eValue8™ Mental Health Deep Dive: Achieving Value in Mental Health Support

October 2, 2019
Webinar
Today’s Agenda

- Welcome
  - Introductions and Context
- eValue8 Mental Health Deep Dive for MN Health Plans
  - Results and Opportunities
- Tools and Resources
- Thank You and Final Thoughts

“Protection of the patient requires our eternal vigilance.”
— Luther Youngdahl
Governor, Minnesota (1954)
Introductions

Deb Krause  
Vice President  
MN Health Action Group

Nance Lee Mosquera  
Employee Benefits Manager  
City of Saint Paul  
and  
Action Group Board Member

Foong-Khwan Siew  
Director of eValue8™  
National Alliance of Healthcare Purchaser Coalitions
Who is The Action Group?

- A nonprofit coalition of **PUBLIC AND PRIVATE PURCHASERS** focused on using their leverage to improve health and **health care**, including:
  - **Corporations:** 3M, API Group, Best Buy, Graco, Fleet Farm, Hubbard Broadcasting, Land O'Lakes, Mortenson, Rosemount, Securian Financial, Thrifty White, Thrivent Financial, UNFI (formerly SUPERVALU), and Wells Fargo.
  - **Health care plans and providers:** Allina Health | Aetna, BCBS MN, Center for Diagnostic Imaging, Fairview, HealthPartners, Medica, Park Nicollet, MN Gastroenterology, PDR Clinics, PreferredOne, UnitedHealth Group, and University of Minnesota Physicians.
  - **Public sector purchasers:** City of Minneapolis, City of Saint Paul, Hennepin County, Metropolitan Council, MN Department of Human Services, MN State Employees Group Insurance Program, and various cities, counties and school districts.
  - **Others:** AbbVie, HealthFitness, Merck, RedBrick Health, Sanofi, and University of Minnesota.

*Representative list (not complete list):*
What Makes The Action Group Unique?

1. Aligned interests

The Action Group is the **only** Minnesota organization whose sole purpose is to align and represent the **collective voice** of those who pay the bill for health care – employers, public purchasers and individuals. Unlike so many others, we have no conflicts of interest in working with employers.

2. Independence

3. Relationships and influence

4. Capabilities and proven track record
Mental Health is a Top Priority* for Employers

Mental health is an important part of the health management strategy over the next two years.

83%

The mental health of our employees is directly related to the overall performance of our organization.

99%

* 2019 Action Group Annual Employer Survey
Employers Have High Expectations

Everyone who needs care can seek it, without discrimination.

*Individuals have access to high-quality, affordable, integrated, and measurement-based care, when and where they need it.*

*Providers are paid fairly, and payments incent and reward providers for high-value care.*

*So that, patients get better.*
Mental Health Deep Dive for Minnesota Health Plans
Summary of Results
Summary of Results

- Background
- Key Findings
- Detailed Results
Background
# National Alliance Mental Health Initiative

## Leadership Summits on Mental Health & Well-Being
- Development of “Collective Agenda”
- eValue8 Mental Health Deep Dive
- Action Briefs
- Webinar and Report

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<tr>
<th>Mental Health Advisory Team Sponsors</th>
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<th>Subject Experts</th>
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<td>Mid-Atlantic Business Group on Health</td>
<td>American Academy of Child and Adolescent Psychiatry</td>
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Overview of eValue8 and the Mental Health Deep Dive

The Philosophy of eValue8

• Articulate purchaser expectations
• Measure plan performance against expectations
• Drive quality improvement

The Deep Dive Philosophy and Process

• Expectations are highly aspirational
• Questions are distributed to health plans; responses collected electronically
• Preliminary analysis is sent back for clarification
• Each participating plan receives a personalized, confidential “Summary and Recommendations” report
• Report is released; results “blinded” in initial year

Health Plan Responses – Plans in MN

• Blue Cross and Blue Shield Minnesota
• HealthPartners
• Medica

Respondents (2018 Report)

• Aetna
• Anthem
• Cigna
• Kaiser Permanente Washington
• Regence (Washington)
• UnitedHealthcare
• Beacon Health Options
• Optum Behavioral Health
Key Findings
Key Findings

• Results of the assessment identified some variations in performance across responding health plans:
  • Plans had individual areas of strength and opportunities for improvement
  • There were also many common areas of concern

• Minnesota health plans generally performed better than their national peers. Potential explanations for this variation include:
  • The one-year difference in time between the assessments
  • Heightened awareness and concern related to mental health in the state
  • More robust measurement and reporting infrastructure and commitment to collaboration in the state

• Even so, ALL PLANS, in Minnesota and nationally, fall short of most aspirational purchaser expectations
### Common Strengths
- Identification of members with BH conditions
- Easy access to BH clinician in after-hours emergency situations
- Some/all medications for AOD and SUD should be available on lowest or no-cost tier
- Tracking key member demographics (age, gender, race, primary language)
- Grace period for coverage with change in insurance carrier
- Robust EAP offerings – evaluation indicates low utilization

### Common Opportunities
- Promoting and reimbursing for Collaborative Care and SBIRT
- Requiring and monitoring use of standardized screening instruments
- Accuracy of directories and monitoring wait times for first appointment
- Comparable compensation for BH clinicians versus M/S clinicians
- Having an external audit conducted on parity compliance, including an assessment of NQTL compliance
- Availability of a value-based formulary and formulary policies that allow for clinical judgment and genetic testing results in access to medications
- Monitoring appropriateness of prescribing of antidepressants, ADHD and pain medications among all clinicians
- Online BH directory and selection tool should be robust and user-friendly

### Where Plans are Differentiated
**Plan A:** Comparable access standards and measurement of % time standards are met; % OON claims comparable; NCQA MBHO Accreditation

**Plan B:** Systemic approach to improving network participation; measure and incent on NQF measures with strong performance on NCQA/NQF measures; incorporate BH measures into payment models; comprehensive monitoring of adherence; access to SUD medications comparable to M/S; assess members with BH conditions for co-existing medical conditions; reimburse for transitional care codes

**Plan C:** % OON claims and % denials comparable; measure first medication failure rate and cover one personalized test; reimburse for transitional care codes; NCQA MBHO Accreditation
Detailed Results
Detailed Results

• Six areas of assessment
  • Networks – Adequacy and Access
  • Physician Measurement, Management and Payment
  • Pharmaceutical Management
  • Member Engagement, Management and Support
  • Accreditation and Compliance with Parity
  • Data Analysis and Reporting

• For each area:
  • First: Each question, results, why this matters, and what we found
  • Then: Summary and recommendations for each area

Key to Color Coding:
- Green: Exceeds/meets all/most of the expectations
- Yellow: Meets some of the expectations
- Orange: Meets fewer of the expectations
- Orange with exclamation mark: Meets few of the expectations
- Red: Meets very few/none of the expectations
Networks - Adequacy and Access

| % psychiatrists in network with no/less than five unique claims in 2018 as proxy for directory accuracy |
| A | B | C |

**Why This Matters:**

- Since criteria used for BH network adequacy is either based on # providers/1,000 members or one provider/every x, y and z mile – important that # psychiatrists in directory actually see patients.

- Having an up-to-date, accurate and complete provider directory is essential to enabling patients to seek and have access to care. Psychiatrists with few or no claims signals a potential concern with regard to psychiatrists shown in the directory actually accepting/seeing patients.

**What We Found:**

- Two of the three respondents had between 20%-25% psychiatrists in network with fewer than five unique claims; other respondent had more than 40% psychiatrists in network with fewer than five unique claims.
Access standards/wait times should be comparable between Medical/Surgical (M/S) and BH

Why This Matters:
• Patients should be able to access mental health care when they need it, and there should be parity between M/S and mental health access standards and wait time.

What We Found:
• When available, access standards for urgent in-network office visits are the same for both M/S and BH, although standards varied from 24 hours to 48 hours.
• Not all respondents reported on % time that access standards were met for the different settings.
Why This Matters:

- Patients should be able to access mental health care when they need it, and they should have access to a network of providers with reasonable wait times that are accepting new patients.
- Parents should be able to differentiate and access child psychiatrist and/or psychologist.

What We Found:

- High proportion (over 95%) of network providers accept new patients.
  - No respondent could provide an estimate of median wait time for first appointment.
  - Not all differentiate between general psychiatrist/psychologist and child psychiatrist/psychologist in response to % accepting new patients.
Adequacy and Access - Addressing Network Participation

There should be a **systemic** approach to improving in-network BH specialist participation (reimbursement, removal of barriers, engaging the specialists)

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Why This Matters:
- A systematic approach demonstrates ongoing commitment and monitoring by the plan and signals effective network management.

What We Found:
- Most common activities to incent greater network participation lack a systemic approach e.g., most **do not**:
  - Assess and align fee levels for BH with medical providers for similar time and effort.
  - Reassess the lengthy and complex credentialing/contracting process.
- All have quality pay-for-performance programs but no other enhanced reimbursement.
- All reimburse for tele-behavioral services with no geographic restrictions.
### Why This Matters:

- Providers should be fairly compensated for their services. Lower reimbursement rates for mental health providers (relative to M/S) are a potential concern for mental health parity compliance. In addition, lower reimbursement rates for mental health providers has implications for network adequacy and workforce development.

### What We Found:

- When reported, weighted average amounts for medical specialties was higher than for BH specialties for similar codes by more than 5% (range was <10% difference to more than 40% difference).
- When compared to the listed National Medicare Fee Schedule allowed amounts for different specialties, % difference was much more positive for medical specialties than for BH specialties.

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## Networks - Adequacy and Access – Summary & Recommendations

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<th><strong>% BH clinicians accepting new patients and median wait time</strong></th>
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### Recommendations:

- When reviewing adequacy for BH coverage, only count those psychiatrists with five or more unique claims in one year; review criteria for inclusion in network directory.
- Continue to ensure that access standards are comparable for M/S and BH services.
- Develop means to measure wait times.
- Important to be able to differentiate between child psychiatrist/psychologist and general psychiatrist/psychologist.
- Ensure adequate network participation among BH specialists.
  - Reimbursement: Equalize reimbursement rates for BH specialist and M/S providers for similar claims codes.
  - Barriers to joining network: Develop a mechanism to fast-track admissions of MH/SUD specialists and remove other hassle factors.
  - Engagement of residents and clinicians not in-network.
Access to in-network care across sites of care should be comparable to Medical/Surgical; if not, plans should have an action plan to address

- In most cases, across all three settings (office visits, outpatient facility and inpatient), % OON claims are comparable for BH and for M/S.
- Compared to national results, % OON claims in MN is generally much lower than national median (2.3%-5% for BH office visits and 0.5-11% for BH inpatient visits).

### % Out-of-Network (OON) Claims

<table>
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<tr>
<th>% Out-of-Network (OON) Claims</th>
<th>Behavioral Health Median (Low: High)</th>
<th>Medical/Surgical Median (Low: High)</th>
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<tr>
<td>Office Visits</td>
<td>13.6%</td>
<td>5.1%</td>
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<td>3.4% (MATL); 34.1% (NY)</td>
<td>0.9% (MATL); 26.8% (MN)</td>
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<td>Inpatient</td>
<td>19.1%</td>
<td>1.8%</td>
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<td>1.6% (WA); 45.7% (CA)</td>
<td>0.1% (NY); 6.2% (TN)</td>
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**Recommendations:**
- Continue to monitor and compare % OON claims for both M/S and BH.
- *Note that higher cost-share to member, tiered benefit design, OON facility benefit inquiry, SUD hotline, and provider referral to in-network providers do not address access issues systemically.*
### Why This Matters:
- Measurement-based care leads to better patient identification and outcomes. Solid processes and valid instruments are fundamental.

### What We Found:
- Except for depression, all are not monitoring, requiring or incenting clinician or PCMH/ACO use of validated screening instrument.
  - For depression, two of three respondents are providing incentives and reports to clinicians.
  - One of three is recommending use of standardized screening instrument for ADHD and alcohol use disorder.
  - One of three is incenting use of screening instrument for autism.
- All are recommending, but not monitoring, that clinicians screen for postpartum depression.
Physician Management, Measurement and Payment - MBC

Why This Matters:
• Measurement-based care leads to better patient outcomes. Solid processes such as monitoring, providing feedback, and transparent reporting and incentives are key to changing clinician practice habits.

What We Found:
• All are monitoring performance on 12 of the 13 listed measures.
  • PQA measure of “Eliminating Antipsychotic Use in Children Under 5 Years Old” is not measured.
  • Two of three respondents included some of the measures in incentive payment and in transparent reporting to member.
  • All are providing feedback reporting to clinicians for some of the measures.
Physician Management, Measurement and Payment – Collaborative Care

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<td>Plans should promote and reimburse for all three Collaborative Care and BH Integration codes</td>
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<td>Plans should provide support, technical assistance, and training on Collaborative Care</td>
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**Why This Matters:**

- Collaborative care is proven, high-value care that lowers cost and improves outcomes.

**What We Found:**

- All reimburse for SBIRT (*Screening, Brief Intervention, Referral and Treatment*) for psychiatrists and other BH clinicians; not all promote the screening and not all reimburse primary care physicians.
  - Only one of three paid over 20 claims in 2018.
  - Two of the three are reimbursing for the three collaborative care codes and one BH integration codes.
    - None are actively promoting codes.
    - One of the two that are reimbursing paid <20 claims in 2018 for BH integration.
    - Only one respondent noted more than 20 paid claims in 2018.
  - None of the respondents have a designated person to coordinate, support or train on the use of, and reimbursement for, the collaborative care codes.
Physician Management, Measurement and Payment – Payment Models

Why This Matters:
• Alternative payment models and innovation can drive improved patient outcomes and BH measures should be as prevalent as measures for diabetes care.

What We Found:
• Not all respondents have implemented payment innovation for BH conditions.
• Case rate, pay-for-performance, and Value-based Collaborative Care Payments are the most common alternative payment models used.
• Most common conditions included are alcohol and substance use disorder.
All clinicians should be required to use validated, standardized instruments to identify and monitor progress among patients. Clinicians should be measured and incented on NQF-endorsed performance measures. Plans should promote and reimburse for SBIRT (Screening, Brief Intervention, Referral and Treatment) for alcohol and substance use for both primary care and BH. Plans should promote and reimburse for Collaborative Care and BH integration codes. Plans should provide support, technical assistance, and training on Collaborative Care. Plans should incorporate BH measures in Payment Innovation Models.

**Recommendations:**

- Medical and behavioral providers should be required and incented to provide measurement-based care (MBC); use standardized instrument to identify patients; measure outcomes; and document progress and use results to make treatment decisions.
- Reporting on NQF-endorsed measures should be transparent to clinicians and members, and performance should be rewarded.
- Collaborative Care and BH integration should be reimbursed with no associated copay and use of codes should be actively promoted. Technical assistance and training to medical providers to bill for the collaborative care codes should be made available.
- Expand payment innovation measures so that BH measures (use of measurement-based care) and clinicians that treat MH/SUD are included in payment innovation models.
Pharmaceutical Management – Coverage

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<td>A value-based formulary for antidepressant medications should be available</td>
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<td>Plans should cover at least one personalized test and report first medication failure rate</td>
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<td>Formulary policies should allow for clinical judgment and genetic testing results in access to medications</td>
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**Why This Matters:**

- Pharmacy coverage and access is important to patient outcomes and an area of potential concern related to mental health parity (e.g., if a value-based formulary is available for medical conditions such as diabetes, it should also be available for mental health).

**What We Found:**

- No respondent has a value-based formulary.

- Only one respondent covers (like other lab tests) at least one of the personalized medicine tests for all four listed conditions.
  - First medication failure rates were reported by one respondent.

- No respondent-based coverage of medication subject to pharmacogenomic criteria for patient appropriateness.
  - Most common policy includes all major generic and brand drugs where no therapeutic equivalent is available on formulary without a step therapy requirement.
Access to medications to treat substance use should have limited obstacles for those diagnosed with SUD. Opioid misuse and appropriate use should be monitored.

Some/all medications for AOD and SUD should be available on lowest or no cost tier

Plans should monitor member adherence to depression and substance use medications and close gaps

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**Why This Matters:**

- Pharmacy coverage, including access to medications and monitoring of medication adherence, is important to patient outcomes and an area of potential concern related to mental health parity (e.g., additional obstacles should not be imposed for MH/SUD conditions, relative to medical conditions).

**What We Found:**

- Only one respondent has removed/have no limits or duration on # episodes and no fail first policies for members identified with substance use disorder.
- Opioid misuse rate ranges from 0.05% to 4.5% (Median from national response = 0.16%); in all instances prescribers are alerted, and sometimes members.
- One respondent had all listed medications for AOD and SUD in lowest/no cost tier.
- Two respondents monitored adherence for both depression and substance use medications.
  - When gaps in adherence are identified, only one respondent reaches out to all stakeholders (members, clinician and care team/coach/case manager).
**Pharmaceutical Management – Physician Monitoring**

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<td>Plans should monitor appropriateness of prescribing of antidepressants, ADHD and pain medications among all clinicians</td>
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**Why This Matters:**
- Pharmacy coverage, including monitoring appropriateness of prescribing, is important to patient outcomes.

**What We Found:**
- Variation in comprehensiveness and level of monitoring of PCPs and BH Specialists on appropriateness of prescribing.
- Monitoring should include:
  - Monitoring rate of prescribing by practitioners compared to rate of diagnosis and investigating outliers once or more per year.
  - Monitoring rates of prescribing multiple medications for condition once or more per year.
  - Review of members on medication to check for assessment using a standardized screening instrument once or more per year.
A value-based formulary for antidepressant medications should be available

Plans should cover at least one personalized test and report first medication failure rate

Formulary policies should allow for clinical judgment and genetic testing results in access to medications

Access to medications to treat substance use should have limited obstacles for those diagnosed with SUD; opioid misuse and appropriate use should be monitored

Some/all medications for AOD and SUD should be available on lowest or no cost tier

Plans should monitor member adherence to depression and substance use medications and close gaps

Plans should monitor appropriateness of prescribing of antidepressants, ADHD and pain medications among all clinicians

**Recommendations:**

- Insist that plans/PBMs measure first medication failure rates and review formulary decisions and coverage of personalized tests using this additional information in discussion with purchasers.
- Ensure that level of access to all medications for treating substance use is comparable to medications for medical conditions, e.g., diabetes.
- Review and assess plan and PBM PA policies for BH medications. PAs may impact network participation – hassle factor.
- Monitoring appropriateness of prescribing among primary care and BH specialists for antidepressants, pain and ADHD medications should be comprehensive.
- Monitoring for adherence should extend beyond depression medications.
### Why This Matters:
- This is a proven strategy for engaging members.

### What We Found:
- All track age and gender, race and primary language.
- Two of three track ethnicity.
### Why This Matters:

- Without identification, members cannot be effectively managed for medical and behavioral conditions.

### What We Found:

- All respondents provided information on estimate of % membership with various BH conditions. Estimates varied with the most prevalent conditions being depression, anxiety, stress (for 2 of the 3 respondents) and ADHD.

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<td>1.9% - .7%</td>
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<td>Anxiety</td>
<td>5% - 17.7%</td>
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<td>Stress</td>
<td>0.5% - 8.6%</td>
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<td>Depression</td>
<td>8.2% - 12.2%</td>
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- MN

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<th>Condition</th>
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<td>ADHD</td>
<td>2.1% -11%</td>
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<td>Anxiety</td>
<td>4.5% - 26%</td>
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<td>Stress</td>
<td>0.1% - 19%</td>
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<td>Depression</td>
<td>3.8% - 27%</td>
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- National

- In many instances, members with BH conditions are not assessed for co-existing medical conditions (CAD, obesity and diabetes) or tobacco use.
Access to BH clinician in after-hours emergency situations should be seamless

**Why This Matters:**
- This is a best practice for managing care.

**What We Found:**
- All respondents reported having provisions in place for members to reach or be warm-transferred to a BH clinician for after-hours emergent calls.
- When member changes insurance carrier, all respondents allow up to 120 days to transition from a provider not in-network to provider in respondent network.
Why This Matters:
• This is necessary to enable members to find a provider.

What We Found:
• Online BH directory and selection tool generally has limited content and functionality.
  • Telemedicine is searchable in the directory for one respondent.
  • Performance summarized using BH-specific composite measures is available from only one respondent.
  • Only one respondent has a cost calculator integrated within the selection tool.
Transitional Care codes should be reimbursed

Why This Matters:
• This is a best practice for managing care.

What We Found:
• Two respondents reimburse for the transitional care codes; however # claims reimbursed in past year is variable (< 300 to over 4,500).
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<tbody>
<tr>
<td>Plans should track and use member demographics to engage them</td>
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<tr>
<td>Membership with BH conditions should be identified</td>
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<td>Plans should assess members with BH conditions for co-existing medical conditions</td>
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<td>Access to BH clinician in after-hours emergency situations should be seamless</td>
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<tr>
<td>Online BH directory and selection tool should be robust and user-friendly</td>
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<tr>
<td>Transitional Care codes should be reimbursed</td>
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**Recommendations:**

- An integrated picture of BH and medical conditions and risk factors is key for total health management.
- Features and content of online BH directory and clinician selection tool should include PCPs, performance and cost and ability to search, filter and rank on multiple characteristics including tele-behavioral.
- Accuracy of directory should be evaluated and ability to measure and display information such as wait times for urgent/non-urgent appointments should be developed.
- Transitional care codes should be reimbursed.
Accreditation and Compliance with Parity

<table>
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<th>Plans providing BH services should have NCQA MBHO Accreditation</th>
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Why This Matters:
• Third-party accreditation provides assurances to employers and patients.

What We Found:
• Most have NCQA MBHO accreditation.
• Two of three respondents have accreditation for telehealth services.
Why This Matters:
- An independent, external audit provides third-party assurance regarding mental health parity to employers and patients.

What We Found:
- None have conducted an external audit on parity compliance including an assessment of NQTL compliance.
  - Only one respondent conducted an internal audit; another assesses parity compliance.

Examples of NQTL
- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for 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; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.
Why This Matters:

- Patients should be able to access mental health care when they need it, and higher denial rates for mental health than M/S may signal issues with access and mental health parity.

What We Found:

- Not all respondents reported % denials by setting or by pre-service versus post-service.
- Not all respondents could report % denials for M/S.
- When reported, % BH denials for pre-service medical necessity services were generally lower than % M/S denials in inpatient, outpatient facility, and office visits.
## Accreditation and Compliance with Parity – Summary & Recommendations

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<tr>
<th>Plans providing BH services should have NCQA MBHO Accreditation</th>
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<tr>
<td>Plans should have Mental Health Parity Compliance Audit conducted and apply for accreditation by a third party (when available)</td>
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<td>% Denials across sites should be comparable to Medical/Surgical; if not, there should be with action plan to address</td>
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### Recommendations:

- **An external audit of MH Parity Compliance, including an assessment of NQTL compliance, should be conducted by an auditor who understands the parity law in depth.**

- Monitoring and comparing pre-and post-service (medical necessity and administrative) % denial rates for M/S and BH across different settings will provide insight into comparability of access.
  - Absolute differences of 5% or greater should be investigated and a plan of correction should be implemented.

- **External accreditation for BH services should be sought even if respondent has health plan accreditation.**
**Why This Matters:**

- Reporting and analysis allow employers and their plans to understand utilization and take action as needed to ensure patients have access to programs.

**What We Found:**

- All respondents have robust EAP offerings, 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 low with a range that matches national response of 0.05% - 7%.

- No respondent had information on impact on disability rates or return-to-work.

- While two respondents monitored absenteeism and presenteeism from condition, results for program were not reported.

- Only one respondent had information on ROI.
Why This Matters:
- Measurement-based care leads to better patient outcomes.

What We Found:
- No respondents used PQA specifications to calculate rate of antipsychotic use in Children Under 5 Years Old.
- For measures tracked by MCM, none of the respondents provided plan-specific results.
- HEDIS results – All respondents had 5 out of 12 HEDIS results that were above the 75th percentile:
  - Follow-up After Hospitalization for Mental Illness (FUH) – 30 day follow-up.
  - Follow-up After Emergency Department Visit for Mental Illness – 7 and 30 days.
  - Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 and 30 days.
- Two measures that need the most improvement (all respondents 50th percentile or below):
  - Follow-up After Hospitalization for Mental Illness (FUH) – 7 day follow-up.
  - Initiation of Alcohol and Other Drug Dependence Treatment.
## Plans should evaluate and report aggregated use of EAP Services

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## The impact of depression and/or alcohol use disorder interventions/programs should be evaluated and reported

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## Plans should report on performance against NQF-endorsed measures

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### Recommendations:

- Calculate rate for “Antipsychotic Use in Children Under 5 Years Old” using PQA specifications.
- Work with MCM to report plan – specific rate for MCM reported measure.
- Assess how to improve performance on:
  - Follow-up After Hospitalization for Mental Illness (FUH) – 7 day follow-up.
  - Initiation of Alcohol and Other Drug Dependence Treatment.
- 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 at least 50% of eligible population participate in program.
Key Opportunities to Drive Marketwide Improved Care and Outcomes

• **Access**
  • Reduce disparities in access (access standards, OON usage, denial rates, wait times).
  • Ensure up-to-date, accurate and complete provider directories with differentiation between child and general psychiatrists/psychologists.

• **Payment**
  • Equalize reimbursement rates for MH/SUD and medical/surgical providers for similar codes and time.
  • Implement innovative payment models that reward high-value BH care.

• **Measurement-based Care**
  • Require, measure and incent use of validated screening instruments to identify, assess and treat patients.
  • Promote, train, support and reimburse providers to increase use of collaborative care.
  • Monitor, report and incent providers on performance in evidence-based measures.

• **Mental Health Parity** (in addition to above noted items)
  • Address disparities and barriers in pharmaceutical coverage and access.
  • Conduct an independent audit to ensure parity including NQTL compliance.
Tools and Resources Available at www.mnhealthactiongroup.org

EXAMPLES

- Guide, “Insights and Actions to Help Minnesota Employers Advance Mental Health in the Workplace”
- eValue8 Mental Health Deep Dive: Webinar deck, Executive Summary, News Release, and Blog
- Model Data Request Form and Model “Hold Harmless” Language
- Blogs and links to relevant articles and resources
Thank You and Final Thoughts…

“No one employer can drive the change needed to transform mental health care. In fact, no group of employers working together can do it.

Employers must lead this effort, but it takes all of the stakeholders in the marketplace, working together with a common focus, toward shared goals, to realize meaningful change.”

Director, Total Rewards, Minnesota Employer

If you have questions related to today’s webinar or would like to engage with The Action Group to improve mental health care and outcomes, please contact Deb Krause, dkrause@mnhealthactiongroup.org