National Alliance
of Healthcare Purchaser Coalitions
Driving Innovation, Health and Value

ACHIEVING VALUE IN MENTAL HEALTH SUPPORT

A Deep Dive Powered by eValue8

AUGUST 2018

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EXECUTIVE SUMMARY

There continues to be widespread concern across the country among purchasers and purchaser coalitions on several issues impacting access to behavioral health specialists, as well as the quality and management of patients with mental health and substance use issues by both primary care and behavioral health specialists. These concerns include:

- Members are not able to consistently access clinicians in their network in a timely fashion
- Consistent use of measurement-based care (validated instruments to identify and monitor progress) is not standard practice among primary care physicians or specialists
- Stigma and silence around behavioral health conditions remains prevalent and limits effective workforce performance and engagement
- Escalating suicide and opiate related death rates

The National Alliance of Healthcare Purchaser Coalitions (National Alliance) developed a collective agenda that supports all stakeholders (employers, health plans, behavioral health organizations and providers) in taking action to address these issues. To support this effort, a new eValue8™ module—the "2018 Mental Health Deep Dive" was developed to assess the current performance of health plans and behavioral health organizations across key areas in behavioral health (mental health and substance use disorder, MH/SUD) including support provided to primary care physicians who treat the majority of people with mild/moderate MH/SUD issues. Because of the enthusiastic support and engagement of the diverse array of MH/SUD experts, coalition leaders, and purchasers participating in the development of the questions, we have great confidence that we've developed the most thorough assessment of mental health support conducted in the past decade.

Highlights

Results of the assessment identified some variations in performance across responding health plans and managed behavioral health organizations (MBHO). There were also many common areas of concern with key findings and observations highlighted below. The latter portion of this report provides further details and recommended actions that purchasers and health plans can take. Appendix 1 summarizes an Employer Checklist.

Networks – Adequacy & Access

- The percent of out-of-network claims are much higher for behavioral health (MH/SUD) services than for medical/surgical services. This is true across all settings (inpatient, outpatient facility and offices) which reinforces concerns about existing access issues related to adequacy of participating MH/SUD providers.
- The access standards for urgent in-network office visits are shorter for medical/surgical than for MH/SUD (24 hours vs. 48 hours). Even more concerning is the inconsistency in monitoring that these standards are consistently met.

- While there is some evidence of patchwork fixes, there does not appear to be a consistent or systemic approach to assess and address the underlying issue of access that include adequate network and appointment wait times, improving reimbursement, removing hassle factors and engaging the MH/SUD specialist community. Instead, typical strategies have focused on member steerage to in-network use through a variety of mechanisms including higher cost-sharing.
- There are considerable efforts in place to expand access through tele-behavioral health.

Physician Measurement, Management & Payment

- Very few respondents are requiring or monitoring that primary care and specialty care clinicians screen for conditions such as stress, anxiety, depression, alcohol use, substance use, ADHD using a recognized standardized instrument to identify and monitor progress.
- Plans use HEDIS measures for reporting; yet only some respondents monitor or provide feedback to clinicians and provide transparent reporting.
- Almost all reimburse for SBIRT (Screening, Brief Intervention, Referral and Treatment); fewer actively promote use of codes.
- Most respondents report they are reimbursing for the three collaborative care codes and one behavioral health (BH) integration code but little evidence that codes are promoted or used.
- Plans that report using alternative payment models use case rates and bundled payments most commonly.

Pharmaceutical Management

- None of the respondents offered a value-based formulary for antidepressant medications where some newer antidepressants with better outcomes and no generic equivalent are on lowest cost tier.
- Although many patients with BH conditions suffer from “first failure” which occurs when the prescribed medication fails to have the intended effect, the most common policy for depression and bipolar disorder includes step therapy with two-three fails limiting timely access to the most appropriate medication
- About half the respondents cover at least one of the personalized medicine tests for four conditions (anxiety, depression, bipolar disorder and ADHD).
- There is variation in level of monitoring of primary care physicians and BH specialists on appropriateness of prescribing.

Member Engagement, Management and Support

- Tracking of member on demographic features varied and not all respondents provided information on estimated membership with various MH/SUD conditions.
- In many instances members with MH/SUD conditions are not assessed for co-existing medical conditions such as coronary heart disease, obesity and diabetes or for tobacco use.

- All respondents reported having provisions in-place for members to reach or be warm-transferred to a MH/SUD clinician for after-hours emergent calls.
- Online MH/SUD Directory and physician selection tool generally have less content and functionality compared to medical directory/physician selection tool. Half the respondents had telemedicine as an indexed and searchable element in the directory.
- Most respondents reimburse for the transitional care codes; however, the number of claims reimbursed in past year varied widely.

Accreditation and Compliance with Parity

- Most respondents have managed behavioral health organizations (MBHO) accreditation conferred by the National Committee on Quality Assurance (NCQA).
- Most have conducted an internal audit on parity compliance but not an external audit by a third party.

Data Analysis and Reporting

- Most respondents can report aggregated employee assistance program (EAP) utilization at the employer level and conduct a targeted follow up via email or phone call to assess user satisfaction. Use of EAP services is typically low.
- There is limited reporting on impact on disability rates and return-to-work although most had information on absenteeism/presenteeism and return on investment.
- HEDIS results varied with the two measures that needed the most improvement being a) Follow-Up Care for Children Prescribed ADHD Medication and b) Metabolic Monitoring for Children and Adolescents on Antipsychotics

Other Work in Progress

The National Alliance is collaborating with the American Psychiatric Association (APA) and the APA Foundation Center for Workplace Mental Health to develop a road map for improvement across the industry recognizing the role of the professional societies, coalitions, employers, health plans and behavioral health organizations (see Appendix 2). In addition, Catalyst for Payment Reform has similarly identified these issues as an industry priority and have developed a set of standards with their employer advisory group (see Appendix 3).

Acknowledgement

The National Alliance is thankful for the collaboration with the following sponsors—the American Psychiatric Foundation, the Center for Workplace Mental Health at American Psychiatric Association, Clear Health Quality Institute, Takeda Pharmaceuticals and Lundbeck.

Final Words

The results of this report highlight significant industry concerns and opportunities to review current practices and develop action plans to improve access to high quality care and support within both the medical (primary care) and behavioral delivery systems. With gaps that have been described in the identification, treatment, and management of behavioral health conditions, we have now set a new bar for purchaser expectations and a collective roadmap to meet those expectations. Efforts are already underway to help educate, engage and promote this agenda with each of the stakeholders. We expect to reassess and report on our collective progress and continuing concerns as we move forward together!

BACKGROUND AND INTRODUCTION

Over the past few years, the National Alliance has convened multiple stakeholder forums to identify issues and understand root causes impacting the support provided for the mental health of our employees and their families. There are clear gaps in the identification, diagnosis, treatment, and management of MH/SUD conditions and a "collective agenda" was developed in which all stakeholders including employers, health plans, behavioral health organizations and providers can contribute. It can be summarized as:

Improving Access

- Promote and reimburse for collaborative care in primary care settings
- Take proactive steps to ensure affordable access to quality networks
- Highlight alternative delivery modalities – e.g., telehealth
- Integrate EAP into a broader employer total health strategy
- Ensure access to medications through appropriate pharmaceutical benefit management

Improving Quality and Performance

- Promote early identification and intervention
- Measure behavioral health performance including accountability metrics
- Integrate mental health within total health and wellbeing strategies
- Support use of personalized medicine

Improving Environment

- Reaffirm the impact of mental health on broader functioning, cognition, and workplace performance as well as other healthcare conditions and costs
- Implement proactive strategies to break the silence and mitigate stigma
- Promote brain wellness, mindfulness, resilience and other innovative sciences focused on mental health
- Develop a culture focused on wellbeing and performance to mitigate chronic stress and positively impact workforce engagement and performance

Efforts are already underway to help educate, engage and promote this agenda with each of the stakeholders. This report focuses on the role of health plans and behavioral health organizations in meeting this collective agenda.

The eValue8 Assessment

eValue8 is a performance evaluation tool that, for more than 15 years, has set consistent, evidence-based, employer-expectations for health plan performance. It was created to support measurement the same way across vendors and across geographic boundaries and includes metrics from other credible sources such as the National Committee for Quality Assurance (NCQA), The Leapfrog Group, Centers for Disease Control and Prevention, Pharmacy Quality Alliance and Catalyst for Payment Reform.

Mental Health Purchaser Advisory Group

- Best Buy
- McMurry Cos
- OPM
- Prudential
- FedEx

Advisory Stakeholders

In developing the Mental Health Deep Dive, the National Alliance received support from a diverse array of mental health experts, coalition leaders, and purchasers. Each brought unique and reinforcing perspectives based on their own knowledge and efforts over the years. The purchaser voice was captured through engagement of a Mental Health Purchaser Advisory Committee consisting of seven purchasers from across the country as well as five-member coalitions (from the Mid-Atlantic, Minnesota, Memphis, Northeast, and Pacific regions) which have spent considerable efforts related to mental or behavioral health.

The National Alliance is thankful for the sponsorship and collaboration with the following sponsors – the American Psychiatric Foundation, the Center for Workplace Mental Health, Clear Health Quality Institute, Takeda Pharmaceuticals and Lundbeck as well as subject matter experts from the American Psychiatric Association (APA), the American Academy of Child & Adolescent Psychiatry, National Institutes of Mental Health, and NORC at the University of Chicago. The National Alliance is especially grateful for the participation of expert advisors Michael Schoenbaum and Henry Harbin. Because of the enthusiastic support of all participants, the National Alliance has great confidence that we've developed the most thorough assessment of mental health to be conducted in the past decade.

Mental Health Deep Dive Respondents

- Aetna
- Anthem
- Cigna
- Kaiser Permanente Washington
- Regence (Washington)
- UnitedHealthcare
- Beacon Health Options
- Optum Behavioral Health

We are also appreciative to the health plans and MBHOs that provided data to this ground-breaking assessment of the marketplace. All these respondents are impressive leaders in the behavioral health field and are committed to continued partnership with the purchaser community to improve access, quality and performance and the environment for mental health. Many of the issues evaluated in this assessment are complex and will require collaboration and coordination across the industry to substantively change the course of a failing mental health system.

Most of the respondents provided information at the national level. For some of the questions, responses were also provided for seven selected markets—California, Colorado, Mid-Atlantic region, Minnesota, New York, Tennessee and Washington.

In addition to the standardized assessment, respondents were invited to share strategy documents with the National Alliance. These strategy documents include activities in various topics such as brain health, reduction of stigma, strategies to break the silence regarding mental health issues and ways to promote wellbeing. These strategy documents are available upon request.

Appendices

Purchasers and plans will find many recommendations for action within this report. An employer checklist (included as Appendix 1) organizes these recommendations into the three areas of Improving Access, Quality & Performance and Environment.

In light of the multiple and inter-related issues highlighted in this report, the National Alliance has collaborated with the APA Foundation, the Center for Workplace Mental Health and the American Psychiatric Association to develop a road map for improvement across the industry recognizing the role of the professional societies, coalitions and employers and health plans and behavioral health organizations. That road map is included as Appendix 2. In addition, Catalyst for Payment Reform has similarly identified these issues as an industry priority and have therefore developed a set of standards with their employer advisory group. To view these, see Appendix 3.

> **"We heard from many of the plans that we were the first to be asking these types of questions and this level of deeper dive into mental healthcare and services. Clearly, these are questions that must be asked."**

Michael Thompson

President & CEO, National Alliance

THE DETAILED RESULTS

The results of this Mental Health Deep Dive, eValue8 assessment process are summarized in the following topical areas: 1) Networks – Adequacy & Access; 2) Physician Management, Measurement & Payment; 3) Pharmaceutical Management; 4) Member Identification, Engagement, Management & Support; 5) Accreditation and Compliance with Parity; and 6) Data Analysis & Performance.

In each section, the accompanying graphic displays the expectations, with the results of each respondent's performance. Plan and MBHO names are blinded as the National Alliance committed to anonymity for each respondent in this initial assessment. High level findings are noted in bullet form in each section along with a narrative to provide background and observations salient to the topic.

KEY TO COLOR CODING

- Exceeds/meets all/almost all the expectations
- Meets some of the expectations
- Meets few/none of the expectations

Networks - Adequacy & Access

For members to have adequate in-network access to MH/SUD services, the network of primary care and specialist clinicians needs to be sufficient. While about 95% of primary care clinicians join plan networks, only about half of MH/SUD specialists are in commercial networks (Milliman, 2017). We have heard for years anecdotally that patients cannot get timely in-network care (access). We also note that the MH/SUD specialists may be advised not to join networks due to reimbursement issues: when these same providers are accessed out-of-network, they may submit claims for higher amounts or get paid in cash at time of service. In addition, many professionals are retiring adding to the network adequacy problems. Purchasers and their vendor partners including plans, MBHOs, and pharmacy benefit managers (PBMs) have a shared responsibility along with the medical profession to break the logjam of poor network adequacy and in-network access. Key concerns include the percent of the time that access standards were met for urgent in-network office visits and wait times to obtain a first appointment with a BH specialist.

What We Found

Criteria for MH/SUD network adequacy varies widely across plans and geographies

- Access standards for urgent in-network office visits are shorter for Medical/Surgical (24 hours) than for MH/SUD (48 hours)
- Little evidence that standards are monitored or that variances acted upon

Percentage of out-of-network claims was much higher for MH/SUD (median of 13.6% for office visits) than for medical/surgical (median of 5.1%), across all three settings (office visits, outpatient facility and inpatient)

Most common activities to improve network access lack a systemic approach. Typical strategies include higher cost-share to member, tiered benefits, or out-of-network facility benefit inquiry hotlines

Not all respondents assess and or adjust relative fee levels for similar claim codes and/or time and effort

All respondents reimburse clinicians for tele-behavioral services regardless of urban versus rural

Recommendations for Purchasers

Insist on same access standards for BH and medical network adequacy, and that vendor partners monitor and compare access (e.g., wait times) quarterly. Ask for evidence to support plan's criteria for adequate access

Review in- and out-of-network use and payment information for medical/surgical and BH services. (Model Data Request Form)

- Insist that plans with significant difference in network access assess root cause(s) and develop an action plan to address them
- Question typical strategies that fail to address the underlying problem of insufficient numbers of BH specialists and request this be addressed
- Equalize reimbursement rates for MH/SUD and medical clinicians for similar services
- Develop mechanism to fast-track credentialing of MH/SUD specialists
- Remove "hassle factors" such as excessive PA which may reduce MH/SUD network participation
- Engage and recruit residents and clinicians who are not in-network
- Promote greater use of tele-behavioral health services and include this feature in provider directory and clinician selection tool

Purchaser Expectations	A	B	C	D	E	F	G	H
Criteria for network adequacy and wait times/standards for access should be comparable and monitored								
Systemic approach to improving in-network MH/SUD specialist participation (reimbursement, removal of barriers, engaging the specialists)								
Access to *in-network* care across sites of care should be comparable with action plan to address if not the case								

KEY Exceeds/meets all/almost all the expectations; Meets some of the expectations; Meets few/none of the expectations

Physician Management, Measurement & Payment

On the medical side, when plans contract with individual providers, provider groups, Patient-Centered Medical Home (PCMH) and/or Accountable Care Organizations (ACOs) to offer high quality of care to purchasers and enrollees, a common contractual obligation for providers especially those in an enhanced payment innovation model is the requirement to document clinical findings such as a blood pressure, using a common metric such as 120 systolic over 80 diastolic) and record these observations in the patient's chart. Unfortunately, many plans have not required the use of a standardized tool for depression, although the PHQ-9 has been the recommended assessment tool for nearly 20 years or other screening tools such as the SBIRT that have great validity in helping to properly identify patients who may have alcohol or substance use disorder.

Why Collaborative Care?

Collaborative care models are becoming more prevalent in all markets. Collaborative care models involve a primary care physician working directly with a behavioral health specialist. Over 70 studies support the value of these models; care is improved, and costs are reduced over time. Problems occur if the primary care provider does not have support from a collaborative care team member: the physician may not feel adequately trained in issues of behavioral health, or may not have the time to assess, treat, and monitor the patient. The Centers for Medicare and Medicaid Services began paying for collaborative care services using new billing codes January 1, 2017.

Nearly one-third of adults with chronic conditions also have MH/SUD conditions and these patients drive up healthcare costs by nearly 3x/300% (Source: Melek S, Norris D, Paulus J: Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. Edited by Milliman I. Denver, CO, Prepared for American Psychiatric Association; 2014. pp. 1–39). Therefore, identification of comorbid MH/SUD conditions by their primary care physician is crucial. PCPs also prescribe most psychotropic drugs and treat the majority of people with mild to moderate MH/SUD conditions. Almost all screening (or lack thereof) occurs in the general medical system. Consequently, primary care physicians should be included when addressing physician quality in management, measurement and payment.

"One thing that has surprised me, is that in medical care, such as for diabetes or hypertension, we find that the usual process is assessment, treatment, re-assess whether the patient is responding, and titrate or change the patient's treatment; but for behavioral health conditions this is NOT happening, which is really a big problem." John Miller, Executive Director of the Mid-Atlantic Business Group on Health and MH Steering Committee Member. With this in mind, we know that PCMHs and/or ACOs are the standards by which advanced primary care practice models are gauged, however PCMH/ACO standards do not require the use of screening tools and documentation that would lead to better managing the mental health needs of the patients (measurement-based care). Therefore, we should insist these measures be a core part of the advanced care models.

About 10 years ago, billing codes were devised to allow for consultation and collaborative care services. The aim was to promote better communication between primary care and specialists in behavioral health. Now, team based, or collaborative care, has become more prevalent as practitioners seek the best model to provide care to patients.

Purchasers should be aware that there are now four current procedural terminology (CPT) codes related to collaborative care and behavioral health integration that allow for reimbursement and consultation with a MH/SUD specialist and requires screening with a validated screening instrument. To have optimal impact, all/most commercial insurers in a market should commit to promote, train and reimburse for these codes.

What We Found

Most plans are *not* measuring, requiring or incenting clinician or PCMH/ACO use of a validated screening instrument for:

- depression, alcohol and substance use disorder
- most are recommending but not monitoring that clinicians screen for post-partum depression

Plans use HEDIS measures for reporting; yet only some respondents monitor or provide feedback to clinicians and provide transparent reporting

Although almost all reimburse for SBIRT; fewer actively promote use of codes

Most respondents report they are reimbursing for the three collaborative care codes and one BH integration code

- only one actively promoted the codes and only two noted paid claims for collaborative care in 2017

Plans that report using alternative payment models use case rates and bundled payments most commonly

Recommendations for Purchasers

Require that all network clinicians, whether independent, in a PCMH or ACO, screen patients for depression, bipolar, anxiety disorder, psychosis, alcoholism and opiate addictions, and post-partum depression. Ask for reports to validate screening, identification rates and to assess progress

Insist that plans require the measurement of outcomes for each patient among *both* medical and behavioral health providers when treating a behavioral disorder. Track and report on outcomes if the ACO is providing the BH (MH/SUD) treatment

Ask plans to report how they provide feedback to clinicians and how those clinicians are using screening and HEDIS and other MH/SUD performance results to make treatment decisions

Ask health plan to turn on and promote the three collaborative care codes and one BH integration code with no associated copay. Develop a plan for promoting, providing technical assistance and training to medical providers to bill for the collaborative care codes

Insist that plans include MH/SUD services and specialists in payment innovation models

Purchaser Expectations	A	B	C	D	E	F	G	H
All clinicians should be required to use validated, standardized instruments to identify and monitor progress among patients								
Clinicians should be measured and incented on performance on NQF measures such as “Depression remission at six months”								
Active promotion and reimbursement for SBIRT for alcohol and substance use for both primary care and BH								
Active promotion and reimbursement for all three collaborative care and one behavioral health integration codes; evidence of paid claims								
Incorporation of MH/SUD measures in payment innovation models								

KEY Exceeds/meets all/almost all the expectations; Meets some of the expectations; Meets few/none of the expectations

Pharmaceutical Management

Critical to achieving high value care and better outcomes is timely access to the most appropriate medication for an individual patient, assurance that medications are taken appropriately, and monitoring the patient for signs of improvement. In many instances, patients with MH/SUD do not respond to the first prescribed medication. In fact, it is known that many patients suffer from "first failure" which occurs when the prescribed medication fails to have the intended effect. This has implications about how the purchaser or the plan constructs the formulary: what medications are included, what medications are excluded, what level of copay is required, and how processes such as step therapy or prior authorizations are applied to prescribe a different medication.

Additionally, new genomic tests have become available, and these provide information about whether a drug may be appropriate for a particular patient. Another unintended consequence is that prior authorizations and step therapy requirements may negatively impact network participation due to the "hassle factor" providers perceive.

Why Value-based Medication Management?

Purchasers expect their health plan/PBM to consider broader implications when considering formulary placement for medications to treat MH/SUD. Given that individuals living with depression and other BH disorders respond differently to prescribed treatments, a value-based formulary would seek to mitigate both delays in access and financial barriers by providing broad coverage with little or no barriers such as PAs, and placing those branded (non-generic) medications on formulary in a no/low-cost tier (first or second tier) when the broader implications (cost, outcomes and impact on employee productivity) across both pharmacy and medical warrant. Implementation of a complementary value-based benefit design with reduction/waiving of copays tied to medication adherence and/or program participation would further facilitate access and improved outcomes

What We Found

None of the respondents offered a value-based formulary for antidepressant medications

- For depression and bipolar disorder, most common policy includes step therapy for all major generic and brand drugs where no therapeutic equivalent is available (two-three fails required)
- For anxiety, most common policy includes all major generic and brand drugs with no available therapeutic equivalent on formulary without a step therapy requirement
- For attention-deficit/hyperactivity disorder (ADHD), responses varied from no step therapy (3), limited formulary (2) and prior authorization (2)

About half the respondents cover at least one of the personalized medicine tests for anxiety, depression, bipolar disorder and ADHD

- First medication failure rates were reported by only three respondents
- No respondent-based coverage of medication on pharmaco-genomic criteria for patient appropriateness

For substance use medication:

- Only two respondents have no limits on prescribing and fail first policies for members with SUD
- Adherence to medication is not always monitored
- Opioid misuse rate ranged widely; in all instances prescribers are alerted, but not members

Variation in level of monitoring of primary care physicians and BH specialists on appropriateness of prescribing

Recommendations for Purchasers

Insist that plans measure "first medication failure" rates and use those rates to assess adequacy of comprehensive coverage of medications in the formulary to ensure timely access to medications

Ask your plan/PBM to assess and review prior-authorization/step therapy policies for MH/SUD medications with you and to implement a value-based insurance design to mitigate both access and financial barriers to appropriate medications. Review coverage and utilization of personalized genomic tests to align with medication access strategies

Ask your plan/PBM to assess coverage to assure comprehensive access to all medications for treating substance use

Ask your plans to detail how they monitor appropriateness of prescribing among primary care and BH specialists for antidepressants, pain medications, and ADHD and their rationale for differences

Insist that plans monitor for adherence to substance use medications

Purchaser Expectations	A	B	C	D	E	F	G	H
Presence of value-based formulary for antidepressant medications								
Coverage of at least one personalized test that may improve impact of prescription medication and patient tolerance, and provided first medication failure rate								
Formulary policies should allow for clinical judgement and genetic testing results in access to medications								
Opioids – access to medications to treat substance use, monitoring opioid misuse and appropriate use								
Monitoring appropriateness of prescribing of antidepressants and ADHD medications								
Monitoring member adherence to depression and substance use medications and closing gaps								

KEY Exceeds/meets all/almost all the expectations | Meets some of the expectations | Meets few/none of the expectations

*To retain anonymity, respondents who could not respond to this topic were assigned color coding based on most common response among respondents

Member Identification, Engagement, Management & Support

As part of total health management, purchasers expect vendor partners to identify members who have behavioral health conditions and assess if they have any other existing medical conditions/issues. On the flip side, when a patient is assessed for a medical condition, they clearly should also be assessed for mental health conditions. Central to engaging the member and assuring appropriate care is tracking demographic information such as ethnicity and primary language and having a robust directory and physician selection tool.

To help patients find the best healthcare professional, current information about clinician specialty, status on accepting new patients, and wait-times as well as after-hours emergency access to BH clinicians are all features that support patient engagement and facilitate high-value access and care. As telehealth is becoming more mainstream, patients will want to access these services through search filters and online directories. Once patients receive the care they need, is important to support their transition from an inpatient setting to their home or other community setting. Knowing what is needed to best support this transition can help patients become more self-sufficient and reduce the need for them to unnecessarily reengage with the healthcare system.

What We Found

While all track member age and gender, about half the respondents track race and/or ethnicity; most track primary language

Not all respondents provided information on estimate membership with various MH/SUD conditions; in many instances members with MH/SUD conditions are not assessed for co-existing medical conditions such as coronary heart disease, obesity and diabetes or for tobacco use

All respondents reported having provisions in-place for members to reach or be warm-transferred to a MH/SUD clinician for after-hours emergent calls

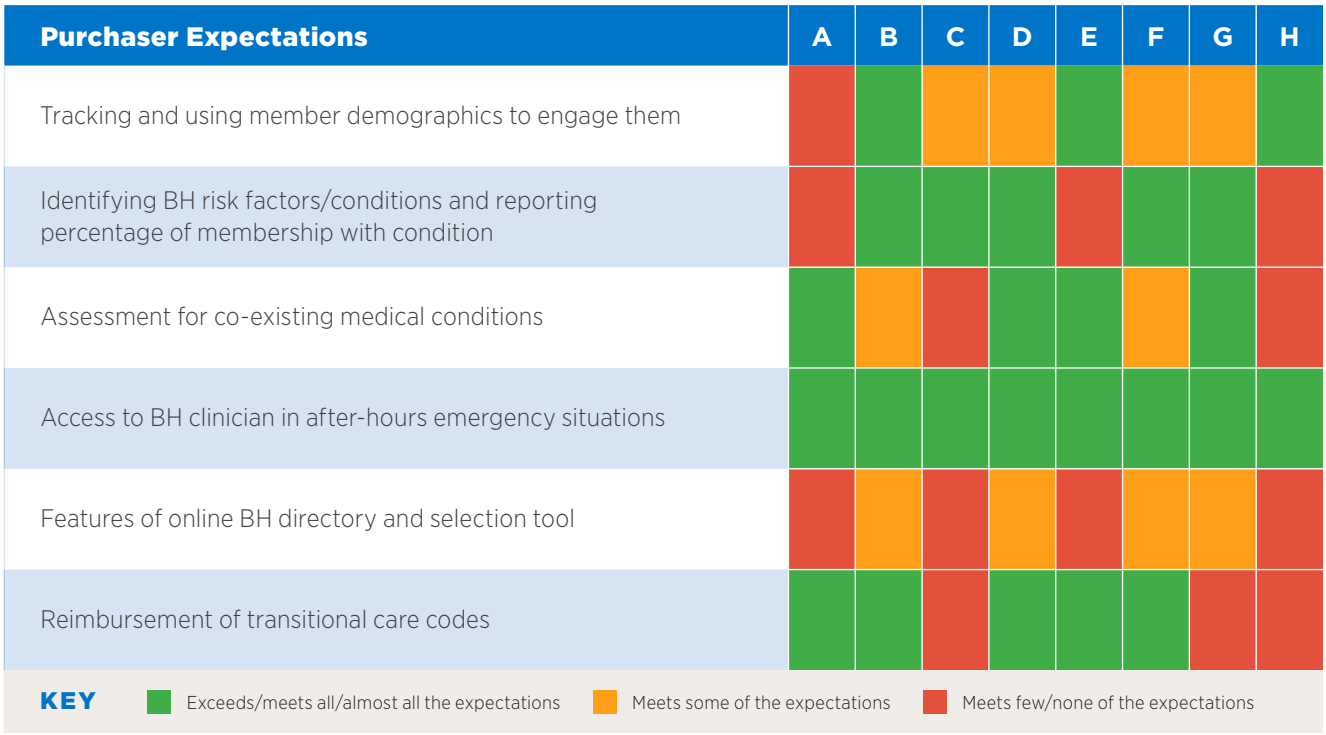
Online MH/SUD directory and selection tool generally has less content and functionality compared to medical directory/selection tool

Half the respondents had telemedicine as an indexed and searchable element on the directory

Most respondents reimburse for the transitional care codes; however, the number of claims reimbursed in past year varied widely

Recommendations for Purchasers

- Work with vendors to capture demographic information including race/ethnicity for employees
- Insist that plans provide to you a report on your employee population containing an integrated picture of MH/SUD and medical conditions and risk factors
- Compare and test features and content of onlineMH/SUD directory and clinician selection tool
  - assure it is as searchable and robust as themedical/surgical provider directory and includesprimary care physicians
  - verify directory accurately reflects specialists accepting new patients
  - assure directory captures wait times for MH/SUDappointments
  - add search/filter for tele-behavioral health
- Insist that plans reimburse for transitional care codes and provide quarterly reports on number of claims received and reimbursed



Accreditation and Compliance with Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires that the financial requirements such as coinsurance and copays and treatment limitations (e.g. visit limits) imposed on BH (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification. In 2018, the Department of Labor and Department of Health and Human Services released a document of FAQs that explains how MHPAEA also applies parity for non- financial requirements by citing several examples of non-quantitative treatment limitations (NQTLs). The FAQs attempt to clarify that, in all these instances, the limitations placed on coverage of BH (MH/SUD) treatment cannot be any more restrictive than for medical and surgical benefits.

Like previously issued FAQs (available at www.dol.gov/ebsa/healthreform/index.html and www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), the FAQ answers questions from stakeholders to help people understand the law and benefit from it, as intended.

Employers need to pay attention to these proposed mental health parity requirements as many ERISA-governed plans may not have been designed or administered with an eye to this level of scrutiny. ERISA law can hold the plan sponsor accountable for any violations of these requirements.

Examples of Non-Quantitative Treatment limitations

- medical management standards limiting or excluding benefits based on medical necessity/appropriateness, or based on whether the treatment is experimental or investigative (including concurrent review)
- formulary design for prescription drugs
- network tier design
- standards for provider admission to participate in a network, including reimbursement rates
- plan methods for determining usual, customary, and reasonable charges
- fail-first policies or step therapy protocols
- exclusions based on failure to complete a course of treatment
- restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided

What We Found

Most respondents have MBHO accreditation conferred by NCQA

Most have conducted an internal audit on parity compliance but not an external audit by a third party, although one respondent reported external audit for about 12% of their employer clients

Some difference in the percent of denials between MH/SUD claims and medical/surgical claims—typically with the percent of denials being higher for MH/SUD.

[Note that plans use different methodologies to count "denials," so plan rates were not compared to each other.]

Recommendations for Purchasers

Insist that plans seek external MBHO accreditation

- Require your plan to have an independent, *external* audit of the NQTL part of parity by an auditor who understands in depth the parity law
- Seek external parity accreditation (when available)

Review denial rates for medical/surgical and MH/SUD services and ask plan to address disparities (Model Data Request Form)

Consider seeking indemnification from your vendor for certain risks associated with parity non-compliance (Model Hold-Harmless Language)

Purchaser Expectations	A	B	C	D	E	F	G	H
Presence of NCQA MBHO Accreditation								
Mental Health Parity Compliance Audit & Accreditation by third party								
Percentage of denials across sites should be comparable with action plan to address if not the case								

KEY Exceeds/meets all/almost all the expectations; Meets some of the expectations; Meets few/none of the expectations

Data Analysis and Performance

Strong metrics of performance, with standardized specifications and mechanisms for reporting have been developed since the 1990s. Yet, purchasers and patients seldom use this information when making choices about high quality vendors and/or clinicians or to demand improved accountability in vendor performance. This is surprising, since nearly every other purchased good or service is evaluated for excellence, safety, accessibility and cost. Achieving value in the delivery of MH/SUD services is critical. Having objective measures that set the bar on poor versus adequate versus excellent performance is not only achievable but should motivate the current system to make more specific and effective changes that will improve overall care.

While a vendor is often evaluated on the number of interventions or programs it offers and whether it has the latest app, a better yardstick should be the outcomes achieved (both clinical and non-clinical) and what processes are, or need to be, in place to assess and improve engagement in programs and services. Clinical outcomes traditionally include tracking performance on HEDIS measures. However, additional measures such as absenteeism, presenteeism, disability, return to work and ROI are important to develop an overall picture of the needs and opportunities within a workforce population. Also critical to that picture are EAP measures such as member utilization that includes the breadth and depth of content as well as on-site support.

What We Found

Three respondents used Pharmacy Quality Alliance specifications to calculate rate of antipsychotic use in children under 5 years old and additionally reported on some of the first-year HEDIS measures

HEDIS results

- Four respondents had four out of eight HEDIS results that were above the 50th percentile including the measure for Initiation & Engagement of Alcohol & Other Drug Dependence Treatment – Initiation
- Two measures that need the most improvement:
  - Follow-Up Care for Children Prescribed ADHD Medication
  - Metabolic Monitoring for Children and Adolescents on Antipsychotic Medications

Most respondents can report aggregated EAP utilization at the employer level and conduct a targeted follow up via email or phone call to assess user satisfaction.

- Use of EAP services is typically low – 0.05% – 7% with one respondent reporting 54%

Only one respondent had information on impact on disability rates and none reported information on return-to-work

Five respondents had information on absenteeism/presenteeism and return on investment

Recommendations for Purchasers

Insist that plans measure, report and improve performance on HEDIS measures

Before buying-up on interventions/programs and EAP, ask plans to provide details of impact of program and action plan on how they plan to have a substantial percentage of the targeted population participate

Insist that plans include a whole person health and wellbeing view when examining the opportunities and impact of programs; coordinate data and processes across vendors as appropriate

Purchaser Expectations	A	B	C	D	E	F	G	H
Evaluating and reporting aggregated use of EAP Services								
Evaluating and reporting impact of depression and/or alcohol use disorder interventions/programs								
Reporting of, and performance on NCQA and other NQF measures								

KEY Exceeds/meets all/almost all the expectations; Meets some of the expectations; Meets few/none of the expectations

*To retain anonymity, respondents who could not respond to this topic were assigned color coding based on most common response among respondents

APPENDIX 1

Employer Checklist for Mental Health

This checklist highlights key actions employers can take to improve the value of mental health and substance use disorder care and build a culture of total wellbeing within their organizations. The best actions for an individual employer depend on their current practices, vendor partner capabilities and, importantly, organizational strategy and culture.

Improving Access

- ☐ Insist on same access standards for behavioral health as for medical and include quarterly monitoring and compare access (e.g., wait times). Ask for evidence to support plan's criteria for plan access
- ☐ Review in- and out-of-network use and payment information as well as denial rate for behavioral health and medical/surgical services. (Model Data Request Form) and consider seeking indemnification from your vendor for certain risks associated with parity non-compliance (Model Hold-Harmless Language)
- ☐ Insist that plans/vendors with significant differences in network access for BH and medical services or have high out-of-network claims for BH services develop an action plan that addresses any barriers to network participation
  - ▶ Equalize reimbursement rates for MH/SUD specialist and medical surgical providers for similar services
  - ▶ Develop a mechanism to fast-track credentialing of MH/SUD specialists
  - ▶ Assess prior-authorization policies to mitigate access hassle factors
  - ▶ Engage residents and clinicians not in-network
- ☐ Insist that vendors turn on and promote all four collaborative care codes with no associated copay and to review their plans for promoting, providing technical assistance and training to medical providers to bill for the collaborative care codes
- ☐ Ask vendors to reimburse for transitional care codes and provide quarterly reports on number of claims received and reimbursed
- ☐ Ask vendor to promote greater use of tele-behavioral health services and include this feature in provider directory and clinician selection tool
- ☐ Test features and content of online behavioral health directory and clinician selection tool which should include primary care physicians
  - ▶ assure it is as searchable and robust as themedical/surgical provider directory and includesprimary care physicians
  - ▶ verify directory accurately reflects specialistsaccepting new patients

- assure directory captures wait times for MH/SUDappointments
- add search/filter for tele-behavioral health

- ☐ Ask your plan/PBM to assess whether coverage for medications for treating substance abuse is comprehensive
- ☐ Ask your plan/PBM to assess pre-authorization policies for behavioral health medications with you—PAs may impact network participation—hassle factor
- ☐ Work with plan/PBM to implement a value-based benefit design to mitigate both access and financial barriers to appropriate medication
- ☐ Insist that plans measure first medication failure rates and use those rates to assess adequacy of comprehensive coverage of medications in the formulary
- ☐ Review coverage and utilization of personalized genomic tests to align with medication access strategies to ensure timely access to medications
- ☐ Require your plan to:
  - Have an independent, *external* audit of the NQTL requirements under parity by an auditor who understands in depth the parity law
  - Seek external parity accreditation (when available)
- ☐ Before buying-up on interventions/programs and EAP, ask plans to provide details of impact of program and action plan on how they plan to have a substantial percentage of the targeted population participate

Improving Quality and Performance

- ☐ Insist that vendors require the measurement of outcomes for each patient among *both* medical and behavioral health providers when treating a behavioral disorder
  - Ask for report on outcomes if the ACO is providing the BH (MH/SUD) treatment
- ☐ Require that all network clinicians, whether independent, in a PCMH, or ACO screen patients for depression, bipolar, anxiety disorder, psychosis, alcoholism and opiate addictions, and post-partum depression
  - Ask for reports to validate screening, identification rates and to assess progress
- ☐ Ask vendors to report how they provide feedback to clinicians and how those clinicians are using screening and HEDIS and other BH performance results to make treatment decisions
- ☐ Insist that plans measure, report and improve performance on HEDIS measures
- ☐ Insist that plans require and monitor that clinicians screen for post-partum depression
- ☐ Insist that plans include BH services and specialists in payment innovation models
- ☐ Ask your plan to detail how they monitor appropriateness of prescribing among primary care and behavioral health specialists for antidepressants, pain and ADHD and rationale for differences. Insist that plans monitor for adherence to substance use medications

- ☐ Work with vendors to capture demographic information including race/ethnicity for employees
- ☐ Insist that plans provide you with a report on your employee population containing an integrated picture of behavioral health and medical conditions and risk factors
- ☐ Ask that vendors seek external MBHO accreditation
- ☐ Insist that plans include a whole person health and wellbeing view when examining the opportunities and impact of programs. Coordinate data and processes across vendors as appropriate

Improving Environment

- ☐ Insist that vendors include a whole person health and wellbeing view when examining the opportunities and impact of programs; coordinate data and processes across vendors as appropriate
- ☐ Rebrand EAP so that it reduces stigma and increases utilization
- ☐ Ensure that EAP and other programs include training for supervisors to include recognizing the signs of behavioral health concerns in employees, how to respond appropriately to encourage employees to connect with services and supports.
- ☐ Engage with community activities to reduce stigma and/or break the silence
- ☐ Encourage vendors to engage in national and/or community activities to reduce stigma and/or break the silence

APPENDIX 2

Recommendations for Improving Access to Mental Health and Substance Use Care

(Developed by the APA Foundation Center for Workplace Mental Health and APA)

The APA is taking steps to improve access to high quality and effective mental health and substance use care, including the following:

- Promoting compliance with the Federal Mental Health Parity and Addiction Equity Act and state laws and regulations.
- Providing APA members and other practitioners access to training in innovative practice models, including the collaborative care model and encouraging implementation of these models.
- Providing APA members and other practitioners the tools, resources and technical assistance needed to implement telepsychiatry and encouraging its use.
- Promoting the use of evidence-based tools, like the PHQ-9 to identify and treat depression, and measurement-based care to improve the quality of care delivered and treatment outcomes.
- Promoting PsychPRO, a national mental health registry developed by the APA for psychiatrists and other practitioners to support the delivery of high-quality care and to assist psychiatrists in meeting quality reporting requirements issued by CMS.

The APA, employers, health plans and other key stakeholders all have key roles to play in improving access to mental health and substance use care. Below are recommendations on how health plans and employers can improve access to mental health and substance use care.

Ensuring Network Adequacy

Health plans and Behavioral Health Organizations: develop an action plan for employers or implement a corrective action plan that addresses access to care and includes the following steps:

- Expand the number of in-network mental health and substance use providers for all services, including inpatient, outpatient facility and outpatient office services.
- Publish up-to-date, accurate, and complete provider directories, including information on which providers are accepting new patients, and the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees.
- Engage regional and national psychiatric organizations to understand and improve network participation and enhance access to effective primary and specialty care treatment of health plan members with mental health and substance use conditions.

- Establish reimbursement rates that ensure that mental health and substance use providers participate with the health plan.
- Provide incentive payments to mental health and substance use providers who are full participants in network and meet designated access and quality metrics (i.e., time to appointments, reporting on PHQ9 and GAD-7 scores).

Health plans: provide employers with a report showing the volume of claims and the number of distinct patient claims of in-network adult and child psychiatrists that have submitted claims for services for an initial assessment and for ongoing treatment at 6 month and 1-year intervals under the following CPT codes:

- Initial Assessment:
  - Psychiatric Diagnostic Evaluation with Medical Services: 90792;
  - New Patient, Office/Outpatient: 99201 – 99205
  - Initial Hospital Care: 99221-99223
- Ongoing treatment:
  - Established Patient, Office/Outpatient: 99212-99215
  - Subsequent Hospital Care: 99231-99233

For psychiatrists that have not billed any codes for 6 months or have fewer than 10 claims for at least 6 months, the plan should do the following:

- validate whether the psychiatrist is in the provider network and seeing patients;
- take steps to correct the provider directory and add additional psychiatrists, if necessary; and
- develop an action plan to notify employers about updates to the provider directory and action to be taken to ensure network adequacy.

This data and information will provide employers with an objective view of network adequacy and the opportunity their employees have to access mental health and substance use treatment.

Mental Health Parity Compliance

Employers and Employer Coalitions: there are multiple national reports showing disparities in access to mental health and substance use care when compared with access to other medical services. Because of these disparities, employers should be asking plans about the following:

- Differences in the frequency of in-network and out of network care for mental health and substance use care by level of care and service type as compared to medical services;
- Denial of care rates for mental health and substance use services compared to medical services by level of care and service type; and

- An explanation of disparities, corrective action and a timeline for action.
- Ensure that the legal department in your organization is familiar with federal and state mental health parity laws and is aware of the risks associated with non-compliance. Here is additional helpful information and steps to consider:
  - Be aware that State Insurance Commissioners are investigating health plan compliance with mental health parity laws and acting to resolve non-compliance.
  - To minimize risk and ensure mental health parity compliance, conduct an independent assessment of your health plan by a qualified expert, examining all aspects of care delivery especially non- quantifiable treatment limits (NQTL).

Advancing Measurement Based Care

Employers and Employer Coalitions:

- Request that health plans provide an action plan that requires providers to use standardized measurement-based tools (e.g. PHQ-9, GAD-7 and others) to guide decisions and requires them to provide aggregate-level outcomes data for employees being treated for mental health and substance use conditions.
- Inform health plans that enrollees should be screened for depression, anxiety, psychosis, bipolar disorder, suicide, substance use and track and report on treatment outcomes.

Health plans and Behavioral Health Organizations:

- Provide incentive payments and minimize administrative requirements to primary care, mental health and substance use providers who participate in network and in quality improvement programs that require the use of standardized measurement tools (e.g. PHQ-9, GAD-7 and others) at regular intervals.

Expanding the Collaborative Care Model

Health plans and Behavioral Health Organizations:

- Pay for the evidence-based collaborative care model (CoCM) using the collaborative care payment codes.
- Develop a process to ensure primary care practices implement the CoCM and use the CPT codes.
- Provide practitioners with a link to the collaborative care training module available from the APA and provide ongoing technical assistance and training on the model and using the code.
- Provide employers with data on the use of the CoCM CPT codes.

Employers and Employer Coalitions:

- Request that health plans provide a plan for ongoing technical assistance and training for practitioners on implementing and working in the CoCM and using the CPT codes.

Expanding Telepsychiatry

Health plans and Behavioral Health Organizations:

- Share a link to the APA's telepsychiatry toolkit with their network of primary care and mental health providers and encourage use of the modality.
- Identify and notify employers of any barriers to expanding care through telepsychiatry and an action plan of steps that will be taken to overcome those barriers.

Employers and Employer Coalitions:

- Educate providers and plan enrollees about telepsychiatry and require health plans to make training available for in-network providers on the mechanics in delivering telepsychiatry.
- Require health plans to reimburse all telehealth care at the same rate as in-person health care.

APPENDIX 3

Sample Employer Performance Standards for Behavioral Health

Developed by Catalyst for Payment Reform

In 2018, based on input from eight purchasers and a subject matter expert, Catalyst for Payment Reform developed a tool for purchasers to assess how well partners are meeting their needs when it comes to access, quality, and integration in mental healthcare. The tool includes evaluation questions and clear specifications for what a purchaser should expect to see moving forward in these key areas.

Sample of standards developed includes:

- 80% of providers in a network should accept new patients at any given time.
- Patients should be offered an urgent mental health appointment within 48 hours.
- Health plan updates provider directory on a daily basis.
- Member satisfaction with care provided should be 85% or higher.
- Quality must be a requirement for receiving a high-performance provider designation.
- Health plans should conduct site visits or audits of 25% of providers every year.

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eValue8 is a resource that assesses health plan performance and highlights key areas of improvement as well as areas of excellence. Performance reports allow participants to evaluate health plans on a local, regional and national level.

Plans and purchasers receive objective scores enabling comparison of plans against regional and national benchmarks and a roadmap for improvement. Plans learn what they need to do to align their strategies with purchaser expectations to maximize the value of the health care investment and ultimately, improve health and quality of care.

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