# Path Forward: Mental Health Access and Parity Recommendations for Plan Sponsors*

**Require your TPA to**:

### Network Adequacy & Access

- Provide MDRF data, for network adequacy evaluation:

  MDRF Summary  Complete MDRF
  Why / TPA Pushback

- Assist employer in organizing an "access" survey (e.g., search times, wait times) by an independent entity

  Why / TPA Pushback

### Collaborative Care (CoCM)

- Waive "out-of-pocket" CoCM expenses  Why / TPA Pushback
- Eliminate limits on use of code 99494  Why / TPA Pushback

### Tele-behavioral Health (TBH)

- Reimburse audio-only and audio-video MH/SUD sessions at the same level as in-person visits

  Why / TPA Pushback

### Measurement Based Care (MBC)

- Submit letters to accreditation agencies urging that use of MBC be a requirement for accreditation of all providers (in and out-of-network) delivering quality MH/SUD care

  Why / TPA Pushback

### Mental Health and Substance Use Parity

- Provide detailed assessment of MHPAEA parity compliance for NQTLs according to the DOL April 2, 2021 FAQs about MHPAEA and the CAA

  Why / TPA Pushback

- Provide additional indemnity to employer generally in format of the Model Hold Harmless Language which addresses MHPAEA parity compliance with respect to **only those matters under the control of the TPA**

  Why / TPA Pushback

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

*This document may be updated – a current version is here.

**Network Adequacy & Access**

- Provide MDRF data, for network adequacy evaluation
  MDRF Summary  Complete MDRF

**Why**

TPA's provider network should include sufficient numbers (and availability of) MH/SUD providers so that members seeking care for MH/SUDs can obtain timely appointments with In-network providers, in order to avoid:

- long "search times" to find an in-network provider accepting patients
- long "wait times" for in-network appointments
- high copays/co-insurance for out-of-network (ONN) care
- foregoing care because they cannot afford OON care

The MDRF allows a Plan Sponsor to see if (i) in-network reimbursement levels for MH/SUD providers are low (compared to levels for Medical/Surgical (M/S) providers), while at the same time (ii) use of OON MH/SUD providers is high and (iii) many MH/SUD providers listed in the network directory have submitted few or no in-network claims. These three circumstances are signs that a TPA has not provided adequate economic incentives for MH/SUD providers to join the TPA's network, even though TPAs do so for M/S providers.

Economic incentives include (a) higher in-network reimbursement rates for care provided and (b) reduced hours of mandatory uncompensated activities, such as responding to time consuming UR and contesting denials…tasks which are burdensome for clinicians and reduce the already limited time available for patient care.

It has been estimated that 86% of PCPs join commercial networks, as compared to approximately 55% of MH/SUD providers. If TPAs offered economic incentives to MH/SUD providers such that (over time) 86% were in-network, then search times, wait times and OON use would all drop significantly.

**Why Cont.**

Many Plan Sponsors have concluded that search times, wait times, and OON care are unacceptably high, so they have either (a) instructed their TPAs to allow members to use OON providers for MH/SUD care with copays/co-insurance at in-network levels (therefore greatly increasing the "effective" in-network reimbursement levels), or (b) directly retained third party organizations such as Lyra and Teladoc (which offer higher reimbursement and require fewer uncompensated hours) in order to supplement the limited availability of MH/SUD providers in their TPAs' networks.

Both "(a)" and "(b)" are "work arounds" for MH/SUD networks which Plan Sponsors believe are inadequate.

**TPA Pushback**

(1) We don't provide this type of confidential data.

**Employer Response:** The information requested about the employer's members belongs to the employer. The information requested about the TPA's network is the same data which (a) DOL frequently requests from employers, (b) several TPAs have provided to employer clients, and (c) Washington State regulators require from insurers.

(2) The thresholds for requiring a plan of improvement are arbitrary and not established by MHPAEA.

**Employer Response:** While not established by MHPAEA, these thresholds are set by the employer based on its judgement regarding access gaps in MH/SUD care.

(3) We often pay M/S providers more because of their greater bargaining power.

**Employer Response:** MH/SUD providers in fact have more bargaining power than M/S providers – this is why so many MH/SUD providers can (and do) decline to join networks.

Return to Slide 1

**Network Adequacy & Access**

- Assist employer in organizing an "access" survey (e.g., search times, wait times) by an independent entity

## Why

To understand the challenges members face in accessing MH/SUD care from in-network providers, by gathering information that cannot be obtained from the data in the MDRF:

- For patients who needed care but didn't receive it:
  - Why they didn't receive care
  - Consequences of not receiving care
- For patients who received care from a new in-network provider:
  - Number of providers contacted to obtain appointment
  - Length of time to obtain appointment ("search time")
  - Length of time until the appointment actually occurred ("wait time")
- For patients who received care from an out-of-network (OON) provider:
  - Why they saw an OON provider

## TPA Pushback

(1) Surveying members is time consuming and response rates may be low.

**Employer Response:** Correct, but the employer wants to know this key information. An independent survey firm will be used in order to encourage participation and minimize TPA workload.

If the TPA were to maintain an up-to-date "new-appointment" portal, members would use it to search for INN providers accepting new patients, and therefore search times and wait times would be easily measured without surveying.

Note: Some TPAs supplement their networks by contracting with networks of behavioral health providers (e.g., Array Behavioral Care, Brightside Health) which track provider access in real time and guarantee reasonable waiting periods. Unfortunately, TPAs often do not make this provider access information available to patients and Plan Sponsors.

Return to Slide 1

## Collaborative Care (CoCM)

- Waive “out-of-pocket” CoCM expenses

### Why

CoCM is the only integrated care model with extensive research demonstrating its effectiveness, with more than 80 randomized control studies showing: (1) improved MH/SUD clinical outcomes, (2) reduced Total Healthcare Costs, and (3) increased provider and patient satisfaction. The use of CoCM should be encouraged and economically incentivized, since members and employers will benefit.

CoCM is most frequently provided in primary care. Members are accustomed to very low out-of-pocket (OOP) expenses in primary care, especially for wellness visits. High OOP costs for each CoCM encounter, which often occur because of plan deductibles, are an economic disincentive for members to accept CoCM treatment. Given the benefits of CoCM, the employer wants CoCM to be readily affordable and used whenever needed.

### TPA Pushback

(1) Health plan policies/rules do not allow waiver of OOP expenses unless the service in question is approved as a preventative service.

**Employers Response:** BCBS of Michigan has waived member OOP expenses for CoCM for both fully-funded and self-funded plans.

Health plan policies can and should be revised when the result is improved member health, client satisfaction and fiscal soundness.

(2) We have an existing contract in place with client that was priced based on existing benefit structures. We cannot provide more liberal benefits without charging the additional costs to the client, which requires a contractual change.

**Employers Response:** Employer will support benefit changes that greatly improve clinical outcomes and reduce Total Healthcare Costs.

Contract amendments may be appropriate. If so, please propose specific edits.

Return to Slide 1

**Collaborative Care (CoCM)**

- Eliminate limits on use of code 99494

**Why**

99494 is a billing code used for short follow-up visits for a member already enrolled in CoCM. Some TPAs limit the frequency of billing for this code, e.g., once per month.

If a member is in distress or crisis, it may be necessary to provide more frequent care. This is not only clinically appropriate, it is also less expensive for the member to receive more frequent intervention from an existing provider than to incur an avoidable ED or hospital admission.

Note: Limiting use of 99494 may be a parity violation and should be examined also from this perspective.

**TPA Pushback**

(1) PCPs can abuse (overbill) the use of 99494. To avoid abuse, we limit use of 99494 and codes similar to it.

**Employers Response:** If abuse of any billing code is suspected, it should be investigated rather than imposing blanket restrictions on its appropriate use.

The cost of removing limits on billing of 99494 will be substantially less than if the member:

- Does not receive care when needed
- Receives care from a MH/SUD specialist, or
- Must go to the ED, which is very expensive and leads to gaps in after-care.

Return to Slide 1

## Tele-behavioral Health (TBH)

- Reimburse audio-only and audio-video MH/SUD sessions at the same level as in-person visits

### Why

People value having a choice among in-office, audio-video and audio-only treatment modalities, and having a choice increases treatment compliance.

Further, virtual appointments are an efficiency-boosting way to utilize scarce MH/SUD resources, as they greatly reduce costly no-shows and time away from work.

To maintain gains we have seen in care access during the pandemic, all TBH modalities should be reimbursed at the same rate: audio-video, audio-only and in-person.

### TPA Pushback

(1) We don't believe there is enough evidence to justify paying the same amount for audio-only TBH.

**Employers Response:** The evidence to date suggests that, for most types of MH/SUD care, TBH care (audio-video or audio-only) is as effective as in-person care.

(2) The cost to the provider to deliver audio-video or audio-only TBH is lower than the cost for in-person visits; therefore: reimbursement should reflect this.

**Employers Response:** Unless providers are delivering only TBH, they maintain similar cost structures to operate a clinical practice whether a visit is audio-only, audio-video or in-person. So, if they are paid less for audio-video or audio-only, the economic disincentives will cause them to move away from (a) offering these modalities or (b) participating in networks. This will decrease efficiency and increase employer costs because of higher no-shows and increased time of members away from work. It will also reduce member satisfaction.

Return to Slide 1

## Measurement Based Care (MBC)

- Submit letters to accreditation agencies urging that use of MBC be a requirement for accreditation of all providers (in and out-of-network) delivering quality MH/SUD care

**Why**

MBC refers to the systematic administration of standardized, validated symptom rating scales to screen for MH/SUD conditions and monitor treatment progress, assess outcomes, and guide treatment decisions. It is considered standard practice in virtually all areas of healthcare except MH/SUD treatment.

Studies show that consistent use of validated symptom measurement tools improves treatment outcomes by 20% – 60% and generates a nearly 75% difference in remission rates between patients receiving MBC and those receiving usual care.

Despite the clear evidence of value, adoption of MBC as a standard of care has been slow and inconsistent. While some strides have been made recently, accreditation agencies have asked for explicit support from TPAs in order to make MBC a universal requirement.

The Joint Commission has made the use of MBC a requirement for some MH/SUD specialists. URAC offers the option of an MBC "designation". These are steps in the right direction. However, these steps are far from adequate. It is essential that all four accreditation agencies make the use of MBC a requirement for all in and out-of-network providers delivering quality MH/SUD care (MH/SUD specialists and Medical/Surgical providers such as PCPs and OBGYNs). This will drive nationwide adoption of MBC and lay the groundwork for implementation of performance-based reimbursement of MH/SUD providers.

**TPA Pushback**

(1) We do not see the need to write this type of letter. We interact with accrediting agencies regularly and they are aware of our support for MBC

**Employers Response:** This could be said of all TPAs, yet at least one major organization – United/Optum – has already written such a letter to URAC, and copies were sent to the other accreditation agencies. We see no reason that [TPA] would not be willing to write a similar letter.

Both TPAs and employers want to know which treatments and which providers are most able to deliver improved clinical outcomes. MBC lays the groundwork for implementation of performance-based reimbursement of providers.

Return to Slide 1

**Mental Health and Substance Use Parity**

- Provide detailed assessment of MHPAEA parity compliance for NQTLs according to the DOL April 2, 2021 FAQs about MHPAEA and the CAA

## Why

The law requires that all Plan Sponsors be prepared, within 45 days of receipt of a request from DOL, to provide to DOL a detailed analysis of NQTLs using a multi-step methodology. It is necessary for the TPA to prepare this analysis because it relates to TPA NQTL policies and procedures developed and managed by the TPA, of which the employer is likely to have little or no knowledge.

## TPA Pushback

(1) Preparation of the multi-step analysis is the Plan Sponsor's responsibility, not the TPA's.

**Employers Response:** It is impossible for a Plan Sponsor to prepare the multi-step analysis required by DOL because only the TPA can provide the required detailed information regarding NQTLs, as written and as applied in operation by TPA staff.

Return to Slide 1

**Mental Health and Substance Use Parity**

- Provide additional indemnity to employer generally in format of the Model Hold Harmless Language which addresses MHPAEA parity compliance with respect to **only those matters under the control of the TPA**

**Why**

Employers are Plan fiduciaries and are liable for noncompliance with MHPAEA. However, employers have little or no knowledge about, or influence over, NQTLs. These are managed by the TPA and are the key subject area of the DOL investigations. See 2022 MHPAEA Report to Congress.

While typical TPA contracts do provide some indemnification by the TPA, that indemnification typically does not specify parity non-compliance matters. Therefore, additional indemnification is desirable.

Based on discussions with DOL, it is recommended that employers seek this additional indemnification.

**TPA Pushback**

(1) We don't provide this type of indemnification.

**Employers Response:** An employer should anticipate that its TPA may not agree to provide the requested indemnification. Nonetheless, it would be worthwhile to have a record of asking for this (a) to clearly signal to the TPA the employer's determination to have its plan be compliant, and (b) to substantiate that the employer is making a good faith effort to be parity compliant.

Some TPAs may be willing to provide the requested indemnification, if they believe it would be economically advantageous to do so – i.e., they can gain new clients by doing so.

Return to Slide 1