders exist on a continuum of severity and chronicity. Among the millions who suffer with these disorders, many could and should be identified and screened at an early and lower level of disease severity. Others experience these disorders at a higher level of severity and require much higher, more intensive levels of specialty care. Additionally, the many that experience these disorders at lower levels of severity go unidentified and do not seek treatment because of the stigma associated with the disorders in our society. This section will outline a system of care that is based on an integrated and continuum-of-care approach to identification, early intervention, treatment, and recovery maintenance of substance use and mental health disorders.
Insurance benefits provided under an integrated ACA and MHPAEA mandate will significantly improve the current system by more adequately aligning the payment system with an evolving care delivery system. There are six classifications of benefits currently used by insurers:

a) Inpatient (Residential) – In Network
b) Inpatient (Residential) – Out of Network
c) Outpatient – In Network
d) Outpatient – Out of Network
e) Emergency Care
f) Prescription Drugs

With the ACA effectively integrating the requirements of the MHPAEA in the essential benefits plan and improving access by providing substance use and mental health disorder coverage to more than 62 million people, there exists an opportunity to address substance use and mental health disorders in a more cost effective and equitable way. The new/evolved system of care will prevent, screen, and intervene early in the course of disease, provide effective specialty care at all levels, and acknowledge the value of providing long term disease/recovery management support.

Primary Care

The primary health care environment provides a robust and accessible system to address patients who could/should be identified and provided with early interventions known to be effective in reducing the adverse effects of the illnesses experienced when the MH/SU disorders progress to more advanced and even chronic levels of severity. Additionally, when patients need a more highly specialized, intensive, and costly level of care, the primary care system can and should be used to help patients access these services and provide disease management care when the more intensive treatment is concluded. This mirrors the system of care provided for the identification, treatment, and recovery management of other very debilitating chronic illnesses such as diabetes, heart disease or cancer. According to the 2008 report by the National Quality Forum, "National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence Based Treatment Practices," primary healthcare providers should screen new patients annually for "at risk drinking, alcohol use problems and illness" as well as try to identify patients who use drugs

[19] Miller, W.R. (2007). Bring addiction treatment out of the closet. *Addiction, 102, 863-869.*

by "employing a systematic method that considers epidemiologic and community factors."[20] The report goes on to recommend that for patients identified with substance use disorders, there should be further assessment to provide patient centered treatment planning for SUDs and any co-occurring disorders. Additionally, the report indicates that the primary care environment should be able to "offer long-term, coordinated management of their care for substance use illness and co-existing conditions." The National Center on Addiction and Substance Abuse at Columbia University (CASA) has published a comprehensive report entitled "Addiction Medicine: Closing the Gap between Science and Practice." The report goes a long way to identify the essential role of mainstream medicine in the care of substance use disorders and has issued recommendations for the "Reform of Health Care Practice." The report also calls for the integration of and alignment with the current fragmented parallel system of substance use disorder services in this country. Substance use disorders are legitimate medical conditions and therefore require medical professionals and the medical health care system to help lead the effort to reduce the burden of these conditions on individuals and society.[21]

There are three essential evidence based practices that should be integrated into the primary care system and other physical healthcare settings that would significantly improve the care of those at risk and those already suffering from the adverse effects of untreated/unmanaged disease.

a) Screening, Brief Intervention, and Referral to Treatment: Screening, brief intervention, and referral to treatment is an evidenced based practice that applies effective protocols to identify those who present with risk factors for substance use and mental health problems and proceeds with brief interventions, which serve to educate, effect behavioral change, and offer effective therapies to arrest the development of the illness or potential exacerbation of the disease. Referral to treatment completes the loop by requiring primary and other physical healthcare providers to make referrals to higher, more intensive treatments when indicated.

b) Pharmacotherapy: The use of medications to treat mental health disorders and to treat and/or manage substance use disorders should be understood by and integrated into primary care practices as part of wellness management. Several new medications deemed to be effective in the treatment of substance use disorders are now available. More will become available as the research effort dedicated to finding effective pharmacotherapies has grown significantly in the last decade. Currently medications exist to effectively treat alcohol, opiate, and nicotine dependencies while others are available to minimize the long-term negative cognitive and psychological effects of chronic substance use problems. Pharmacotherapy for substance use disorders is also effective for the care of patients with more advanced substance use disorders when combined with other psychosocial therapies and higher levels of care.

c) Disease Management: Just as in the care and treatment of other chronic illness, mental health and substance use disorders often require referral to more specialized and intensive

[20] National Behavioral Health Quality Framework, Substance Abuse and Mental Health Services Administration, August 22, 2013-Draft for Public Comment.
[21] Addiction Medicine: Closing the Gap Between Science and Practice, The National Center on Addiction and Substance Abuse at Columbia University, 2012.

levels of treatment than can be provided in the primary care setting. When this is the case, primary care providers can function in a disease management capacity for patients who initiate recovery in such a specialized setting but need well-informed and competent follow-up in the primary care setting.

It is important to note that the substance use and mental health disorder treatment systems evolved on parallel tracks. With the development and implementation of the ACA, truly integrated care should treat substance use and mental health disorders within the context of the whole person, focusing on the effect that behavioral condition(s) have on the physical well-being of the individual being served, and the effect that physical ailment(s) may have on the behavioral well-being of the individual being served.

Specialty Care

A "coordinated management of substance use disorders" by definition requires primary care providers to understand and navigate the specialty sector of addiction and mental health services. Patients who require a more intensive and specialized service to treat and manage recovery from substance use and co-occurring disorders should have efficient access and ongoing coordinated care at facilities and with providers competent to provide these specialty care services.
When primary and other physical healthcare providers identify and assess the need for more specialized and intensive treatments to address more advanced substance use and/or mental health disorders, the system of care should be easily accessible and available to those providers. As said previously, this "behavioral health" system of care should become integrated and standardized to provide the most advanced and scientifically validated treatments available. Just as with the treatment and management of other chronic disorders, varying levels of specialty care should and do exist, appropriate to the level of disease being treated. The American Society of Addiction Medicine (ASAM) has established treatment guidelines that describe these levels of specialty care for substance use disorders. ASAM outlines criteria applied to determine which level of intensity is most appropriate to the current level of need. There are five identified levels of specialty care that should be seen as offering a range of services appropriate to both the level of severity of pathology and the bio psychosocial factors that support or impair recovery. The following are the levels of care outlined in the ASAM Criteria. Within each level there are gradations of intensity and medical/clinical monitoring required. The criteria should also be applied in a disease management manner where the levels of care are applied as symptoms remit or abate, as is expected with all chronic conditions.[22]

a) ASAM Level I
    i. Standard Outpatient Specialty Care
    ii. Ambulatory Detoxification

b) ASAM Level II
    i. Intensive Outpatient
    ii. Partial Hospitalization
    iii. Ambulatory Detoxification with On-site Monitoring

[22] ASAM, Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition -Revised (ASAM PPC-2R). April 2001.

c) ASAM Level III
    i. Residential/Inpatient

d) ASAM Level IV
    i. Medically Managed Inpatient Care
    ii. Medically Managed Inpatient Detoxification

e) Opioid Maintenance Therapies

Corresponding treatment guidelines that describe the levels of specialty care for mental health disorders do not exist. Individual insurance companies/managed care organizations have published "clinical criteria" for treating mental health disorders, however, these criteria are not accepted with the same level of universality that the ASAM criteria are. This represents the profound need for a "continuum of care", much like what the ASAM criteria represents in substance use disorder treatment, to manage the chronic nature of mental health disorders. Specialty treatment services should be integrated along physical, mental, and substance use health parameters. This means that providers of the levels of specialty care should be trained and competent to screen, diagnose, treat, and provide recovery support for people who will likely present with physical, substance use and mental health disorders concurrently.[23]

Recovery management is a concept garnering much attention in recent years. Recovery management is based on the premise that mental health and substance use disorders are chronic conditions and that proper management of them requires a long-term and sustained effort. Recovery management includes the use of professional and peer-based levels of support over the natural course a person's recovery career. If we really believe substance use and mental health disorders are chronic conditions, then recovery management should be expected and integral to the system of care. Traditionally, treatment for mental health and substance use disorders (more so within the SUD system) has been delivered in a system that is more accurately described as an acute care system. A. Thomas McClellan, Executive Director of the Treatment Research Institute, has outlined the importance of viewing behavioral health disorders as chronic conditions requiring a disease management approach and has called for the integration of the behavioral health system with the larger healthcare system.[24]

William White, Senior Researcher for Chestnut Health Systems, has championed the application of recovery management approaches to improve the long-term recovery outcomes of those served in the substance use disorder treatment system. Some systems of care and provider organizations in the public and private sectors are gradually embracing this call to action and developing professionally and "peer-based" processes aimed at supporting people long after initiating recovery in the acute care specialty treatment settings. Additionally, White proposes that the system of care should play an important role in combatting the culture of addiction in our society by nurturing and supporting a culture of recovery which embeds treatment and recovery management processes in the indigenous communities of recovery where our patients and

[23] ASAM, Public Policy Statement on Treatment for Alcohol and Other Drug Addiction, 2010.
[24] McLellan A.T., Treating Addiction as a Chronic Disease – How do We Get from Here to There, Addiction Professional Magazine, July 2, 2013.

families live their lives. The history of peer-based recovery support is deep and rich in the specialty addiction treatment sector. White proposes that recovery be the organizing principle and that truly integrated systems become Recovery Oriented Systems of Care.[25] There are several important tenets to realize this vision including:

a) Shift from a focus on pathology to one that revolves around recovery.
b) Extend the design of addiction treatment from being focused almost solely on acute bio psychosocial stabilization (recovery initiation) to one that encompasses support for long-term personal and family recovery (recovery maintenance and improved quality of life).
c) Nest these models of sustained addiction recovery management (ARM) within larger recovery oriented systems of care (ROSC).

It is imperative that any recovery oriented system of care include both professional clinicians from various disciplines trained and competent in mental health and/or substance use disorder services, and peer-based communities of recovery who rely on "experiential credentials" in a system that embeds care and services in the indigenous communities where patients and families live their lives. Professional treatment systems can and should embrace and find ways to involve those successful in recovery from mental health/substance use disorders in the process of providing care.[26, 27]

8. A Business Case for Providing Substance Use and Mental Health Disorder Treatment

As the U. S. economy faces unsustainable escalations in health care costs, we need to ensure that effective substance use and mental health disorder treatment and recovery programs are provided, to help reduce related health care and societal costs. The benefits of treatment far outweigh the costs. Even beyond the enormous physical and psychological costs, treatment saves money by diminishing the huge financial consequences imposed on employers and taxpayers.

In a report entitled "Successful Employer Implementation of the Federal Mental Health Parity and Addiction Equity Act" published by the Research Works Partnership for Workplace Mental Health, the authors assert that substance use and mental health disorders impact a significant percentage of the working population.[28] Up to thirty to forty percent of the US population experience mental health and substance use disorders at some point in their lives. About half of these people (15% to 20%) require professional care every year. Nearly ten percent of workers are identified as drinking large amounts of alcohol on a regular basis. Eight percent of US workers use illicit drugs. There is also a significant co-occurrence of substance use and mental

[25] White, W. (2005a). Recovery management: What if we really believed that addiction was a chronic disorder? *GLATTC Bulletin, September, 1-8. Chicago, IL:* Great Lakes Addiction Technology Transfer Center.
[26] White, William L. (1990). Pathways from the Culture of Addiction to the Culture of Recovery.
[27] White, W., & Kurtz, E (2005). "The Varieties of Recovery Experience". Chicago, IL: Great Lakes Addiction Technology Transfer Center.
[28] "Successful Employer Implementation of the Federal Mental Health Parity and Addiction Equity Act" published by the Research Works Partnership for Workplace Mental Health December 2009

health disorders (up to 25%) and significant co-occurrence of substance use and mental health disorders along with other chronic medical conditions, such as diabetes, asthma, and cancer.[29] Employers are impacted by substance use and mental health disorders as measured by loss of productivity, absenteeism, and quality of work product. Mental illness and substance use disorders cost employers an estimated $80 to $100 billion in indirect costs annually.[30] More days of work loss and work impairment are caused by mental illness than by other chronic health conditions, including arthritis, asthma, back pain, diabetes, hypertension, and heart disease.[31, 32, 33] Employees with depression cost employers an estimated $44 billion per year in lost productive time.[34] Even employees with light to moderate alcohol use (e. g., binge or hazardous drinking) can have high rates of absenteeism, tardiness, and poor work quality.[35] Studies show that 1. substance-abusing employees function at about two thirds of their capability; 2. employees who use drugs are three times more likely to be late for work; 3. approximately 500 million workdays are lost every year due to alcohol abuse; and 4. employees who use drugs are more likely to request early dismissal or time off and to have absences of eight days or more.[36]

It is important to factor the effectiveness of treatment into the cost-benefit analysis for the treatment of substance use and mental health disorders. Numerous critical reviews and meta-analyses conducted in the last 25 years examining the cost-benefit question offer significant evidence that providing treatment offsets or reduces the subsequent use of medical care services and their associated health care and disability costs.[37] For an employer, providing an employee with appropriate substance use or mental health disorder treatment as soon as the need is identified ultimately means less healthcare associated costs for the employer.

Research shows an even greater cost savings for employers in the areas of indirect costs: employee productivity, absenteeism, speed and quality of return to work after disability, and

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[29] Substance Abuse and Mental Health Services Administration. (2007) National Survey on Drug Use and Health 2005 and 2006: Table 5.8A. Rockville, MD: Author. Available from: http://oas.samhsa.gov/nsduh/2k6nsduh/tabs/Sect5peTabs1to13.pdf

[30] Finch, R.A. & Phillips, K. (2005) An employer's guide to behavioral health services. Washington, DC: National Business Group on Health/Center for Prevention and Health Services. Available from: www.businessgrouphealth.org/publications/index.cfm.

[31] Druss, B. G., & Rosenheck. R. A. (1999). Patterns of health care costs associated with depression and substance abuse in a national sample. Psychiatric Services, 50, 214–218.

[32] Kessler, R. C., Greenberg, P. E., Mickelson, K. D., Meneades, L. M., & Wang, P. S. (2001). The effects of chronic medical conditions on work loss and work cutback. Journal of Occupational and Environmental Medicine, 43(3), 218-225.

[33] Stewart, W. F., Ricci, J. A., Chee, E., Hahn, S. R., & Morganstein, D. (2003). Cost of lost productive work time among U.S. employees with depression. Journal of the American Medical Association, 289(23), 3135-3144.

[34] Marlowe, J. F. (2002). Depression's surprising toll on employee productivity. Employee Benefits Journal, March, 16-20.

[35] Larson, S. L., Eyerman, J., Foster, M. S., & Gfroerer, J. C. (2007). Worker substance use and workplace policies and programs (DHHS Publication No. SMA 07-4273, Analytic Series A-29). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Available from: www.oas.samhsa.gov/work2k7/work.htm

[36] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2008). Drugs in the workplace: What an employer needs to know. Rockville, MD: Author. Available from: http://workplace.samhsa.gov/DrugTesting/Files_Drug_Testing/FactSheet/factsheet041906.aspx.

[37] "Successful Employer Implementation of the Federal Mental Health Parity and Addiction Equity Act" published by the Research Works Partnership for Workplace Mental Health December 2009

reduced turnover. One study found that antidepressant medication treatment for depression resulted in improved workplace productivity for over 80 percent of cases.[38] Similarly, screening, brief intervention, and referral to treatment, a practice combining the use of validated screening instruments and short-term intervention to reduce or eliminate harmful substance use, has been shown to have a positive return on investment.[39]

To further make the business case for parity, in 2012 the Community Preventative Services Task Force recommended mental health benefits legislation, particularly comprehensive parity legislation, based on sufficient evidence that mental health benefits legislation is associated with improved financial protection and increased appropriate utilization of mental health services for people with mental health conditions. Appropriate utilization includes, but is not limited to, mental health visits for people identified with a mental health need, visits rendered by mental health specialists, or care visits that are in line with evidence-based guidelines for mental health care. This review also found evidence associating mental health benefits legislation with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health, and reduced suicide rates. The Task Force conducted a systematic review of 30 studies reported in 37 papers in its review. Twenty eight studies examined the effects of state or federal mental health parity legislation or policies, and two studies examined the effects of state mandated coverage for mental health and substance abuse. Six of these studies examined the effects of comprehensive parity legislation or policies and generally found stronger effects for comprehensive parity legislation or policies versus those that were less comprehensive.[40]

9. A Path Forward: Equity in the Care of Substance Use and Mental Health Disorders

We all have a stake in, and will all benefit from the guarantee of MHPAEA: insurance coverage provided on par with other medical conditions to restore individuals living with substance use and mental health disorders to health. Let us move forward with this opportunity to initiate and sustain the changes needed to realize this benefit and improve the quality of life for these individuals, be they strangers or be they colleagues, neighbors, friends or family members.

Significant strides have been made in serving those with mental health and substance use disorders. In the past 50 years legislative action has ushered in a nationalized system of community-based treatment and funded research for the care of those with substance use and mental health disorders.[41] On November 8, 2013, the Departments of Treasury, Labor, and Health and Human Services issued the final rule on MHPAEA, which further serves to protect the rights of people with mental health and substance use disorders. The current opportunity to implement these protections and improve access to care in the context of the Affordable Care

[38] Finkelstein, S., Berndt, E., Greenberg, P., Parsley, R., Russell, J., & Keller, M. (1996). Improvement in subjective work performance after treatment of chronic depression: Some preliminary results. Psychopharmacology Bulletin, 32, 33-40.

[39] Substance Abuse and Mental Health Services Administration. (2008). Screening works: Update from the field. SAMHSA News, March/April, 16(4). Available from: www.samhsa.gov/samhsa_news/VolumeXVI_2/article2.htm

[40] : Guide to Community Preventive Services. Improving mental health and addressing mental illness: mental health benefits legislation. Available from: www.thecommunityguide.org/mentalhealth/benefitslegis.html. August 2012.

[41] SAMHSA, *Behavioral Health is Essential to Health, Prevention Works, Treatment is Effective, People Recover*

Act is unprecedented both in terms of a system of payment and in further refining a system for the delivery of care, treatment, and services. We know significantly more about the organic nature of these disorders, the impact they have on individuals, families, communities, and our nation when they are not addressed; and about effective, science-based strategies for prevention, early intervention, treatment, and recovery support. A vision for the system of the future will preserve the integrity of our current behavioral healthcare system, while integrating with, and not being subsumed by the larger health care system.

Armed with the knowledge we have, at no other time in the evolution of substance use and mental health disorder treatment have we had the potential to effect as much positive change in the lives of the individuals we serve, their families, our communities, and the nation than we have right now. That potential rests in a fragile balance between the assurance for equity written into MHPAEA and the requirement for more integrated care and parity found in the ACA. In the words of former Representative Patrick Kennedy, "Put simply, this is a time of tremendous opportunity for our nation to set the course for future breakthroughs in care and in public policy. Together, we must seize this moment if we are going to finally end the stigma associated with mental illness and help millions of our fellow citizens lead better, healthier lives."[42] The well-being of Coloradoans who experience substance use and/or mental health disorders depends on our thoughtful and collaborative efforts to implement these two pieces of legislation. When payment and financial systems are aligned with an optimized system of care, the health and well-being of individuals, families, and communities are improved. Learning from the mistakes of the past, we move forward with what we know now to transform and improve our care, treatment, and service delivery systems.

[42] "Honoring JFK and Heeding His Call on Mental Health" Patrick J. Kennedy, The Boston Globe, October 21, 2013, www.BostonGlobe.com.