

Population Health: Improving Behavioral Health Services

CalPERS Board Offsite
Concord, July 17, 2018

Agenda

- Two Decades of Federal Mental Health Parity: Impact?
 - Susan L. Ettner, Ph.D., UCLA
- Four Ways to Improve Behavioral Health Care
 - Ewuria Darley, M.S., American Psychiatric Association Foundation
- Barriers to Quality Mental Health Treatment and Potential Solutions
 - Rebecca Fraynt, Ph.D., SEIU 775 Benefits Group
- Questions and Answers

Two Decades of Federal Mental Health Parity: Impact?

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Introduction to parity (1)

- Historically, insurance coverage was worse for mental health (MH) and substance use disorder (SUD) services, possibly motivated by stigma, adverse selection and/or moral hazard
- 2/3 of primary care providers (PCPs) reported difficulty getting outpatient MH care for patients
 - Twice as much difficulty as for other medical services
 - 85% of the PCPs said major reason was inadequate insurance
- Improving generosity of behavioral health (BH) benefits may have positive spillover effects onto medical care
 - More substitution of specialists for PCPs for sickest patients
 - Possible cost “offsets” in ED and hospital use

Introduction to parity (2)

- Starting in 1970s, states began passing insurance parity (equality of coverage for BH and medical care) laws
 - e.g., CA State Assembly Bill 88 (effective July 2000): Plans must cover diagnosis and medically necessary treatment of certain mental conditions under same “terms and conditions” as medical conditions
- Advocates viewed state parity laws as inadequate
 - Exemptions, benefits and conditions varied greatly
 - ERISA exempts self-insured plans from state mandate

Mental Health Parity Act of 1996

- First federal parity law stated that large-group plans offering MH benefits could not have lower annual and lifetime spending limits on MH than medical services
- Unintended consequences
 - Example #1: GAO found most newly-compliant employers changed plans to be more restrictive in cost-sharing features or visit/day limits
 - Example #2: Federal Employees Health Benefits Program increased direct utilization management by switching to “carve-out” model
- Led to effort to specify parity in all benefit design features, including quantitative and non-quantitative treatment limits (QTLs and NQTLs)

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

- Effective starting October 2009 as plans renewed
- Employers offering MH and/or SUD coverage cannot apply financial requirements (e.g., deductibles and copayments) or treatment limits (e.g., number of visits or days of coverage) more restrictive than predominant requirements / limits applying to substantially all medical/surgical benefits
- Prohibited separate accumulation of deductibles and out-of-pocket maximums
- Did not require coverage or specify diagnoses that had to be covered; included small group & cost exemptions

MHPAEA Interim Final Rule and Final Rule

- **Interim Final Rule: Effective 7/1/10 as plans renewed**
 - Added legal compliance and parity in NQTLs (e.g., pre-authorization, medical necessity review, reimbursement, etc.)
- **Final Rule: Effective starting 7/1/14 as plans renewed**
 - Retained NQTLs and clarified interactions with the Affordable Care Act, e.g., “essential health benefits” include BH services
 - Parity rules would apply broadly, including existing and newly eligible Medicaid populations and individual coverage
- In first published evaluation of MHPAEA, Busch et al. (2014) found only modest effects, but only examined SUD treatment and first year post-parity (2010)

UCLA MHPAEA Evaluation (1)

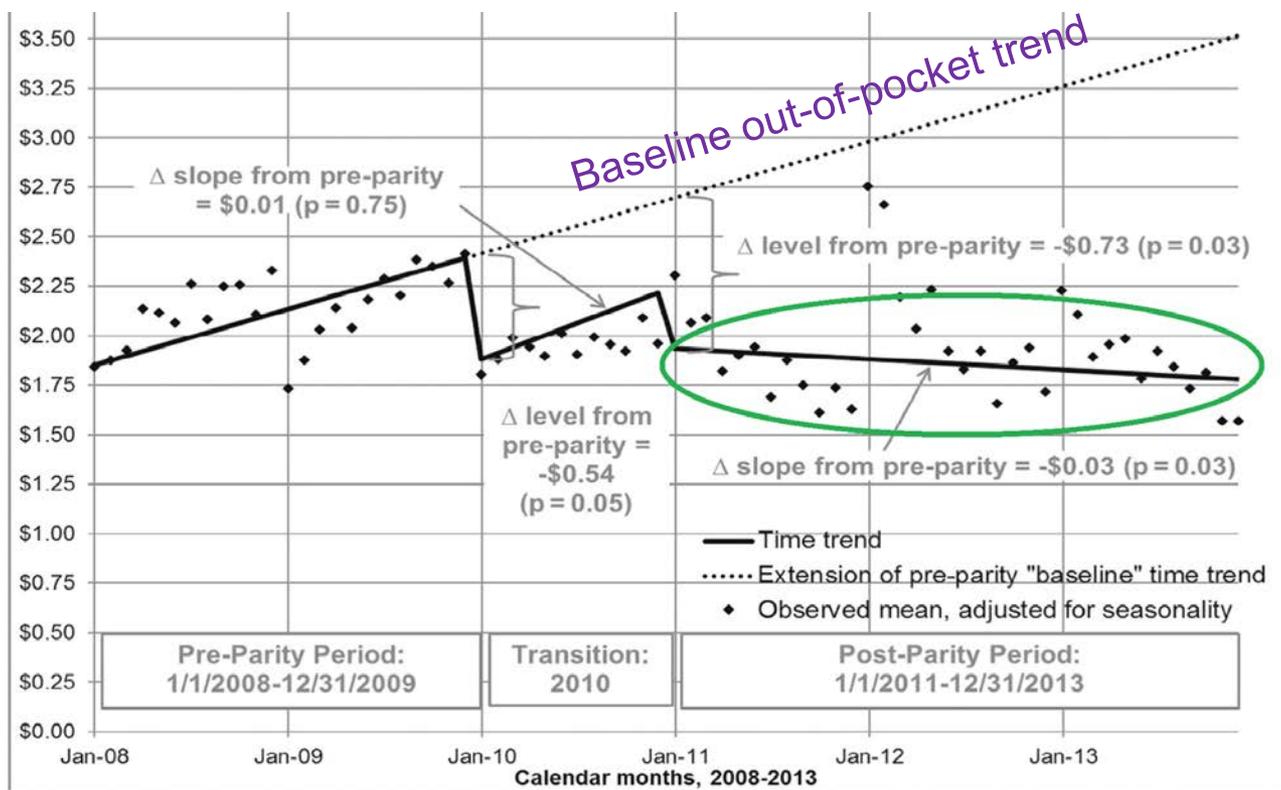
- 2008-13 administrative databases from a large national managed behavioral healthcare organization
- Used regression to compare benefit design, utilization and costs in the pre- (2008-9), transition (2010) and post-parity (2011-2013) periods
- We found no evidence that employers dropped BH coverage, but use of carve-outs declined post-parity, due to greater administrative burden for complying
- Only modest/mixed impact on financial requirements because most plans were already at parity

UCLA MHPAEA Evaluation (2)

- MHPAEA did improve insurance benefits, but mostly by eliminating QTLs, relaxing some NQTLs and (for carve-outs) newly combining deductibles
 - Vast majority of plans imposed visit/day limits pre-parity; post-parity, limits disappeared
 - Many pre-authorization requirements less stringent post-parity
- Few notable changes were seen in BH care use, but stronger effects among carve-ins
 - Increases in individual psychotherapy visits and plan and total spending, driven by out-of-network use
 - Estimated per-enrollee total spending in July 2012 was \$6.90 w/o MHPAEA, \$8.40 with MHPAEA

UCLA MHPAEA Evaluation (3)

- Parity effects stronger for children and young adults & patients with SUD (but not Severe Mental Illness)
- Less consistent impact on use in carve-outs but patient financial protections improved by cost-shifting onto plans



Why Weren't Effects Larger?

- Non-compliance in measures not studied here, e.g., were there discrepancies in the definition of medical necessity?
- Or the opposite – too many plans already compliant?
- Limited networks/provider supply?
- Commercially insured patients too healthy/wealthy to respond strongly to out-of-pocket costs?
- Perceived stigma?
- Poor information among providers and patients?
 - In a 2014 APA survey of 1000 Americans, only 4% were aware of MHPAEA
 - When asked about their BH coverage, many described benefit designs that were incompatible with parity compliance

Conclusion: Thinking Beyond Parity (I)

- To some extent, MHPAEA did improve BH benefits, especially for high utilizers
- However, parity laws alone may be insufficient
- In an era of shrinking medical benefits and PCP shortages, may prefer an absolute rather than relative standard
 - Under parity, inadequate primary care allows inadequate BH care
 - How generous should benefits be, and how many providers do we need, to ensure access to needed BH care?

Conclusion: Thinking Beyond Parity (II)

- Need to address non-financial barriers, such as geographic barriers (provider shortages in rural and underserved areas); lack of integration with medical care; and lack of diversity in the BH care workforce (e.g., only 6% of psychologists come from diverse background)
- Need interventions to identify unmet need for BH services, educate patients and address perceived stigma, especially among older and minority populations

Four Ways to Improve Behavioral Health Care

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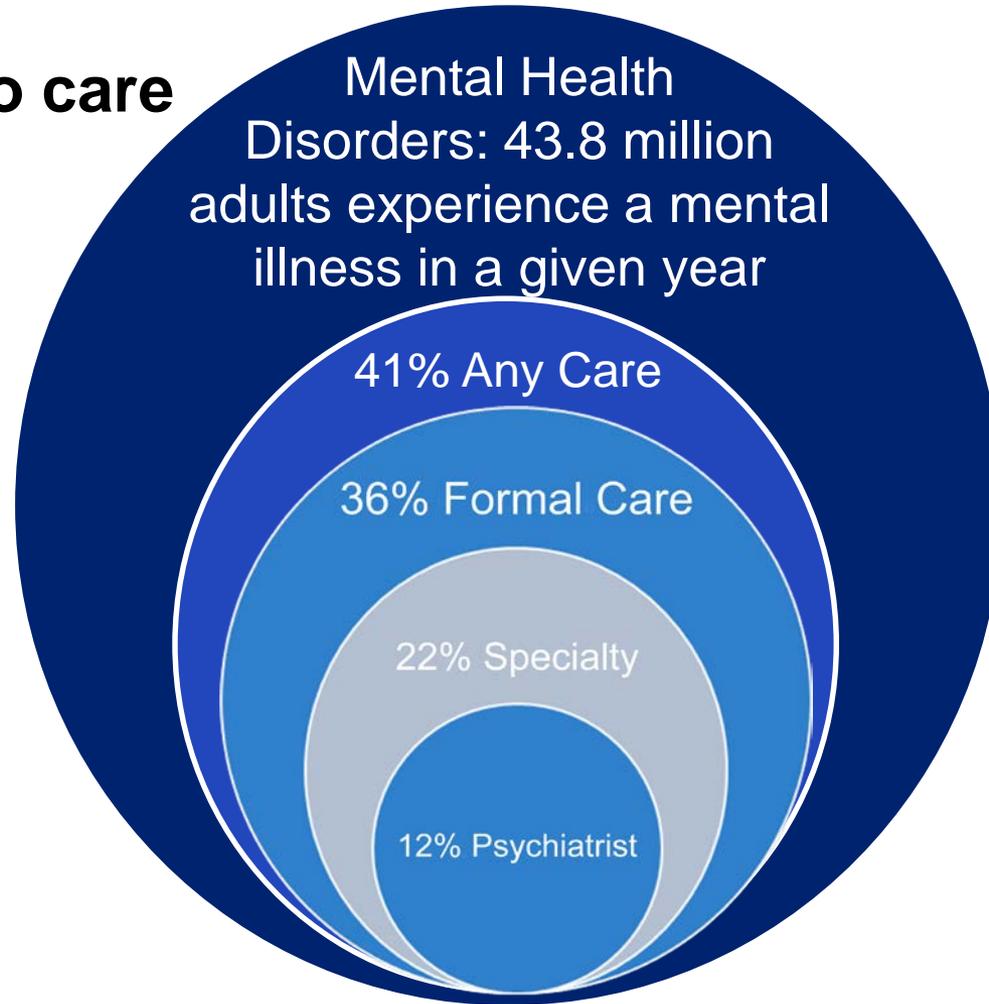
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Objectives

- Describe growing concerns with behavioral health and access to care.
- Describe concerns with traditional approach.
- Describe effective treatment approaches.
- Describe recommendations for health plans and employers to improve behavioral health care.

GROWING CONCERNS IN BEHAVIORAL HEALTH

Access to care

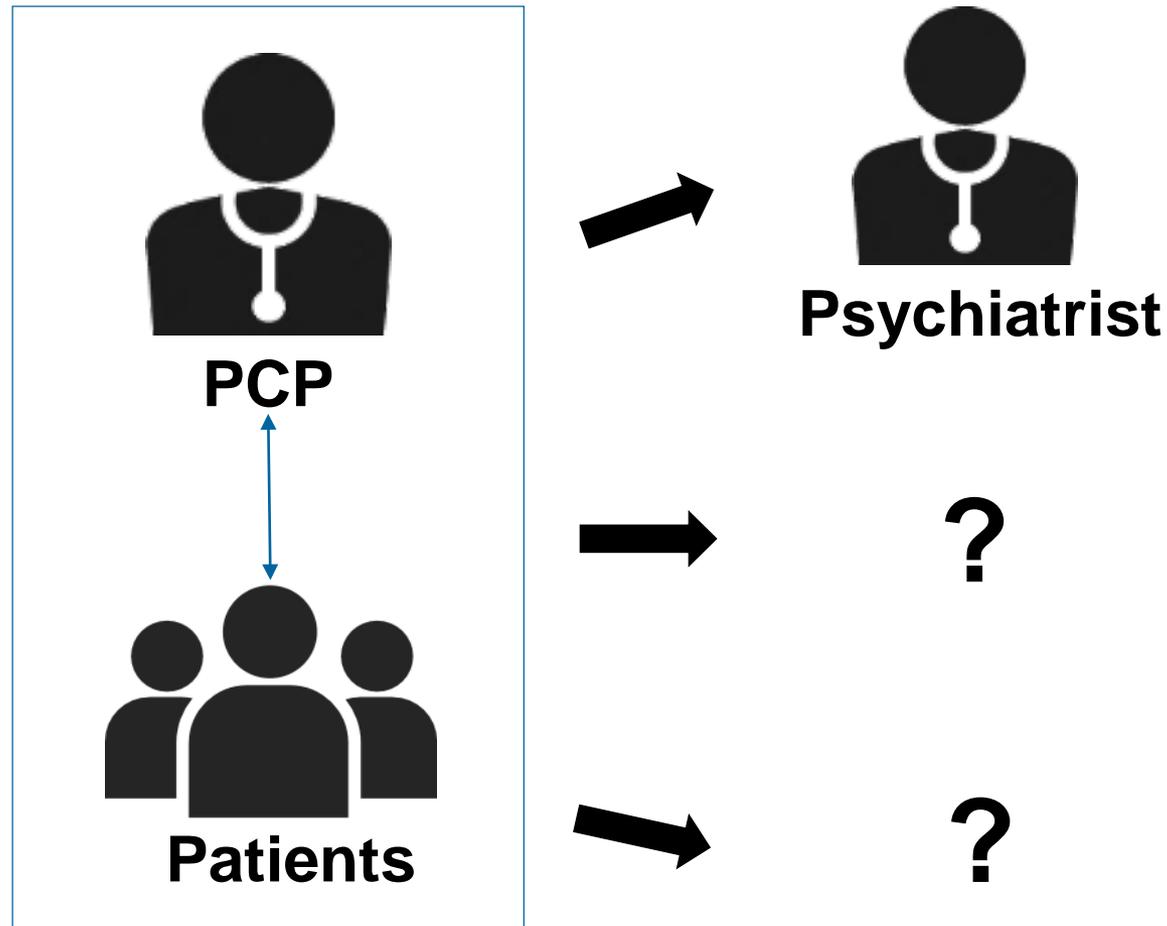


GROWING CONCERNS IN BEHAVIORAL HEALTH

- Mental health disorders cause 21.2% (possibly 32.4%) of all years lived with disability worldwide*
 - 4x all injuries, 8x all cardiovascular and circulatory diseases, 24x all cancers
- One suicide every 14 minutes in the US
- Health plan participation
- Shortage of behavioral health specialists
- Rising healthcare costs

* Vigo D, et al. Estimating the true global burden of mental illness. *Lancet Psychiatry* 2016 Feb;3(2):171-8.

TRADITIONAL CARE MODEL



EFFECTIVE TREATMENT APPROACH



Prepared, Pro-active Practice Team

Effective Collaboration



Informed, Active Patient

↑
Practice Support



Outcome Measures

[ACTIVE PATIENTS]						
Flask	[Patient ID]	[Name]	[Encounter Date]	[Status]	[Encounter Date]	[Encounter Page]
	0001	Test, Test	2/6/2013	[T]	0/24/2013	
	0008	Test, Sory	4/2/2013	[T]	5/21/2013	12
#	0010	Test, Test	4/17/2012	[T]	4/25/2013	18
	0025	Test, Rpo Reminder	1/10/2013	[T]	1/10/2013	
#	0038	Test Patient, Misc	1/23/2014	[T]	1/23/2014	22
#	0041	Test, Test	3/4/2014	[T]	3/4/2014	
#	0042	Test, Test	3/7/2014	[T]	3/7/2014	

Population Registry



Psychiatric Consultation

RECOMMENDATIONS FOR IMPROVING CARE

Expanding Collaborative Care Model

Advancing Measurement Based Care

Ensuring Network Adequacy and Mental Health Parity

Expanding Telepsychiatry

RECOMMENDATIONS: EXPANDING COLLABORATIVE CARE

Health plans:

- Pay for collaborative care (CC) model using new CPT codes.
- Ensure primary care providers (PCPs) implement CC and use CC - CPT codes.
- Provide practitioners link to APA's CC training module* and provide ongoing technical assistance (TA).
- Provide employers with data on adoption of CPT codes.

Employers:

- Request health plans provide a plan for ongoing TA and training for practitioners on implementing and working with the CC model and CPT codes.

* <https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained>

RECOMMENDATIONS: ADVANCING MEASUREMENT BASED CARE

Health plans:

- Provide incentive payments and minimize administrative requirements to 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.

Employers:

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

RECOMMENDATIONS: NETWORK ADEQUACY & MH PARITY COMPLIANCE

Health plans:

- Develop an action plan for employers or implement a corrective action plan that addresses access to care and includes the following steps:
 - Expand in-network mental health and substance use providers.
 - Publish up-to-date, accurate, and complete provider directories with easily accessible information for plan enrollees, prospective enrollees.
 - 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).

RECOMMENDATIONS: NETWORK ADEQUACY & MH PARITY COMPLIANCE

Employers:

Ask health 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.
- An explanation of disparities, corrective action and a timeline for action.
- Responses to selected non-quantifiable treatment limitation (NQTL) questions consistent with the analysis called for in the parity Self-Compliance Tool issued by the Department of Labor.*

* <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf>

RECOMMENDATIONS: NETWORK ADEQUACY & MH PARITY COMPLIANCE

Employers:

- Ensure that the legal department is familiar with federal and state mental health parity laws and is aware of risks associated with non-compliance.
- Be aware that State Insurance Commissioners are investigating health plan compliance with MH parity laws and acting to resolve non-compliance.
- Conduct an independent assessment of your health plan by a qualified expert, examining all aspects of care delivery.

RECOMMENDATIONS: EXPANDING TELEPSYCHIATRY

Health plans:

- Share a link to the APA's telepsychiatry toolkit* with 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 to overcome those barriers.

Employers:

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

* <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry>

Thank you!

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To learn more visit:

www.workplacementalhealth.org

Barriers to Quality Mental Health Treatment and Potential Solutions

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What is SEIU 775 Benefits Group and What Do We Know about Mental Health?



SEIU 775 BENEFITS GROUP

- Taft-Hartley trust that administers health, training, and retirement benefits to home care workers in Washington state
- ~50,000 home care workers who are part of the SEIU 775 union
- ~18,000 of these workers are enrolled in our health benefits package
- We have spent the last three years working hard to better understand how to improve access to high quality mental health treatment in this population

BG's Philosophy for Solving Health Problems in Our Population

- Use claims data, customer service complaints, etc. to identify areas of opportunity
- Use a combination of literature review, qualitative methods, service design approaches, and survey data to get a fine-grained understanding of the problem
- Pilot solutions at small scale to test for effectiveness
- Scale the most promising pilot solutions

National Mental Health Statistics

- Almost 50% of people in the US will have a mental health condition at some point during their lifetime¹
- 20% of US adults have a mental health disorder every year²
- 60% of people with mental health conditions did not get ANY treatment in the last year²
- Despite the fact that effective mental health treatments exist, most people who receive mental health care do not get enough treatment to recover³

Prevalence of Mental Health Conditions and Risk Factors Among Home Care Workers

Internal survey work indicated that mental health problems significantly impact our population

Survey Type	Results
Exposure to Adverse Childhood Events (ACEs, which are associated with negative physiological and psychological health outcomes)	Home care aides (HCAs) were almost 2x more likely than members in a general population survey to have experienced 4 or more ACEs.
Anonymous Depression Screener (over 12,000 screeners completed as of April 2018)	1 in 5 respondents report moderate to severe depressive symptoms
Anxiety Screening (administered to random sample of HCAs)	50% had screening results suggestive of some distress caused by anxiety symptoms (20% had a likely anxiety disorders)

Benefits Group's Approach to the Problem

Step 1: We Analyzed Our Claims and Health Plan Partner Data

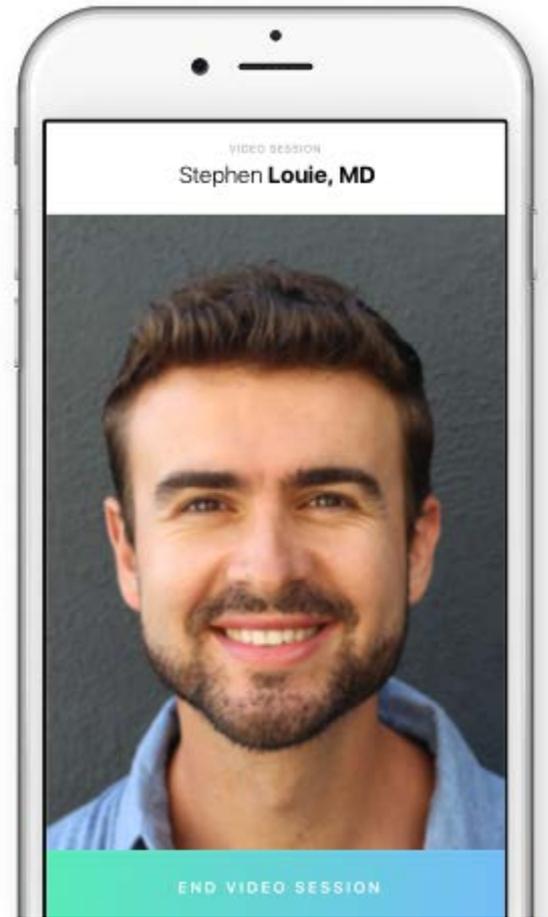
- Mental health services are under-utilized
 - Significantly less than 1% of our health plan members initiate specialty behavioral health care per month
- Wait times are long
 - Average wait of 28 days to an initial treatment appointment

Step 2: We Talked to Home Care Workers about Barriers to Care

Focus Groups (about HCA preferences re: communications)	Mental Health Navigator (two month pilot phone line to help with mental health appointments)	HCA Informant Interviews (n=12, about experiences with behavioral health)
<ul style="list-style-type: none">• Desire for asynchronous/text-based communication*• Confusion about available resources*• Stigma*• Desire for peer community*	<ul style="list-style-type: none">• Desire for asynchronous/text-based communication*• Relationship building is very important to help motivate HCAs to schedule appointments• Systems barriers	<ul style="list-style-type: none">• Caregiving is a stressor*• Confusion about available resources*• Desire for peer community*• Stigma*

Step 3: Implemented Solutions to Address Specific Problem Components

- Eliminated behavioral health copays
- Ginger.io app
- Mindfulness courses (both online and in-person)
- EAP



Spotlight on Mindfulness Courses and Ginger.io

Mindfulness Courses

Why This Solution?

- Significantly reduces stigma
- Can offer as a CE course, so HCAs learn skills without needing to identify a specific behavioral health issue
- Online and in-person offerings increase access for HCAs in rural areas

Initial Results and Next Steps

- Pilot study participants had significant reductions in anxiety and depression symptoms
- Online versions of the course had even higher engagement than in-person offerings
- 87% of participants continue to practice mindfulness 3 months after the course
- Currently working with Center for Mindfulness at University of Massachusetts Medical Center to bring program to scale

Ginger.io

Why This Solution?

- Ginger.io offers text-based wellness coaching, which addresses many HCAs' desire for asynchronous communication around mental health needs
- The ability to combine paraprofessional coaching with specialty behavioral health services via video chat has the potential to significantly reduce wait times

Initial Results and Next Steps

- Pilot study participants received text messages from their coach in less than 1 minute
- Time to an initial video chat appointment with a licensed therapist/psychiatrist was 4 days
- Users were highly satisfied (coaches received an average rating for 4.57 of 5 stars)
- Clinical outcomes were good. 37% of users with moderate to severe depression have clinically significant symptom improvement in 12 weeks.

Challenges and Next Steps

Ongoing Challenges

- How do we communicate with home care workers about mental health benefits in a way that reduces stigma and optimizes engagement?
- The majority of health solutions that are scalable and affordable involve a digital component. How do we roll these out to a population that sometimes needs more help accessing digital technology?

Next Steps

- Scale the Mindfulness and Ginger.io programs
- Continue to refine our mental health communications strategy
- Address the digital literacy gap in our population

Questions and Answers