The Path Forward
for mental health and substance use
Health Equity for all Americans

MidAtlantic Mental Health Path Forward

A Regional Employer **Stakeholder Engagement** Team

MidAtlantic Business Group on Health

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

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

American Health Policy Institute

American Psychiatric Association

American Psychiatric Association Foundation | Center for Workplace Mental Health

Bowman Family Foundation

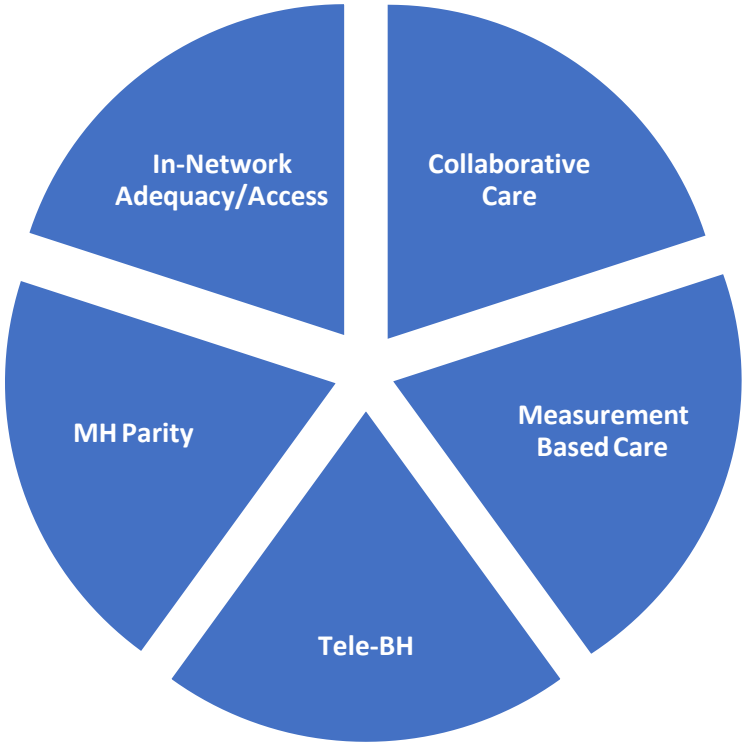
HR Policy Association

Meadows Mental Health Policy Institute

Five Priority Strategies

To Improve Early Detection and Access to Effective BH Healthcare

- Improve **in- network access** to BH providers
- Achieve true **mental health parity**
- Expand integration of BH care into primary care settings through implementation of the **Collaborative Care** model (CoCM)
- Improve and expand use of **tele-behavioral health** (TBH)
- Expand MHSU screening and monitoring through **Measurement Based Care**



Each of these:

- Improves **outcomes** and **cost efficiencies**
- Has been **endorsed** by accrediting bodies, provider groups, payers

Together, they can overcome the multidimensional, interdependent barriers to accessing affordable, effective BH care

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Success Will Require Multi-Stakeholder Involvement

- True systemic reform is beyond the practical reach of any single stakeholder group
- Inclusive, multi-stakeholder involvement at the national and regional level:
  - Primary care, BH providers and clinical health systems
  - Payers - health plans, employers, states
  - Benefit consultants
  - State and federal regulators and policy makers
  - Local medical societies and associations
  - BH advocates
  - Private sector/philanthropic organizations

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Leading Business Groups and Behavioral Health Organizations Supporting The Path Forward's Priorities & Recommendations

Leading Business Groups

- HR Policy Association and The American Health Policy Institute
- National Alliance of Healthcare Purchaser Coalitions
- Dallas-Fort Worth Business Group on Health
- Florida Alliance for Healthcare Value
- Houston Business Coalition on Health
- Kansas Business Group on Health
- MidAtlantic Business Group on Health
- Minnesota Health Action Group
- Pacific Business Group on Health

Behavioral Health Organizations

- American Psychiatric Association
- American Psychiatric Association Foundation Center for Workplace Mental Health
- American Psychological Association
- Baylor Scott & White Health
- The Bowman Family Foundation
- Columbia University Department of Psychiatry
- The Kennedy Forum
- Massachusetts General Hospital Department of Psychiatry
- Meadows Mental Health Policy Institute
- Mental Health Association of Maryland
- National Action Alliance for Suicide Prevention
- National Alliance on Mental Illness
- National Association for Behavioral Healthcare
- National Association of Addiction Treatment Providers
- National Council for Behavioral Health
- One Mind and One Mind at Work
- Shatterproof

See The Path Forward Press Release on High-cost Study:
https://www.globenewswire.com/news-release/2020/08/13/2078017/0/en/Study-Reveals-Individuals-with-Behavioral-Health-Conditions-in-Addition-to-Physical-Conditions-Drive-High-Total-Healthcare-Costs-Small-Portion-Spent-on-Behavioral-Treatment-Vast-Ma.html

HR Policy Association and American Health Policy Institute

HR Policy Association is the lead public policy organization of chief human resource officers ***representing the largest Fortune 500 employers (over 375 members)*** doing business in the United States and globally.

The Association brings these executives together not simply to discuss how human resource practices and policies should be improved, but also to create a vision for successful HR strategies and pursue initiatives that promote job growth, employment security and competitiveness.

RESET Regions and Coalitions

California – Pacific Business Group on Health and Silicon Valley Employers Forum

Florida – Florida Alliance for Healthcare Value

Kansas – Kansas Business Group on Health

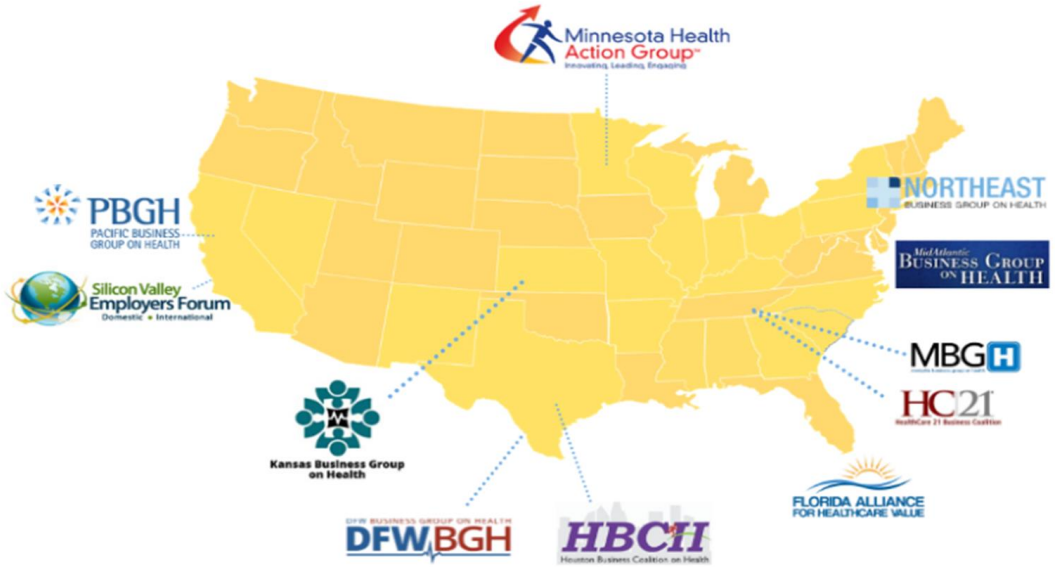
Maryland, DC and Northern VA – MidAtlantic Business Group on Health

Minnesota – Minnesota Health Action Group

NYC metro area including northern NJ and southern CT – Northeast Business Group on Health

Tennessee – Memphis Business Group on Health and HealthCare 21 Business Coalition

Texas – DFW Business Group on Health and Houston Business Coalition on Health



Headquarters: D.C. based team leading more than 30 employer/union coalitions across the country

Member employers and unions sponsor over [45] million Americans

The 11 coalitions in "RESET regions" represent over 30 million Americans

The MidAtlantic Version: a Partnership

- MidAtlantic Business Group on Health: John Miller
- MHA of Maryland: Linda Raines
- Maryland Primary Care Program: Howard Haft, MD

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MidAtlantic
Business Group
on Health

Launching the MidAtlantic Path Forward

Getting Group Consensus

ASHA
Daniel G Schuster, LLC
Legg Mason
Marriott International
State of Maryland Employees
Office of Personnel Management
CBIZ Consulting
Managed Care Advisors
Segal Consulting

Maryland Department of Health
Maryland Insurance Administration

Child & Adolescent Society of Greater Washington
GBMC Health Care System
Johns Hopkins Medical Center, Bayview
MATClinics
Med Chi
MedStar Health
Mindoula Health
University of Maryland Medical System

Aetna
Anthem
CareFirst Blue Cross Blue Shield
Cigna
Optum
UnitedHealthcare

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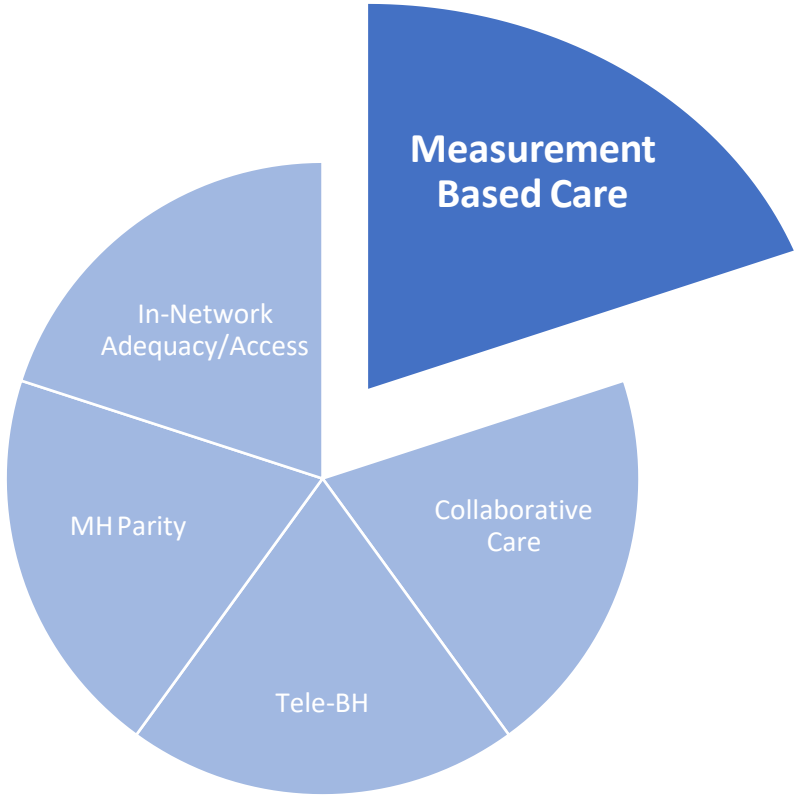
Strategy: Expand Screening, Monitoring Through Measurement-Based Care



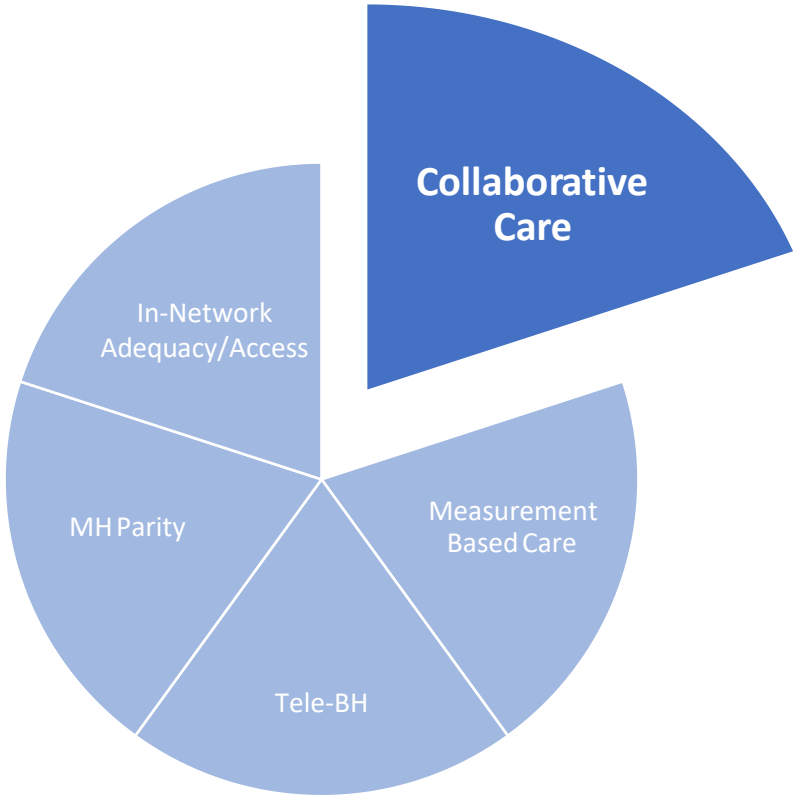
- **Problem Definition**
  - Most practices not utilizing MBC
  - Talk to all stakeholders - individually and collectively
- **Measurements - Baseline, Progress**
  - Provider awareness – of need, growing demand for MBC
- **Actions – As Defined & Prioritized**
  - Identify strategies to increase MBC in practices
  - Growing presence of MBC in QI/Regulatory standards
    - Develop plan around compliance
  - Provider education/case studies
  - Incentivize – “Star ratings”?
  - Help mobilize the URAC standards
- **Impact Assessment**
  - Increased use of MBC by (>= 40%) of PCMHs and ACOs - including largest health systems in each RESET region

Execution: Expand Screening, Monitoring Through Measurement-Based Care

- **Critical stakeholders**
  - Employers/purchasers
  - Health plan/BH CMOs and provider relations staff
  - Health delivery systems (including BH divisions)
- **Key issues and barriers**
  - Health plan knowledge of health systems' compliance with JC/URAC/other key QI/regulatory requirements
  - Incentives for compliance?
- **Approach**
  - Encourage/facilitate BH QI programs' use of MBC
  - Purchaser support of MBC
  - Develop concurrence of health plan, health system CMOs regarding importance of MBC
- **Measures**
  - Provider use of standard tools (PHQ-9, GAD-7, etc.)
  - Compliance with BH QI program incorporation of MBC

- **Actions to be Considered:**
  - Encourage plan & provider support for URAC MBC standards
  - Push for use of validated screening and outcome tracking measures for in common BH disorders
  - Review of reimbursement practices & mechanisms to
  - encourage use of MBC
  - Garner purchaser support to communicate expectations for MBC, including recommended measures
  - Encourage & support health plans in developing BH-focused QI studies incorporating MBC

Strategy: Expand Implementation of Collaborative Care in Primary Care

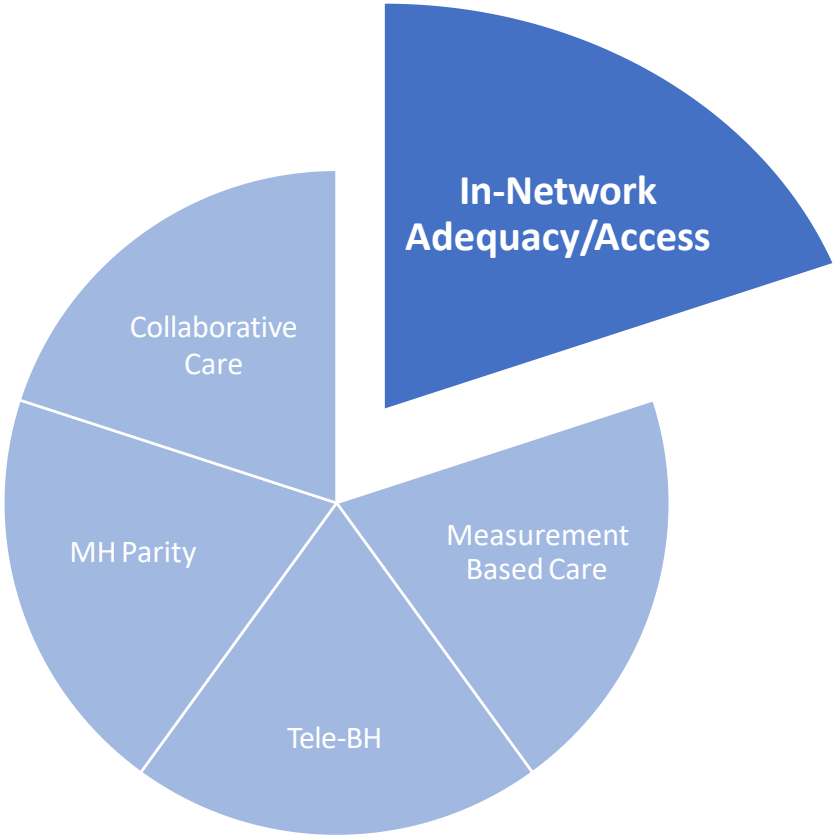


- **Problem Definition**
  - Understanding of the model – purchasers/providers/payers
  - Reimbursement – can CoCM code reimbursement sustain CoCM?
  - What do PC practices need? What are their barriers?
  - How can PF help?
  - How can health plans/payers help?
- **Measurements – Baseline, Progress**
  - Cost of BH co-morbidities (medical, BH, total)
  - Health systems now providing CoCM (number, billing volumes)
  - Reimbursement for CoCM (rates, claim volumes), co-morbidity costs
- **Actions – As Defined & Prioritized**
  - Education – development/presentation of case studies
  - Implementation assistance – business/operational model, identification of solutions to structural/administrative hurdles (EMR)
- **Impact Assessment**
  - Substantial adoption of CoCM (50%) in primary care practices in the largest health systems in each RESET region

Execution: Expand Implementation of Collaborative Care in Primary Care

- **Critical stakeholders**
  - Employers/purchasers
  - Health plan provider relations, and CMOs
  - Health delivery systems (not BH)
  - Primary care, OB/Gyn, professional societies (not BH)
- **Key issues and barriers**
  - Health plans knowledge of PC practices submitting/not submitting claims for CoCM
  - Incentives for those that do
  - Key to addressing health equity
- **Approach**
  - Garner purchaser support for CoCM as a priority
  - Advocate with stakeholders to cover start-up CoCM
- **Measures**
  - Health system implementation of CoCM
  - Claims paid and percent of PCPs using CoCM
  - CPT payment codes (99492, 99493, 99494 and 99484)
- **Actions to be Considered:**
  - Request that major medical provider systems in region implement CoCM
  - Request that all health plans reimburse for CoCM codes (99492, 99493, 99494 and 99484)
  - Provide health systems with support for CoCM billing
  - Ask each health plan what technical assistance is/can be provided to medical groups not currently billing (or billing minimally) for CoCM to help them implement the codes and CoCM
  - https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDPrevention.pdf

Strategy: Improving In-Network Adequacy/Access



- **Problem Definition**
  - Define problem & scope – purchasers/providers/payers
  - BH Provider availability/shortages?
  - Are providers/payers talking? Listening?
- **Measurements – Baseline, Progress**
  - Identifying the measures – MDRF, other metrics?
  - Reimbursement - In-network vs. OON, Medicaid, Medicare
  - Rates/billings: In-network vs. OON, medical vs BH
- **Actions – As Defined & Prioritized**
  - Stakeholder commitments to data provision
  - Assessment of service mix/reimbursement
  - Network configuration?
  - How to fill interim gaps and increase network participation
- **Impact Assessment**
  - Reduction from baseline in % of no/low-billing network psychiatrists
  - Reduction in OON disparities (BH vs. other medical services)
  - Reduction in BH denial rate disparities (BH vs. other medical services)

Execution: Improving In-Network Adequacy/Access

- **Critical stakeholders**
  - Employers/purchasers
  - Health plan provider relations, BH staff
  - Psychiatry, psychology, professional societies
- **Key issues and barriers**
  - Administrative barriers
  - Reimbursement barriers
  - Currency, accuracy of provider directories
- **Approach**
  - Confirm/define issues with stakeholders
  - Measure baseline metrics
  - Identify key barriers, Take actions and remeasure
- **Measures**
  - Use quantitative network measures (e.g., MDRF) to collect & report data in standardized format
- **Actions to be Considered:**
  - Adoption of standardized measures to assess adequacy of network BH providers & mechanisms for monitoring
    - Adoption of quantitative metrics (MDRF or comparable tool) to assess gaps/disparities
  - Identify & address financial barriers
    - Reimburse at rates reflecting supply & demand
    - Reimburse at comparable rates
  - Collaborate with providers & payers to
    - Streamline authorization processes
    - Expedite credentialing - especially where gaps exist
    - Reduce administrative requirements – for BH and non-BH medical providers
  - Initial & periodic review of reimbursement practices, mechanisms - modify as needed

Model Data Request Form

MHTARI has funded the development of the "**Model Data Request Form**" ("**MDRF**") as a tool for the collection of key data on certain parity compliance and network access issues that may exist for MH/SUD health care.

The **MDRF** contains specific, detailed instructions and definitions developed to elicit targeted, consistent and reliable responses from plans on quantitative measures for determining outcomes disparities related to network adequacy and other NQTLs The MDRF requests data that measures the following:

1) Disparities in Out-of-Network Use for MH/SUD vs. medical/surgical

2) Disparities in Reimbursement Rates for MH/SUD vs. medical/surgical providers

3) Disparities in Denial Rates for MH/SUD vs. medical/surgical services

4) Accuracy of Network Provider Directories

Absent specific definitions and methodology for analysis incorporated in the **MDRF**, plans are simply not able to test or report outcomes disparities in a consistent, reliable or meaningful manner.

The MDRF can be viewed and downloaded at: http://www.mhtari.org/