Ensuring Access to Quality Behavioral Health Care: Health Plan Examples
Ensuring Access to Quality Behavioral Health Care

KEY TAKEAWAYS

In 2014, an estimated 38 million people had access to behavioral health care and benefits.

Health plans have demonstrated strong leadership in pioneering innovative programs to coordinate patients' care and meet their individual health needs.

Health plans meet network adequacy and benefit requirements under federal and state laws.

New payment and care delivery models integrate behavioral health services with patients' treatment plans for chronic conditions.

Health plans use the same evidence-driven methodology and processes across medical and behavioral benefits to determine coverage policies.

Background

Untreated behavioral health conditions, including both mental health and substance use disorders, have a significant impact on individuals, families, our economy and society. Individuals with mental health conditions and/or substance use disorders need access to evidence-based services – the care that, based on scientific research, has been shown to result in improved health outcomes – as well as coordination with their primary medical care and assistance with basic needs, such as housing, transportation, and job training. Health plans and behavioral health care organizations recognize the importance of these services in contributing to the overall well-being of their members and are committed to implementing programs that ensure patients have affordable access to high-quality, evidence-based treatments and care.

For these reasons, health plans and behavioral health care organizations support the protections established by the Mental Health Parity and Addiction Equity Act (MHPAEA). Beyond meeting the parity requirements of MHPAEA, health plans have demonstrated strong leadership in pioneering innovative programs to meet the health care needs of patients with mental health and substance use disorders, often through partnerships with behavioral health care organizations. These programs are designed to
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raise member awareness of the importance and availability of behavioral health care, to encourage discussions with providers, and to focus on proactive identification of behavioral health needs. For example, the U.S. Preventive Services Task Force recently recommended that all adults, including pregnant women and new mothers, be screened for depression. This recommendation is consistent with growing efforts by health plans to emphasize the role of primary care providers (PCPs) in identifying individuals at risk for behavioral health conditions, coordinating their ongoing care, and engaging consumers in better identifying potential signs of behavioral concerns such as depression.

Additionally, regular assessment of the adequacy of provider networks helps ensure that members have timely access to behavioral health care while accepted metrics are used to track and improve patients' outcomes. Evidence-based clinical criteria are used to help guide coverage decisions, and there is a heightened focus on integrating behavioral and medical care through greater coordination and communication. Lastly, many health plans and behavioral health care organizations are developing programs specific to certain areas of concern, such as opioid addiction and treatment.

**Awareness and Education**

Health plans provide information about their medical and behavioral health benefits through online websites, handbooks, and newsletters. Health plans are focused on reducing the stigma associated with mental illness by offering consumers general information on various conditions, such as autism, eating disorders and substance use disorders. These communication methods are similar and aligned with the information provided for medical conditions, such as cardiovascular disease, asthma, and diabetes.

**Proactive Identification and Outreach**

Health plans use a variety of approaches to identify members who may be at-risk for mental health issues and may conduct outreach to those individuals through multiple channels. For example, health plans may use health risk assessments (HRAs), claims information and other predictive analytics to engage members through case managers, behavioral health providers, self-help tools, and other resources. This first step of engagement helps individuals understand their behavioral health condition and offers support and treatment to prevent their condition from worsening. This is consistent with the approaches plans use for other chronic medical conditions, such as diabetes and cardiovascular disease. Additionally, because of the close ties between physical and behavioral health (e.g., patients with type II diabetes may be likely to experience depression), medical case managers working with patients who have chronic medical conditions may screen those individuals for behavioral health concerns. When screening identifies potential issues, case managers will help connect those patients with behavioral health case managers to navigate the system and coordinate ongoing care.

**Timely Access to Care**

In addition to meeting network adequacy requirements under federal and state law, health plans and behavioral health care organizations actively recruit behavioral health professionals. This is important because there is a national shortage of such providers. Plans also monitor the availability of appointments and assist members in getting appointments when needed. Many plans use telemedicine to augment capacity and improve convenience and access for their members. However, state restrictions and Medicare’s telemedicine reimbursement limitations are barriers to more widespread use of telemedicine services.

**Quality Measurement**

Health plans rely on measures such as Healthcare Effectiveness Data and Information
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Set (HEDIS) to track and improve behavioral health care quality. They also assess member satisfaction, and many are beginning to designate centers of excellence for specialized behavioral health care. Health plans emphasize the need for clinical outcome measures in behavioral health care and more widespread provider use of symptom severity rating scales with patients to measure progress on an ongoing basis.

Evidence-Based Clinical Criteria

In establishing clinical guidelines for behavioral health conditions, most plans use a combination of nationally recognized external sources and internally developed criteria, based on the latest medical evidence – just as they do for other medical conditions. External sources may include American Society of Addiction Medicine (ASAM) provider-developed criteria for managing levels of care for individuals with substance use disorder, CALOCUS (Child & Adolescent Levels of Care Utilization System), McKesson/InterQual for higher levels of care, and Hearst Health’s MCG guidelines (formerly known as Milliman Care Guidelines). These evidence-based criteria are used to treat initial episodes and relapses. Plans and behavioral health care organizations use the same evidence-driven methodology and processes across medical and behavioral benefits to determine what services are covered. Similarly, with respect to medications, evidence-driven methods are used to make formulary decisions for prescription medications for behavioral and medical conditions.

Occasionally, changes in coverage may occur when a provider or member believes that a higher level of care may be needed. In these situations, health plans work with the patient and provider to determine the most appropriate treatment plan for the patient.

Coordination and Integration

Plans emphasize care coordination and integration of medical and behavioral health care through a variety of approaches to treat diverse patient populations. For example, when a member is diagnosed with a chronic medical condition, like diabetes or asthma, the case manager or health coach engages with the individual to identify potential signs of depression or other behavioral conditions and the patient may be offered a behavioral health coach to help manage those conditions. This approach helps promote care for patients that is more holistic and integrated.

Virtually all plans have case managers who inform the patient’s PCP when the individual leaves the hospital and helps with follow-up care, such as managing medications, establishing an emergency plan, finding community support resources, and supporting ongoing care coordination. In addition, some plans have created behavioral health home models and are building upon patient centered medical homes (PCMHs) to improve care coordination. Other plans have embedded behavioral health providers in primary care doctor offices and/or train PCPs to identify behavioral health conditions in their patients.

Notably, current federal and state privacy regulations, which restrict the sharing of information about mental health and substance use diagnoses and treatments, are a significant barrier to better care coordination.

Programs Targeting Opioid Use

Growing concern over opioid overuse and addiction has led to the development of comprehensive services to assist members and their physicians in carefully managing opioid use, preventing overuse, and addressing abuse-related conditions. Approaches include: non-opioid therapies to treat pain; member access to pain experts; medical management techniques,
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such as step therapy, prior authorization, and quantity limits to encourage cautious prescribing; proactive identification of members at high risk of potential overuse or abuse through predictive modeling and claims records; coordination between physicians and pharmacies to reduce the risk of patients obtaining more opioids than providers are aware of including “lock in” programs to limit patients to a single pharmacy and a single prescriber; careful and regular review of patients on opiates for more than a month or two; identification of centers of excellence for treatment; phone and home-based member engagement and support; and access to substance use disorder coaching for members.

To gain a deeper understanding of approaches health plans have in place to engage with consumers, the following case studies include detailed information on health plans’ programs and initiatives around behavioral health care.
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“Health Homes” Integrate Behavioral and Medical Health Services

Integration is an important focus of Anthem – both in terms of the member engagement components as well as with providers. Improved integration of services by providers involves more effective screening by PCPs and referrals to behavioral health care providers. For example, one Anthem model that is currently operating in several sites – with further expansion planned – involves mental health professionals working directly in a PCP practice. These clinicians are readily available to meet with and screen patients on a regular basis, offer brief health coaching, and assist with referrals when needed. Primary care staff are also trained in how to treat behavioral health issues within the primary care setting and how to appropriately refer individuals to a psychiatric professional when a need has been identified.

Implementing Delivery and Payment Models that Enhance Value

Anthem uses HEDIS health plan measures to track and improve quality. In addition, Anthem’s Medicaid business focuses on working with Community Mental Health Centers (CMHCs) and other high-volume mental health and substance use disorder providers to move toward value-driven payment arrangements. Anthem is currently implementing models in several states that look at a range of measures designed to enhance value, including measures to achieve:

- Decrease in mental health and substance use disorder inpatient readmission rates;
- Decrease in emergency room visits;
- Increase in PCP visits;
- 7 day / 30 day follow-up after discharge from hospitalization for treatment of a mental health condition;
- Follow-up care for children prescribed ADHD medication; and
- Adherence to antidepressant medication for adults diagnosed with major depression.

Care Managers Help Members Integrate Into Community and Find Community Support

Anthem’s commercial and government business routinely refers individuals who have received inpatient, intensive outpatient program treatment (IOP), residential treatment, or partial care facility treatment for a substance use disorder to a care manager. These care managers engage members and family members (with the member’s consent) around transitions from one level of care to another. These case managers also reach out to high-risk individuals on a more proactive basis to offer support and connections to community resources. For individuals younger than 17 years, Anthem has a family support component to its case management program.

In Anthem’s commercial and government business, the plan has successfully implemented models that use on-site care managers in high volume hospitals. The care managers meet with members and members’ families to focus on transition and aftercare planning after a psychiatric hospitalization or inpatient treatment for a substance use disorder.
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**Examples of Strategies to Assist Medicaid Members in the Community**

Within Anthem’s Medicaid business, there are multiple strategies for assisting members during their transition to the community, due in part to state variation in Medicaid programs and requirements. Examples include:

- In New York, an Anthem-affiliated plan provides community health workers to support individuals who are homeless upon transition from a hospital. Additionally, these workers often conduct outreach to members at the homeless shelter to ensure the individual is connected with the support he or she needs to prevent readmission and to ensure a successful recovery.

- In Tarrant County, Texas, an Anthem-affiliated plan has partnered with a local non-profit to provide supportive housing for individuals experiencing homelessness. This project has helped individuals remain stable after discharge and prevent repeat hospitalizations.

- Anthem contracts with and employs peer support providers across many states. Peer support assists individuals in their transition to the community by engaging the individual in a proactive manner in managing his or her condition on a day-to-day basis.

**Special Eating Disorders Program Leverages Innovative Collaborations with Providers**

Anthem has developed a comprehensive Eating Disorders (EDO) Program for its commercial population with an integrated team of Anthem Care Management associates who are dedicated to help individuals with such conditions. Anthem Clinical Guidelines for Eating Disorder treatment conform closely to the American Psychiatric Association’s practice guidelines. Anthem has launched several innovative collaborations with providers that include in-home family-based treatment programs and the exchange of quality metrics to provide feedback to providers and monitor program outcomes. As a result of the EDO program, Anthem has seen a reduction in readmission rates as well as a reduction in denials and appeals. Key program elements are also being applied to Anthem’s Medicaid program.
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Beacon Health Options

As a specialty behavioral health organization, improving the system of care for behavioral health is Beacon Health Options’ single, driving force. To that end, Beacon believes in partnership, adherence to the evidence base and system redesign.

Partnering to Provide Access to Behavioral Health Benefits

Beacon works with health plans, employers, and federal, state and local governments to develop behavioral health benefits packages that meet the needs of commercial enrollees and public sector beneficiaries. In that role, Beacon works with its partners to make enrollees aware of Employee Assistance Programs (EAPs) and other behavioral health resources. Members can access information about specific behavioral health conditions through Beacon’s self-help platform. Additionally, Beacon enhances behavioral health education by routinely contributing to member newsletters and other materials distributed by its partners.

As part of Beacon’s efforts to increase awareness and education about behavioral health conditions, it participates in the Association for Behavioral Health and Wellness’ Stamp Out Stigma public awareness campaign. This campaign is designed to reduce the stigma associated with mental illness and substance use disorders in order to promote increased access to behavioral health services and treatment.

Strong Provider Networks and Partnerships

From its inception, Beacon has recognized the importance of building strong provider networks and enhancing relationships within those networks. Beacon promotes excellence through identifying high performing facilities that function above the service standard for its members. Beacon also plays an educational role with its providers by offering continued education and training on issues such as parity, reimbursement, credentialing and best practices.

Finally, in addition to pursuing signature networks and centers of excellence, Beacon continually reviews its networks and looks for new ways to improve access to behavioral health services. For example, currently Beacon is developing a national network of providers who can deliver care via telemedicine, a step that will supplement its existing services and improve access for people living in remote areas or those who are unable to travel to appointments.

An Evidence-Based Company

Beacon builds on its strong provider relationships by ensuring that its providers, as well as the company, adhere to evidence-base care. At the most fundamental level, that means assessing medical necessity criteria for behavioral health based on clinical practice guidelines from at least 20 national organizations, including the American Psychiatric Association, the American Psychological Association, and the National Institutes of Health. For substance use disorders, Beacon uses the American Society of Addiction Medicine’s (ASAM) criteria.
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In addition to clinical criteria regarding medical necessity, Beacon also refers to treatment technology and procedural criteria. Beacon’s clinical experts review the available literature to support when and how a technology or procedure should be used. These criteria are developed internally and cross-referenced against national sources such as the MCG guidelines and a multitude of national organizations. With respect to member information, one of Beacon’s goals is to provide members with the same high quality, evidence-based, treatment information as is currently made available to providers, and to explore new avenues for member communications, including social network platforms.

**Going Forward: Redesign of Delivery System Based on the Evidence – Opioid Addiction, Health Care Integration, and Value-based Payments**

In addition to running the day-to-day operations of a specialty behavioral health management company, Beacon is focusing on three specific areas: opioid addiction, health care integration and payment reform.

Regarding the treatment of opioid addiction, Beacon supports a model of care targeted to treat chronic conditions with community-based care coordination. In working with their health plan partners, Beacon helps ensure that plan members and providers have access to evidence-based resources to prevent opioid overuse. Their strategies include ensuring that appropriate providers deliver the services to patients; establishing a thoughtful prescribing process and initiatives to prevent overuse; and offering case and care management that are an important part of addiction treatment.

Further, Beacon has launched several pilot programs around opioid addiction. One focuses on reducing early discharges from residential treatment facilities for substance use. Another addresses opioid withdrawal management with same-day transfer of members to medication-assisted treatment (MAT) programs. To determine the best way to reimburse for addiction treatment, Beacon has partnered with both leading academic medical experts and providers to develop a pilot with alternative bundled payments.

Health care integration is another multi-year initiative focused on promoting evidence-base care and improving access to services. In support of the AIMS Center’s collaborative care model as the best-in-class approach to integration, Beacon is enhancing its existing integration efforts to ensure that its internal operations, provider partnerships, clinical protocols and product development align with the collaborative care model.

At the root of these initiatives are payment reform efforts, specifically reimbursing for the value of care provided (as measured through outcomes). For example, in 2016, Beacon co-launched a new integrated care coordination model for adults with bipolar affective disorder and/or psychotic disorders that emphasizes medical, behavioral and social support. Using a monthly case rate, participating providers that meet certain quality outcome metrics are eligible to share in any resultant savings related to total medical expenditure.
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Blue Shield of California

Proactive Identification of Members Tailored to How Care is Accessed

Over the past several years, Blue Shield of California has increased efforts to proactively identify and engage with their members around behavioral health care. Working with Magellan Health Services, a behavioral health specialty organization, Blue Shield of California works to identify behavioral health needs based on how members may be accessing care. For example, Blue Shield of California identifies members who have been hospitalized in the past year and proactively reaches out to provide them relevant information and support for mental health services.

When a member is hospitalized in an acute care psychiatric facility, the member is automatically referred to case management. The plan also reviews pharmacy claims information for certain medications and identifies whether those medications have been filled in order to follow up with providers or members when there are issues. Additionally, during the process of concurrent review, if the plan determines that a member would benefit from case management services, the member is referred accordingly at that time.

Identifying Opportunities to Enhance Collaboration Among Providers

One of the biggest barriers to coordination of medical and behavioral care is communication between providers. Behavioral health professionals traditionally are not accustomed to communicating with other health professionals because of the privacy and security restrictions to sharing sensitive health information. Blue Shield of California believes that an important first step is to get providers acquainted with one another and to develop collaborative relationships. In addition to the benefits of electronic medical records to allow quick and accurate communication between providers, Blue Shield of California is undertaking efforts to improve that collaboration by convening monthly meetings between behavioral health staff from both Magellan and Blue Shield of California to review complex cases and collaborate on patient care. Case managers are also contacting PCPs and behavioral health professionals to offer assistance and to promote integration and collaboration. Additionally, Blue Shield of California has a pilot project underway to increase the communication and collaboration between behavioral health and medical providers within their accountable care organization (ACO) models.

Paying Close Attention to Network Accessibility

Blue Shield of California regularly solicits information from their network providers through surveys in an effort to make sure that their network of behavioral health providers is sufficient to meet the needs of their members. In addition to reviewing the survey information submitted by providers, the plan looks beyond the raw numbers and gathers information on whether a provider is accepting new patients and whether patients can make appointments in a timely manner. This enables the plan to validate the data and identify issues with network access. Additionally, if members report difficulty accessing services or obtaining timely appointments, case managers will call providers on their behalf to find an available provider who can see the patient.
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**Going Forward**

Blue Shield of California believes that the delivery model of the future will be characterized by collaboration among a range of behavioral health providers co-located and working with primary care and other medical providers. Individuals with the right expertise can effectively assess patients and refer them as appropriate. This model will be more responsive to member needs and more efficient for the provider team. Blue Shield of California’s approach to behavioral health care will continue to evolve with these goals in mind.
Patient Centered Medical Home As Gateway to Behavioral Health Care

CareFirst identifies members with behavioral health care needs through the plan’s PCMH program. Because 85 percent of CareFirst’s physicians are affiliated with its PCMH program, this is the principal way members with behavioral health needs are identified in a practice setting. In addition, CareFirst's PCMH program has 300 clinical care coordinators and 70 case managers.

When a PCMH physician identifies a member who may benefit from behavioral health care services, he or she refers the member to a behavioral health coordinator who develops and works with the member as part a customized care plan. The behavioral health care coordinators are typically psychiatric social workers and function in the same manner as care coordinators do for medical care.

Another important referral source into the program is inpatient behavioral health. In inpatient settings, CareFirst views every member admitted to a behavioral health hospital unit or a clinic as a candidate for a personalized behavioral health care plan. CareFirst has nurses on-site at many inpatient facilities in its program to promote access and coordination. A behavioral health coordinator is assigned to work with each of these members to make sure they have the appointments they need, understand their medications and treatments, and to overcome any anxiety they may have with receiving care.

Lastly, in addition to using the PCMHs and inpatient admissions process, CareFirst analyzes its claims data to identify members with certain conditions for targeted outreach. This avenue is important in light of the overlap between members with medical conditions and those that could benefit from behavioral health planning.

"My Care Link Up" Connects Members and Providers

CareFirst is continually evaluating members’ access to mental health and substance abuse providers. The national shortage of behavioral health providers, particularly providers who treat children, has resulted in CareFirst working on an ongoing basis to recruit more child psychiatrists and psychologists. A major barrier to patient access to behavioral health services has been out-of-network clinicians. An estimated 50 percent of psychiatrists choose not to contract with health plans or participate in health plan networks. Because of this, CareFirst has developed "My Care Link Up," a service which enables members to contact CareFirst staff for help finding appointments with behavioral health care providers.

Data on Quality and Access Collected Regularly

In addition to collecting data on traditional measures of quality, such as medication management and follow-up appointments, CareFirst also receives feedback from behavioral health physicians, primary care providers, members receiving behavioral health services, and members with behavioral health care plans. This feedback helps inform CareFirst on clinicians’ experiences with integration of medical and behavioral health services as well as members’ experiences with timely appointments and satisfaction measures.
**Going Forward**

CareFirst recognizes the importance of community support and will continue to work with its members to help them transition back into their community. At the end of a care plan, CareFirst’s goal is for members to become more independent; thus a crucial part of the care coordinator’s role is to link members to community support. However, CareFirst also recognizes that with chronic conditions, relapses occur. The plan’s treatment of relapses is the same as how it addresses multiple hospitalizations for a patient with heart failure. As with other chronic conditions, treatment of behavioral health conditions is an ongoing process which is why CareFirst will continue to emphasize education, outreach, quality and coordination.
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**Education & Outreach a Top Priority**

Education begins the moment an individual receives a behavioral health care diagnosis. Cigna sends members informational materials and references relative to their diagnosis and links them to the services and programs that are available to them. Cigna also has several “awareness series” on certain conditions, such as autism, eating disorders, substance use disorders, and mental illness in adolescents. These monthly seminars are open to individuals and their families and bring in national experts to provide information on these topics.

As Cigna recruits new providers into its network, the plan provides them with information on how the providers can successfully partner to promote access to quality behavioral health care. Cigna is also active with numerous professional societies, such as the American Psychiatric Association, presenting at their national meetings and contributing articles for their newsletters and journals on issues specific to coverage of behavioral health care.

**Condition-Specific Personal “Coaches”**

Cigna uses several different predictive models to identify individuals with a behavioral health condition before the condition becomes more serious. For example, by looking at medical and pharmacy claims, Cigna can identify members who may be at risk for more serious symptoms or future behavioral health inpatient stays. By first assessing pharmacy data for members filling prescriptions for antidepressants, Cigna can identify members at risk for depression. With respect to attention deficit disorder (ADD), once Cigna receives a claim for ADD on a child, the plan reaches out to the parents to provide information on what to look for in their other children, given the increased likelihood that additional children in the family will show symptoms of ADD.

Once members have been identified through these predictive models, they are referred to care managers, or “coaches.” Patients and coaches establish a relationship that spans the duration of the patient’s care, helping them access services and promote coordination of their care with their medical providers. Cigna’s “end-to-end” coaching approach allows case managers to build strong relationships with their patients and helps ensure consistency of care, enabling the care managers to work with patients regardless of what level of care they are in so patients have consistent care management experiences.

**Connecting Patients to Community Support**

To help integrate members back into the community, Cigna identifies support services that members may need and works with the family to connect them with the resources they may need to care for the individual returning home. If a patient is in the hospital, a major focus of Cigna’s care management team during the inpatient stay is looking at what services the patient may need once they return home. For those with significant psychosocial issues, Cigna has a community support program focused on addressing their members’ non-medical issues, such as identifying food banks and helping them find transportation to their appointments. Cigna care managers assess physiological needs for both chronic behavioral and medical conditions.
Patient Identification Integral to Opioid Addiction Prevention and Pain Management Efforts

Cigna’s pharmacy team reviews prescription patterns to identify potential opioid overuse. If found, Cigna works with the prescriber to encourage a referral to a behavioral health intervention and treatment program. Cigna uses predictive models and claims records to help identify members who could benefit from the plan’s substance abuse case management program. Cigna then works with those members who enter a detoxification program to keep them engaged in their care. Cigna puts significant effort into identifying members with a substance use disorder and engaging them in ongoing, appropriate care. Cigna’s program also involves the use of substance use disorder “coaches” or care managers to serve as a resource for patients and involve patients in their care on an ongoing basis.

Going Forward

Promoting coordination between a patient’s medical and behavioral health care will continue to be a priority for Cigna going forward. One challenge to seamless integration and coordination are regulations designed to protect the privacy of individuals with substance use conditions but in doing so silo communication between providers. Cigna has found that in some instances a medical case manager may be unable to access the behavioral health record of a patient who have may an extensive substance use history and, as a result, is not aware of those issues or the need to coordinate and communicate with the patient’s behavioral health provider.
Co-Location of Behavioral Health and Medical Staff Promotes Coordination

In addition to having a dedicated behavioral health case management staff that accepts referrals from medical case managers and vice versa, HCSC uses the same clinical information platform for its behavioral health and medical providers to promote secure exchange of information and coordination of care. In some instances, the plan has enhanced this common platform by co-locating the behavioral health and medical staff so that they are physically in close proximity to each other to further promote care coordination. With respect to its Medicare and Medicaid plans, HCSC builds coordination of care services into the foundation of its plans by utilizing providers who are dually functional. This is especially important for Medicare and Medicaid populations, where there is typically a high co-morbidity between behavioral and medical health issues.

Functioning Like a Virtual Health Information Exchange to Improve Quality

To improve the quality of behavioral health care treatment, HCSC assesses a range of quality measures, including readmission rates, length-of-stay, prescription profiles, and medication adherence. The plan takes a close look at how individual patients are being managed and treated by both facilities and providers. For example, with respect to readmission rates, HCSC pays particular attention to high volume readmitted patients and collaborates with the facilities and providers to provide information for targeted outreach to improve care. In many cases, the plan is functioning as a virtual health information exchange, with case managers available to be on-site in certain markets in order to share information and collaborate on quality improvement.

Collaborative Program Addresses Opioid Addiction Prevention and Treatment

HCSC relies on a collaborative approach across all its health plan products that includes staff from pharmacy, behavioral health, medical, case management, and special investigations to prevent opioid overuse, identify potential abuse, and promote appropriate treatment. As part of the Controlled Substances Integration (CSI) program, members that might benefit from further evaluation are presented to a multi-disciplinary Action Committee. This program’s action committee reviews cases and recommends individual interventions. For example, the committee might refer a member to behavioral health, have peer-to-peer conversations with the clinician involved, refer the member to case management, or if fraud is suspected, refer the case for further investigation.

Whenever a potential problem is identified for a specific member, the committee considers the next option for intervention, which often includes case management. The case management team reaches out to the member to offer assistance from the behavioral health team. The case management team provides education on addiction and helps coordinate access to in-network care. The plan can also have a peer-to-peer conversation with the prescriber who may be unaware of the problem. When appropriate, there is also the option of a “lock-in” to one provider to help establish care.
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HCSC tracks the success of its approach by looking at outcomes such as reductions in controlled substances utilization, and reductions in ER visits/hospital admissions. Identifying specific outcomes continues to be a work in progress as some quality of life changes are not easily measured.

HCSC has found this integrative process to be a positive approach in addressing the spectrum of managing pain.

**Going Forward**

Looking ahead, HCSC is in the process of pilot testing multiple mobile applications designed to identify behavioral health conditions early. Designed to work with smart phones and other mobile devices, these applications attempt to create an early warning system for conditions or declines in conditions in order to trigger behavioral health intervention and treatment. For example, one mobile app platform performs analytics to provide alerts when someone is not sleeping and may have a mood disorder. In addition to sleeping patterns, the application tracks voice and social media patterns. It also may help look for not so obvious evidence that someone has a substance use issue as well.
Consumer Outreach Begins with Community Campaign to Reduce Stigma

The stigma against mental illnesses can keep people from seeking treatment or accessing their benefits. To remove this barrier, HealthPartners piloted an anti-stigma campaign at Regions Hospital, its flagship hospital, four years ago. HealthPartners and Regions Hospital then expanded that effort to include a partnership with Twin Cities Public Television and the Minnesota chapter of the National Alliance on Mental Illness (NAMI). With the help of a local advertising agency, the partnership developed an anti-stigma campaign called Make It OK. The campaign includes the makeitok.org interactive website, four documentaries that feature people living with mental illness, and a speakers bureau for community groups looking for speakers on behavioral health issues.

Building on these efforts to reduce stigma, HealthPartners has disease management programs that help members understand how to access the behavioral health benefits and programs available to them, including medication adherence programs.

Predictive Algorithm Prevents Behavioral Health Crises

To identify individuals who are highly likely to be hospitalized with a mental health crisis within the next six months, HealthPartners developed a patented predictive algorithm that uses claims data. By identifying these individuals early, dedicated behavioral health staff can proactively reach out to those members. With the patient’s permission, care coordination staff help members understand their benefits, find providers, and access care before their condition worsens. This outreach is especially important for members who have never used behavioral health care before since they may not be aware of their benefits or how to access them. Members can call a dedicated phone number for assistance with behavioral health care services and they can also get a “warm transfer” from member services.

Measuring and Ensuring Access to Care

HealthPartners conducts an annual satisfaction survey of their members to measure their access to behavioral health care clinicians. The survey asks members to report on their satisfaction with being able to schedule both initial and ongoing appointments with psychologists and psychiatrists. In addition, HealthPartners pre-purchases a limited number of appointment slots with psychiatrists and makes them available to members who need timely access. Because there can be a lot of “no shows” for psychiatry appointments (up to 30-40 percent) and late cancellations, HealthPartners’ behavioral health navigators are able to search for appointments on a targeted basis to help members get appointments. This also benefits the behavioral health practices by keeping them at full or near full capacity.
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**Online Cognitive Behavior Therapy and Emotional Resilience Coaching**

HealthPartners has two initiatives that provide evidence-based, cost effective interventions that offer an alternative or supplement to psychotherapy or medication. These services meet members where they are and can be accessed anywhere and anytime on a tablet, laptop, or personal computer.

The first is emotional resilience group coaching, which HealthPartners began offering in 2013, to 2,200 of its employees. The group coaching was supplemented with online virtual coaching on topics such as positive thinking, stress management, and healthy sleep. HealthPartners researchers reported in the American College of Sports Medicine’s Health & Fitness Journal that, among a group of employees who participated in three one-hour emotional resilience sessions, well being persisted at least one year later. Results were measured by looking at lifestyle, diet and exercise, quality of life measures, and missed work. HealthPartners is in the process of offering this cognitive behavioral approach, which involves teaching skills and replacing negative habits, to other employer groups.

HealthPartners built on this success by offering Beating the Blues® online behavior therapy for its members and employees. Beating the Blues® is listed on the National Institutes of Health Substance Abuse and Mental Health Services Administration’s (SAMHSA) national registry of evidence-based programs and practices (NREPP), and consists of eight half-hour sessions of cognitive behavioral therapy. The online therapy program can either be self-guided or offered as an adjunct to treatment through a recommendation from primary care, behavioral health or specialty care. Peer reviewed research indicates that Beating the Blues® improves conditions such as depression, anxiety and stress, making it especially relevant for a variety of patients including those that are coping with a co-existing medical condition such as those vulnerable to post-partum depression, chronic pain or those engaged in cardiac rehabilitation. HealthPartners’ behavioral health providers are using the online program as part of both individual and group psychotherapy and specialty providers are beginning to offer it as well.

There are currently over 1,800 members and employees using Beating the Blues® cognitive behavior therapy. Early results suggest that completing even six sessions of the program lead to a statistically significant decrease in symptoms. After sufficient implementation time, HealthPartners intends to look at a variety of data elements to develop a more thorough assessment around areas of improvement.
Greater Awareness of Co-Morbidities Promotes Early Access to Services

Individuals with successfully treated medical conditions and untreated behavioral health conditions often incur health care costs that are double (or more) those costs compared to when the behavioral health condition is successfully treated. Encouraging “positive use” of behavioral health services, while initially increasing episodic health care costs, ultimately lowers the overall cost of care for these members over the long-term.

Highmark’s medical health coaches routinely screen the members they work with for behavioral health symptoms and, if indicated, ask the members if they would like to talk with a behavioral health coach. If behavioral health symptoms are present, members are assessed based on their level of risk for a behavioral health condition. For example, members identified as high-risk for depression will be connected with a personal health coach to help them access the right providers and services. Members identified as low-risk will receive materials and resources on their condition with information on who to call and how to access services if their condition worsens.

Care Management Addresses Clinical and Psychosocial Needs

When a member is admitted to an inpatient substance use treatment or psychiatric facility, a care manager immediately begins a dialogue with staff at the facility to develop a discharge plan that will transition the member to an appropriate level of care or facilitate the member’s integration back into the community when appropriate. The behavioral health coach contacts the member and/or family immediately upon discharge to assess the member’s ongoing needs and facilitate arrangements for post-acute care, including identifying concerns that might present the member with barriers to receiving appropriate treatment, such as financial strains, transportation, and access to other community resources. The behavioral health coach then serves as the member’s ongoing single point of contact for additional issues the member may have. In addition, the behavioral health coach may serve as a liaison between the member and his/her provider should questions arise related to benefits or out-of-pocket costs.

Residential Treatment Centers – Opportunities and Challenges

Beginning in January 2016, Highmark will include a residential treatment benefit across its commercial product lines. If a member meets the medical necessity criteria for residential treatment, it will be covered. There are several challenges with residential treatment centers (RTCs), one of which is that RTCs and their scope of services are very loosely defined and may include group homes, halfway houses, and other such places where the treatment being provided is not supported by strong medical evidence. They also can be of disparate quality, with few clear metrics to support more in-depth quality analyses. Lastly, RTCs are often inaccessible, in isolated places far from where the member’s family is located, making it unrealistic for families to be involved in the member’s treatment. Because of the nature of RTCs, it presents challenges during treatment for continuity and care coordination, and additional challenges for the member when integrating back into their “real world” environment and trying to practice the skills they learned during treatment.
Behavioral Health Case Management Key to Helping Members with Opioid Addiction

Behavioral health case management is provided by individuals on Highmark’s team with substance use treatment expertise and is available to all commercial and Medicare Advantage members. Highmark’s subsidiary, Gateway Health Plan, provides medical and behavioral health coverage for Medicaid beneficiaries. Members are identified for case management through a variety of systems as well as referrals, including referrals from medical health coaches, physicians, family members, and occasionally employer group clients. Benefits offered include coverage for Suboxone and other medication assisted treatment (MAT), such as Methadone, but specific treatment programs are left to the discretion of Highmark’s network providers.

Highmark has developed many close working relationships with senior executives at their large employer clients who look to the plan’s behavioral health team for a “personal touch” when dealing with opiate addicted employees. The relationships Highmark has built with its employer groups and the support it has provided to them in the area of behavioral health has resulted in fostering significant credibility of Highmark’s behavioral health team and its capability to help members through many difficult situations.

To help address potential opiate addiction and overuse, Highmark is currently piloting a pharmacy “lock-in” program where members who have been identified by the plan as “doctor and pharmacy shopping” to fill multiple prescriptions for opiates, are informed that they will be permitted to use their pharmacy benefit to fill prescriptions at only one designated pharmacy. Highmark’s behavioral health team contacts these individuals and encourages them to engage in their case management program and substance use treatment.

Going Forward

Highmark’s commercial health plans have a telemedicine benefit that includes a telemedicine behavioral health benefit. To date, there are a limited number of providers who have the technology necessary, such as cameras and software, to be enabled as telehealth providers. In addition, regulatory restrictions limit the use of telemedicine in certain circumstances. One goal for the future, particularly as a way to address the national shortage of behavioral health providers, is to promote the use of behavioral health telemedicine by removing the barriers to greater telehealth use.
Ensuring Access to Quality Behavioral Health Care

Integrated IT Platforms Benefit Members with Medical and Behavioral Conditions

Humana has conducted extensive internal research which has given the company an understanding of the behavioral health impact on the progression of disease. This led Humana to integrate its medical and behavioral health information technology (IT) platforms so that the information is available to care managers and providers. This integrated platform enables medical and behavioral care managers to provide integrated management of members with co-occurring medical and behavioral conditions.

Recognizing the value of integrated information, Humana’s website provides members with information on specific topics, such as quality improvement, the impact of behavioral health co-morbidity, ADHD, depression, and diabetes. Members can also access a provider search link to find both medical and behavioral health services in their area.

Proactive Identification Creates Opportunity for Personalized Medicine

Humana pioneered the development of an integrated predictive model for behavioral health and medical conditions. Humana's integrated predictive model enables the plan to identify members with co-morbidities and to predict the progression of disease to help inform appropriate interventions. The model also creates an opportunity to develop personalized medicine by placing members in one of four quadrants, with each quadrant identifying specific needs and resulting in Humana-designed programs around those members’ specific needs. Beginning with the predictive modeling and proactive outreach, Humana’s care managers work with members on their coexisting medical and behavioral health issues to support behavior change to improve outcomes, facilitate family support, care coordination, and connections to community resources, and to provide members with a full picture of their health.

Developing a New Paradigm for Team-Oriented Care

Traditionally there have been logistical barriers to coordination of an individual's medical and behavioral health care based on how medicine has typically been practiced. For example, behavioral health practitioners have historically tended to practice independently and may not be accustomed to working as part of a team. Believing strongly that separation is not an option and integration will become the norm, Humana is working to develop a new paradigm for team-oriented care to ensure appropriate coordination across the continuum of care. One of the ways Humana is promoting this paradigm is by holding integrated clinical rounds where care teams present cases and promote dialogue across medical and behavioral health care providers. Humana is also developing communications for primary care physicians, offering continuing medical education for better understanding behavioral health care delivery and integrating it into primary care practice. Humana is working with primary care groups through behavioral health care management and through physically embedding behavioral health practitioners into primary care practices. Humana offers a variety of approaches along a continuum of integrated services – which approach is used depends on the specific needs of the primary care group.
Ensuring Access to Quality Behavioral Health Care

One area where integration has already shown positive results is in the area of substance use. A study released in 2015 showed that Humana’s integration of a substance use treatment program into population-based behavioral care resulted in more members receiving needed treatment, fewer emergency room visits and inpatient hospitalizations, and lower health care costs.

**Going Forward**

Building on the success of integrating the medical and behavioral IT platforms, Humana is in the process of unifying the criteria used by medical and behavioral to enable the same integrated view to their members. In addition, Humana is devoting significant effort to determining the best ways to promote the quality of mental health and substance use care. Humana has created a quality forum within the office of chief medical officer. This group is reviewing enterprise quality metrics. The next step is to develop a consolidated set of behavioral health quality metrics and standardize those metrics across Humana plans so they can be used regardless of medical condition.
Identification and Outreach Targets Key Populations

Kaiser Permanente pays close attention to populations where behavioral health conditions tend to be more prevalent, such as individuals with chronic conditions, adolescents, and pregnant women. For these populations, Kaiser Permanente clinicians screen for depression and alcohol misuse during regular visits and, based on the results, members receive information tailored to them. The screening tools are validated tools that are built into clinicians’ total assessment of a patient, and Kaiser Permanente conducts extensive staff training on how to administer, score and interpret the screening tools. As an example, if a member is identified as having moderate depression, the member receives information on brief counseling, health education classes, peer support and employee assistance programs. Kaiser Permanente also puts resources on its member-facing website that enables members to do their own assessment for depression and substance use and encourages shared decision making.

Evidence-Based Clinical Criteria Accessible at Point-of-Care

The approach to developing clinical criteria and guidelines is based on evidence for medical as well as behavioral conditions. For high priority conditions, Kaiser Permanente either develops full clinical practice guidelines or endorses guidelines developed by other sources, but both must meet robust, evidence-based clinical criteria and include both medication and non-medication options. Kaiser Permanente also uses other clinical tools that are grounded in evidence but are not necessarily full practice guidelines. These are often built into their electronic health record (EHR) system to inform decision-making at the point-of-care. Clinicians can use these decision-support tools as a reference. One challenge is that there are still areas where robust evidence does not exist on the effectiveness of certain treatment options. More research is needed in those areas. In the area of suicide prevention, Kaiser Permanente is evaluating the research from other systems, such as the Department of Veterans Affairs, Department of Defense, and the Henry Ford Health System, to identify best practices in identification, safety planning and psychotherapy to prevent suicide.

Breaking Down Barriers to Promote Greater Coordination

Kaiser Permanente uses a suite of primary care based strategies as one approach to promoting coordination and integration. By using nurse case managers and integrating clinicians such as psychotherapists as part of the primary care team, Kaiser Permanente is able provide early access to behavioral health services for individuals at the primary care entry point before conditions progress to become more severe. These integrated clinicians strive to address the issue in the primary care setting but also play the role of care coordinator when members transition in between care venues. Kaiser Permanente works system-wide to break down the barriers to sharing information and removing firewalls in its EHR to allow information to flow more freely between medical and behavioral health clinicians, such as working to make medications prescribed by psychiatrists more visible to medical providers treating the same patient. One challenge has been federal regulations restricting the sharing of information related to substance use, 42 CFR Part 2, which hinders coordination between substance use and medical clinicians treating the same patient.
Ensuring Access to Quality Behavioral Health Care

**Finding the Right Balance Between Managing Pain and Avoiding Addiction**

Kaiser Permanente takes a two-pronged approach to preventing opioid overuse by focusing on patients who have been prescribed pain medication as well as the prescribing providers. The plan’s chronic pain management program relies on pharmacy claims analyses to identify patients who have been prescribed pain medication and target those individuals who may be misusing these medications. Pharmacist review of refill requests provides an additional opportunity to prevent misuse and minimize the risk of addiction. Kaiser Permanente also emphasizes primary care education as this is where pain medication prescriptions start.

**Going Forward**

The economic and social needs of some behavioral health patients adversely impact their ability to recover from their conditions, and addressing these needs is a continuing challenge. Kaiser Permanente provides support for members throughout the episode of care and offer services matched to the needs of members at any given time, including, where appropriate, using peer support specialists, linking members with community resources and supports, and facilitating self-managed care. In alignment with its philosophy of total health – integration, prevention, and empowerment – Kaiser Permanente aims to define the vision of 21st century mental health care with a high-quality community of providers, emerging technologies that make it easy and convenient for members to connect, and evidence-based care with outcomes measured so we know it is working, and that members are being helped.
Proactive Outreach Before Conditions Become More Serious

WellCare analyzes claims data to identify members with a behavioral health condition before it becomes more serious. By examining a year of claims data, WellCare categorizes its members based on their levels of risk. WellCare’s clinicians then conduct brief screenings on depressive symptoms, anxiety symptoms, and general health. If the screening results indicate the presence of or risk for a behavioral health condition, the member is referred to the appropriate type of care.

In addition to analyzing claims data, WellCare conducts HRAs that assess a member’s risk for both medical and behavioral conditions. Based on the results, a case manager may follow-up with the member to refer him or her to a behavioral health clinician and initiate appropriate care. If the symptoms are moderate or the individual prefers a “self-help” approach, WellCare offers online programs and tools that can help members with issues like negative thinking and managing stress to potentially avoid symptom escalation and more intensive treatment.

Ongoing Assessment of Provider Accessibility

WellCare goes above and beyond the state, federal and private accreditation standards for network adequacy. In addition to maintaining the required number of providers in the network, WellCare recognizes that providers are not always actively taking new patients. In those instances, WellCare conducts additional provider recruiting. WellCare also uses telephonic surveys to determine providers’ next available appointments and monitors accessibility through patient feedback on their experiences with getting appointments.

Behavioral Health Home Model of Care

Coordination between a patient’s medical and behavioral health care is an important priority. In some geographic areas, WellCare conducts a quarterly audit of behavioral health providers to assess whether there has been communication with PCPs. Increasingly, WellCare is moving into a behavioral health home model of care, where communication and integration are core components that are monitored on a monthly basis. Under this behavioral health home model of care, quarterly audits will be replaced with care coordination payments.

Going Forward

The shortage of behavioral health providers, particularly psychiatrists, is a national problem. WellCare is continually assessing the adequacy of its network and has augmented face-to-face treatment with telemedicine where possible, however more needs to be done at the national level to address the provider shortage.
Conclusion

Health plans are successfully collaborating with providers and consumers to help facilitate access to coordinated, affordable, evidence-based behavioral health services. Ongoing challenges, which may benefit from policymaker attention and potential policy solutions include:

- Implementing new workforce programs to address widespread shortages of behavioral clinicians, such as psychiatrists and psychologists who specialize in caring for children and teens;
- Addressing barriers to more widespread use of telemedicine which can augment provider capacity and improve consumer convenience; and
- Allowing for substance use diagnosis and treatment information to be securely shared among providers to support care coordination and quality.

Health plans recognize the importance of behavioral health care. In addition to meeting parity requirements, plans are proactively engaging with consumers who need behavioral health care, coordinating their care across the continuum, and working with them to find community-based support services they may need.

Related Topic

Partnering to Provide Mental Health and Substance Abuse

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2 Anthem and its affiliate companies serve nearly 71 million people, with more than 38 million enrolled in its family of health plans. Anthem offers health insurance products and services to multi-state and local employer groups, individuals, Medicare and Medicaid beneficiaries, and federal employees. (http://www.antheminc.com/AboutAnthemInc/index.htm)
3 Beacon Health Options is a behavioral health management company that serves more than 48 million people across all 50 states and the United Kingdom. Beacon Health Options provides behavioral health services for regional and specialty health plans, employers and labor organizations, and federal, state and local governments. (https://www.beaconhealthoptions.com/who-we-are/)
4 Blue Shield of California and its affiliates provide health, dental, vision, Medicaid and Medicare health care service plans in California, serving approximately 4 million members. (https://www.blueshieldca.com/basca/about-blue-shield/corporate/fast-facts.sp) Blue Shield of California’s behavioral health programs apply across all its lines of business.
5 CareFirst serves 3.4 million commercial members in the Mid-Atlantic region and serves more than 377,000 members in the Federal Employees Health Program. (https://individual.carefirst.com/individuals-families/about-us/company-overview.page/) CareFirst’s behavioral health programs apply across all its lines of business.
6 Cigna Corporation is a global health service company that offers an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, and supplemental benefits to approximately 15 million members. 82% of Cigna’s commercial medical customers are in employer self-insured funding arrangements. In addition, Cigna serves 459,000 Medicare Advantage customers, 1.2 million Medicare prescription drug customers, and 59,000 Medicaid customers. (http://www.cigna.com/about-us/investors/quarterly-reports-and-sec-filings/WT.z_nav=aboutus%2Finvestors%3BInvestors%3BInvestorRelations%3BFinancialearnings%3BRelease and http://www.cigna.com/about-us/company-profile/cigna-factsheet/) Cigna’s behavioral health programs apply across all its lines of business.
7 Health Care Service Corporation (HCSC) is the largest customer-owned health insurance company in the United States. HCSC offers a wide variety of health and life insurance products and related services, through its operating divisions and subsidiaries; including Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas The company employs more than 22,000 people and serves more than 15 million members. (http://www.hcsc.com/)
8 HealthPartners is an integrated health care organization providing health care services and health plan financing and administration founded in 1957 as a cooperative. It’s the largest consumer governed nonprofit health care organization in the nation - serving more than 1.5 million medical and dental health plan members nationwide. HealthPartners includes a multi-specialty group practice of more than 1,700 physicians and employs over 22,500 people. (https://www.healthpartners.com/hp/about/)
9 Highmark operates health insurance plans in Pennsylvania, Delaware and West Virginia, serving 5.3 million members through its businesses in health insurance, dental insurance, vision care, and reinsurance. (https://www.highmark.com/hmk2/about/corpprofile/index.shtm) Highmark’s behavioral health programs apply across all its lines of business with the exception of Medicaid, which is managed by a Highmark subsidiary, Gateway Health Plan.
10 Humana serves approximately 10 million members, offering individual and family plans, employer-sponsored plans, and Medicare Advantage plans. (AIS’s Directory of Health Plans 2015 and https://www.humana.com/about/) Humana’s behavioral health programs apply across all its lines of business.
11 Kaiser Permanente currently serves more than 10 million members in eight states and the District of Columbia, offering individual and family plans, employer-sponsored plans, as well as Medicare and Medicaid plans. (http://share.kaiserpermanente.org/about-kaiser-permanente/#sthash.bOKCHwX.dpuf)
12 WellCare Health Plans, Inc. focuses exclusively on providing government-sponsored managed care services, primarily through Medicaid, Medicare Advantage and Medicare Prescription Drug Plans, to families, children, seniors and individuals with complex medical needs. The company served approximately 3.8 million members nationwide as of Sept. 30, 2015. (https://wellcare.com/District-of-Columbia/Corporate/About-Us)