Delay Sought in Final Mental Health Parity Rules

BY ALICIA AULT

Saying that there is too much confusion between the requirements of the new health reform law and the not-yet-final mental health parity law regulations, a group of mental health behavioral care organizations has sued the federal government to delay the implementation of the rules.

Meanwhile, the American Psychiatric Association is pressing the government to move forward, saying that some health plans are imposing cost control techniques that subvert the parity law's intent and are restricting patient access to care.

The litigation was filed by Magellan Health Services, Beacon Health Strategies, and ValueOptions. The companies supported the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, but are not satisfied with the interim final rules issued in February by the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor, Pamela Greenberg, president and CEO of the Association for Behavioral Health and Wellness, said in an interview.

The association is not involved in the suit, she said, but would prefer a 1-year delay in the issuance of the final rules to give mental health managers time to comply.

The law went into effect Jan. 1. Most insurers and employer-based plans began complying with the intent of the law at that time, but awaited the exact details that would be spelled out in the regulations. With the issuance of the interim final rules, all plans must comply for plan years that start July 1.

Insurers and managed behavioral companies object to the "nonquantitative treatment limits" spelled out in the interim final rules, Kris Haltmeyer, executive director of policy for the BlueCross BlueShield Association, said in an interview. The Blues did not join the suit, but is also seeking a delay until July 2011, Mr. Haltmeyer said.

According to the rules, viewable at www.regulations.gov, everything must be equal between medical and surgical care and mental health care. Plans cannot employ more restrictive benefit management techniques for mental health and substance abuse treatment than for medical and surgical care. These were the nonquantitative limits. Plans also cannot charge separate deductibles, or have different levels of copayment or coinsurance for mental health care.

The Blues would argue that the parity legislation never explicitly discussed whether plans could use traditional behavioral benefit management techniques, such as prior authorization or formulary tiers, so the rules go beyond the intent of the legislation, Mr. Haltmeyer said. Without those tools, plans might have to clamp down further on all health care services to achieve true parity in benefits and cost control, he said.

Psychiatrists, however, say they increasingly are being burdened with bureaucratic requests from insurers that seem designed "to drive physicians out of the network and to block patient access," Jennifer Tassler, deputy director of regulatory affairs for the APA, said in an interview.

Plan administrators have the legal right to manage the benefit, but it's being overzealously and unfairly applied, she said. The APA has received reports that physicians are being asked in some cases to get prior authorization before every patient visit or to submit treatment plans after every few visits.

In comments to the government, the APA expressed its support for the restrictions on nonquantitative limitations and a single deductible. The organization is concerned, however, that the rules did not appear to apply to Medicaid-managed care plans and urged the government to issue regulations to cover those plans.

Overall, though, the interim final rules "went a long way to clear up what the law intended and covered," Ms. Tassler said.

No one knows when final rules might be issued. The government also issues interim final rules that stand, she said. The insurers are aware of that possibility, which is why they are seeking a delay in implementation, Mr. Haltmeyer said. ■

Mental Health Parity's Evolution

September 1996 The Mental Health Parity Act establishes parity for lifetime and annual dollar limits.
October 2008 The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) is enacted, guaranteeing full parity with medical and surgical benefits and out-of-pocket costs.
April 2009 The federal government seeks comments on how to implement MHPAEA.
October 2009 MHPAEA goes into effect for the plan year starting January 2010.
February 2010 Interim final rules are published.
May 2010 The comment period closes for the interim final rules.
July 2010 The rules apply to all plans.

EHR REPORT

Teamwork Is Key to a Successful Transition

BY CHRISTOPHER NOTTE, M.D., AND NEIL SKOLNIK, M.D.

The failure of EHR implementations is often due to productivity loss, and nothing is more detrimental to productivity than discouraged employees. Before taking the giant leap, it is critical to solidify support from all members of a practice staff and build enthusiasm for the transition. The only proven way to do this is to create a transition team to effectively guide the process and allay fears about the changes to office workflow.

The first team-member role that should be defined is the "physician champion," who will communicate with fellow providers and foster an environment that is excited about change. No matter how big or small a practice, there will always be naysayers, and that means the champion will need to have strong staff rapport and be effective at communicating the goals of the transition.

This person will have a significant impact on how the new technology will affect patient care, so the other providers must trust the champion to act in their best interests. He or she will act as a "superuser" of the EHR software, possessing a firm grasp on most aspects of its operation, and be available to help the staff with technical questions.

Next, identify the team manager. This may be the office manager or another staff member with good organizational and communication skills.

With the primary responsibility of overseeing the transition team, this person must clearly understand the needs of the practice and keep the process moving forward according to the established timeline. He or she will be the go-between for the EHR vendor and the transition team to ensure that all concerns are addressed and will keep track of information related to the process. Together with the physician champion, the team manager will select the rest of the transition committee.

It is typically beneficial to select one individual from each department—including members of the front, back, and clinical office staff—so that all aspects of office workflow can be considered. It can be invaluable to choose influential individuals who are excited about the new technology. Be sure to spend some time assessing the strengths and relationships of individual staff members prior to making the choice.

Once the team members are identified, the real work begins. The first step is to establish a common vision. Early on, presentations providing a preview of the EHR software can be helpful to ensure that the team members are all on board with the same objectives.

Ask the EHR vendor to provide a demonstration to the entire office that highlights the features of the product and allows them to interact with it. Often, this demo will raise questions and concerns that can then be addressed by the transition team. This leads to the next—and perhaps the most important—step to implementation success: Create buy-in from the staff.

Medical professionals have a reputation, whether deserved or not, of disliking change. After all, routine in the workplace is often the source of efficiency, and disrupting the routine can significantly impact workflow. There is no question that introducing information technologies into an office will be disruptive. For those employees with limited technical skill, the mere idea of spending any more time interacting with computers may be daunting. For others, it may feel like an unnecessary inconvenience.

To address these concerns, highlight ways in which the EHR implementation may save time and make life easier: automating appointment reminders and refill requests, simplifying repetitive office processes, and increasing the legibility of progress notes. What once was handwritten and clipped onto a paper chart can now be documented electronically. This is not only more secure, but also makes it easier to search for notes and other documents later. Charge capture can be dramatically improved with more accurate coding and billing, and staff time can be optimized by avoiding chart pulls and streamlining quality data reporting.

If the technology is used to its full potential, every office process will be affected by the transition. The hope is that ultimately it will provide an opportunity to examine current workflow procedures and improve on them. This can be achieved if the leadership communicates the vision and reason for the change and addresses employee concerns.

DR. SKOLNIK *is associate director of the family medicine residency program at Abington (Pa.) Memorial Hospital and professor of family and community medicine at Temple University, Philadelphia.* DR. NOTTE *is in private practice in Chalfont, Pa. They are partners in EHR Practice Consultants (www.ehrpc.com).*