The State of the Mental Health Marketplace

A Report for Employers Seeking to Implement High-Value Mental Health Strategies

catalyst
FOR PAYMENT REFORM

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Thank you to CPR's Contributors whose support helped make this report possible.

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Note: *Contributors did not have direct editorial input into the content presented here within.*

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"Improving access, quality, and integration with medical care are key areas to consider for an improved mental health experience."

INTRODUCTION

Over the past several years, mental health has started to gain the attention it deserves as an essential element of our overall health and productivity. The prevalence of mental health conditions reached an all-time high in 2016, when 44.7 million Americans reported living with a mental illness. This translates to nearly one in five people. As a result, the U.S. spends over $201 billion annually on treatment for mental health conditions, and yet, mental illness still costs the country $193 billion in lost earnings and productivity each year. We are either not spending enough or not deriving value from what we do spend. For all these reasons, employers and other health care purchasers have made mental health a priority.

However, even the most committed purchasers face sizable barriers to delivering high-value mental health care to the members of their populations. Throughout 2017-2018, Catalyst for Payment Reform (CPR) worked with eight purchasers, including AT&T, Equity Healthcare, and Service Employees International Union (SEIU) 775 Benefits Group, to understand the major obstacles and how employers can overcome them. The three priority areas defined by the group include:

- Ensuring sufficient **access** to mental health care
- Measuring and improving **quality of care**
- Pushing for a holistic, **integrated** approach

The final output from this effort is a hands-on toolkit with standard evaluation questions and specifications that purchasers can use to assess health plans, employee assistance programs (EAPs), telehealth providers, digital solutions, and navigation vendors on their ability to address these areas. CPR has piloted this tool with leading companies in today's mental health marketplace.

This corresponding report will provide background on the state of mental health care from the purchaser perspective and dive deeper into the three priority areas, discussing the main findings, gaps, and opportunities for purchasers to push the market in the right direction. The report incorporates CPR's learnings and includes perspectives from purchasers, experts, and innovators working to address this area.

HISTORY OF MENTAL HEALTH CARE IN THE U.S.

The history of how the U.S. has approached mental health care has had a lasting impact. Historically, mental health has been considered a private topic. Individuals with mental illness were institutionalized for treatment and quarantined from society in asylums. With deinstitutionalization in the 1960's and 1970's, many were relieved from the confines of asylums, but found it difficult to find effective treatment in the community.[1] Over the last several decades, our country has worked to advance treatment options and transform our perspective on mental health, but the system remains fragmented and there is a very powerful, lingering stigma associated with these conditions. As research about mental health as a medical condition accumulates, the topic has become a scientific, social, and political priority, transitioning from an isolationist to a recovery approach.[2]

The passage of the Mental Health Parity and Addition Equity Act (MHPAEA) in 2008 was a major step closing the gap between how medical and behavioral health care is covered by insurance across the country. The law requires employers offering behavioral health coverage to provide equal benefits for behavioral health and medical/surgical benefits. Advocates for parity had attempted to implement similar legislation in the late 1990's and early 2000's but faced obstacles.[3] Ensuring compliance with MHPAEA is complex, however, and employers in conjunction with their health plan and consulting brokerage partners have made a good faith effort to close the gap that existed prior to MHPAEA.

A FOCUS ON MORE COMMON MENTAL HEALTH ISSUES

Americans face a broad spectrum of behavioral health challenges today, including the sudden rise in substance use and opioid-related deaths, suicide, and autism. Based on input from health care purchasers in 2016, CPR decided to focus on more common mental health conditions, including depression, anxiety, and stress. These conditions are staggeringly prevalent in the United States. In a given year, 1 in 5 Americans experience symptoms of these mental health conditions and almost half of us will over the course of our lifetimes. They impact direct medical costs, particularly for those who have both a chronic condition and a behavioral health condition, who can cost up to 3 times more to treat than someone without the comorbidity. Stress in the workplace is also a costly proposition. Based on findings from Mental Health America, 63 percent of employees reported that workplace stress had significant impact on their mental and behavioral health. Employees experiencing stress in the workplace are much more likely be distracted at work, miss days, or quit their jobs.

> "People are people. People are complicated. A scenario where someone has a little bit of stress, but nothing else going on, is rare in the real world. In fact, **over 85% of our user base indicate they want help with multiple focus areas."**
>
> **Abigail Hirsh, PhD, Chief Clinical Officer, myStrength**

Coinciding with the increasing evidence on mental health's impact, there has been a rise in the number of companies seeking to serve populations suffering from these conditions, including "the worried well,"

[1] https://fas.org/sgp/crs/misc/R40536.pdf
[2] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.26.6.1548
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2950754/

"silent sufferers," or those clinically diagnosed with depression or anxiety. Given the scalability of technology-supported programs, some vendors claim that 100% of an employee population could benefit from some type of intervention. Better understanding segmentation and clinical efficacy will be a priority as mental health becomes part of a larger culture of health and wellbeing and employees' needs change over time.

As we attempt to normalize the presence of these conditions, employers are hoping to increase the percentage of members who seek care and ultimately reverse the cost and productivity trends in the workplace. To do this effectively, some are experimenting with treatment alternatives outside of the traditional therapy model, including virtual therapy or digital solutions. CPR's work to date has focused on identifying opportunities for improvement within traditional network offerings and critically evaluating how these new offerings can play a role moving forward.

ENSURING SUFFICIENT ACCESS TO MENTAL HEALTH CARE

Addressing barriers to accessing care is commonly identified as the highest priority for employers and other health care purchasers. The most observable warning sign of the current system's failure is the fact that 57% of those in need go untreated today. There are multiple issues contributing to this, including stigma preventing employees from seeking care in the first place and the shortage of available providers when they do decide to pursue treatment. Below we outline these gaps, where the market stands in addressing them, and what actions employers should take to move the needle.

BARRIERS AND EMPLOYER PAIN POINTS

> "Of the 20% of Americans who suffer from clinical depression, **the majority don't know that they have the condition.** Or if they do know, they don't seek treatment for a variety of reasons."
>
> **Tomer Ben-Kiki, CEO, Happify**

Stigma: Given how society has historically approached mental health disorders, it is no wonder that stigma and shame underlie attitudes toward treatment. According to the National Alliance on Mental Health (NAMH), 80 percent of workers with a mental health condition attribute their nontreatment to shame and stigma. Relatedly, the average person waits 8 to 10 years after the onset of initial symptoms before seeking treatment.[4]

Why is the effect of stigma so powerful? Employees may be afraid to admit, even to themselves, that they need support with mental health. Those who do seek treatment may be afraid to leave the office on a regular basis for therapy appointments as their co-workers and employer may notice. Many fear negative repercussions if their employer finds out that they are experiencing a mental health condition. A 2017 survey shows that 31% of employees would be afraid of being labeled as weak, and 22% fear it would impact their promotion opportunities. We won't make progress until we begin to talk about and treat mental illness the way we do other chronic conditions such as diabetes and cardiovascular disease.

[4] http://www.bhsonline.com/blog/ending-mental-health-stigma-in-the-workplace/

Network Adequacy: Employers and other purchasers rely on their behavioral health plan's network of licensed clinical social workers, psychologists, psychiatrists, and others to provide clinical support and therapy for those across the behavioral health spectrum. But limitations of today's networks pose serious threats to their ability to do this well on the employer's behalf. According to Mental Health America, over 4,000 areas in the U.S. qualify as "mental health professional shortage areas." These areas, many of them rural, impact over 110 million Americans.[5] Compounding the problem, many providers have stopped taking insurance, leaving Americans with few affordable options. In fact, only 50% of mental health or substance use specialists are in commercial networks compared with 96% of primary care physicians.[6] This trend can be attributed to low reimbursement rates, high demand from patients willing to pay out of pocket, and the administrative burden and paperwork required of practitioners, many of whom run individual practices.

> "We found that about 70% of the therapists in the greater Bay Area don't accept any health plan or EAP insurance at all. We **need to fix the aspects of the system that are broken on both sides.** It's broken for individuals who are trying to find care and it's broken for providers."
>
> **Sean McBride, Head of Partnerships, Lyra Health**

Speed to Care: A direct corollary to the provider shortage is the inconsistent or excessively long wait times an individual faces to see a mental health provider, particularly specialists. For both psychologists and psychiatrists to meet NCQA standards, routine appointments must be available within 10 business days and urgent appointments within 48 hours.[7] And while many health plans indicate compliance with these timeframes, it is difficult to reconcile these assertions with employers' experiences and research, which shows a three- to six-week wait for a routine appointment. The National Alliance for Healthcare Purchaser Coalitions surveyed health plans on this topic and found "little evidence that standards are monitored or that variances are acted upon."[8] These metrics have huge impacts, as employees are likely either to forego care or see someone out-of-network instead. In 2015, behavioral health care was four to six times more likely to be provided out-of-network than medical or surgical care. Employers are turning to virtual networks to resolve this gap, which CPR examined in its marketplace review.

KEY FINDINGS AND RECOMMENDATIONS

There is no silver bullet to resolving the access challenges that we face, but there are findings and recommendations that employers should consider as they attempt to make headway:

Be proactive in changing the narrative for your employee population. Many employers and companies are experimenting and refining campaigns and messaging aimed at combatting the stigma, framing mental health as a natural extension of health.

Ask how your mental health vendors are identifying and reaching out to members in need. These capabilities are critical to helping members overcome access barriers. In CPR's corresponding toolkit, we incorporated specific questions and expectations for health plans, EAPs, telehealth providers, and others on this capability. Best practices include prompting identification of mental health conditions through regular screening and assessments, claims algorithms that identify those with chronic conditions who are more likely to experience comorbid mental health issues, warm hand-offs, and referrals.

Set a high bar for speed to care. CPR's toolkit pushes employers to send a clear message to all mental health partners that speed to care is a priority. CPR largely aligns its specifications for health plans with NCQA standards, including 10 business days for an in-person routine appointment and 48 hours for an in-

[5] http://www.mentalhealthamerica.net/issues/mental-health-america-access-care-data
[6] Achieving Value in Mental Health Support, powered by eValue8, August 2018, the National Alliance of Healthcare Purchaser Coalitions
[7] http://www.sphanalytics.com/provider-access-to-care-requirements/
[8] Achieving Value in Mental Health Support, powered by eValue8, August 2018, the National Alliance of Healthcare Purchaser Coalitions

person urgent appointment. However, to send a signal about the importance of supporting those members in crisis, CPR set a target of 2 hours for emergent care.

Ask your health plan how reimbursement for mental health compares to medical. The American Psychiatric Association recently published recommendations for improving access to mental health care and increasing the amount that mental health providers are paid is a key focus area.[9] As of 2015, primary care providers were paid over 20% more for an office visit than behavioral health providers.[10] Employers must push health plans to establish higher payment rates to encourage mental health providers to participate in-network and to provide incentive payments to providers who meet quality and speed to care targets.

Understand the role that telehealth can play. Tele-mental health care can address some of the access challenges, but purchasers need to understand which ones. One of the major upsides of virtual therapy is the potential to treat individuals who otherwise would not have received care at all. However, those building a virtual network face the same shortage of high-quality providers as traditional in-person networks. In addition, providers delivering care virtually need additional training and onboarding to use online platforms, a capability that can serve as a barrier. Practitioners also need to be licensed in the state where the patient is receiving care, which limits the scalability of a virtual network. Companies seeking to overcome this are paying to have key providers licensed across multiple states.

> "We have been surprised by how many people indicate they wouldn't have otherwise accessed care if they didn't have a virtual option. Interestingly, **we are seeing a pocket of males acknowledge their inability to speak up.** The virtual platform allows them to feel more comfortable, which is critical."
>
> **Lorence Miller, PhD Psychology, Behavioral Health Operations Manager, Teladoc Health**

One of the underlying assumptions CPR found is that virtual care should be on-demand care and help those with urgent needs. With this in mind, CPR set ambitious speed to care metrics for virtual networks (i.e., 4-hours for a routine appointment), but such metrics do not reflect the current capabilities of virtual networks, many of which don't offer virtual urgent care for behavioral health at all. Instead, members can expect to receive care from a virtual provider within several days. This may still represent a substantial improvement in speed to care, combined with convenience and reduced concern about stigma, making telehealth a much-needed addition or alternative to in-person care.

Watch for vanity metrics on adoption and engagement from digital solutions. The addition of newer, digital offerings, such as resiliency training or computerized cognitive behavioral training (cCBT), brings new ways to measure adoption and engagement. Be on the look-out for inflationary adoption metrics, like tracking users who download a mobile application or create a profile. These types of solutions also face an uphill battle in driving sustained engagement. In some cases, companies expect use to be episodic in nature. In others, employers may be looking for continued use over a longer period of time to achieve a desired clinical outcome. Make sure to determine specific relevant goals for the digital program and track engagement measures that support those goals.

[9] http://workplacementalhealth.org/media/WorkPlaceMentalHealthDevSite/Employer-Resources/CWMH-Recommendations-for-Improving-Access-to-Care.pdf
[10] http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf

Can digital solutions meaningfully solve access challenges?

"Most people in the space think it's a labor problem, that it's a question of hiring enough providers to address the growing need. But there is an opportunity to **arm the existing workforce with better tools and a better environment** and introduce a new level of care that can support a broader spectrum of need using technology."

Karan Singh, Co-Founder and Head of Clinical & Strategy of Ginger.io on how technology can increase scalability and efficiency

"Introducing a digital tool can rapidly shift the trajectory of emerging or current depression. Instead of having an employee hit a bump and slowly drift towards feeling better over the course of 3-6 months, **employees generally feel better within two weeks**. For an employer, this means far less lost productivity in the workforce as well as for employees a digital tool like myStrength offers a quick, simple pathway to help."

Abigail Hirsh, PhD, Chief Clinical Officer of myStrength, on technology as a faster treatment option

"We aim to get the entire population engaged in something that promotes healthy emotional habits - similar to eating your greens. But the solution goes with you to **address needs across the spectrum**. Among Happify users, we find It is actually more clinically effective for those with higher level needs."

Tomer Ben-Kiki, CEO of Happify, on how technology can address needs across the spectrum

MEASURING AND IMPROVING QUALITY OF CARE

Even when an employee does receive treatment, it is challenging to measure and track the quality of the care received. While our health care system has made strides toward measuring the quality of care for conditions like hypertension and diabetes, we are just beginning to define what "good" looks like for treatment of depression and anxiety. CPR looked at the current state of both clinical and non-clinical quality measurement for employers in the mental health arena.

BARRIERS AND EMPLOYER PAIN POINTS

Inconsistent use of screening and clinical quality measures: Mental health conditions can be difficult to diagnose. Studies have shown that primary care providers may miss up to 40% of depression diagnoses, particularly if a patient is younger or demonstrates less severe symptoms.[11] These findings led the U.S. Preventative Services Task Force to recommend that all adults are screened for depression, however, it did not endorse a specific screening tool. The good news is there is no shortage of validated, evidence-based screening tools available (e.g. PHQ, GAD-7, DASS-21). The bad news is that across the marketplace, there is little consensus around which ones should be used.

"One of the biggest gaps in this space is measurement.
Understanding what works, for whom when, and in what timeline, and is that repeatable? We have engineered a focus on measuring outcomes into the system."

Karan Singh, Co-Founder and Head of Clinical & Strategy, Ginger.io

Some health plans require providers to use a specific tool. Others allow choice to ease the burden on providers who may be receiving conflicting direction from payers. Some companies have developed their own internal, validated assessments.

There are similar challenges when examining which endorsed clinical quality measures are being measured and reported to employers. Health plans typically report on the NCQA's HEDIS measures, but most of these focus on more severe behavioral health conditions or needs (e.g., schizophrenia, hospitalization) as opposed to less severe mental health conditions.

For that reason, CPR's workgroup selected a set of measures (see below) to serve as the baseline for mental health clinical quality but found that there is little standard reporting on them from health plans, providers,

[11] https://www.ncbi.nlm.nih.gov/books/NBK36406/

or other vendors. More work needs to be done to advance quality measurement and reporting in mental health. The lack of standardization for screening and measurement makes it difficult for employers to compare the clinical effectiveness of interventions or of providers or to structure meaningful performance-based incentives.

Screening and monitoring provider networks: Challenges with assessing the quality of care extend beyond clinical quality measurement. Many employers in our workgroup shared anecdotes about sub-par employee experiences when seeking mental health care. Professionalism, trust, and safety between a patient and a provider are vital when treating mental health and yet, today, can go unchecked. The shortage of providers available creates a perceived trade-off for payers and employers between access and quality. As a result, employers need to evaluate critically how its health plan, EAP, or telehealth provider screen providers based on quality, audit their performance, and curate the network over time. Some health plans and EAPs admit difficulty in setting specific quality thresholds for provider performance, in large part due to the lack of standardization identified above.

Limited quality transparency for employees choosing a provider: Given the personal nature of therapy, the initial match between a mental health professional and a patient is incredibly important and yet, consumers are currently provided limited information about their provider options. While behavioral health provider directories commonly feature basic provider information, like office hours, gender, or languages spoken, there is limited visibility into actionable quality information for members or guidance on how to select the right type of mental health provider based on needs (e.g., counselor, psychologist, psychiatrist, or other specialist). Certain directories display provider designations, like the Bridges to Excellence Depression Care Recognition, or highlight patient experience measures, but provider-level quality reporting is still inconsistent across the marketplace.

KEY FINDINGS AND RECOMMENDATIONS:

Push for standardization in screening and assessment. CPR encourages employers to push for standardization in assessment and measurement. CPR found that use of the PHQ-9 and GAD-7 are the closest to being industry standards and recommend their use. However, the options available are continually evolving and many partners may have validated other approaches for good reason. Without consensus in the marketplace, CPR encourages employers to start by selecting a partner that ensures internal standardization by its providers (regardless of which tool they require) and who are willing to be held accountable for the outcomes produced as a result.

> "We started off using the PHQ-9, the GAD-7, and a few others. They are very specific to depression and anxiety and they were inconsistent in its ability to track and trend. **The DSM-5 allowed for a broader spectrum of symptomatology to be measured,** including functional assessment. I use it with every patient I see, every time."
>
> **Dr. Chris Dennis**
> **A psychiatrist using Teladoc Health**

Ask your partners to report on the following clinical quality measures (if applicable):

- Depression Remission at Six Months
- Depression Remission at Twelve Months
- Depression Response at Six Months - Progress Towards Remission
- Depression Response at Twelve Months - Progress Towards Remission
- Use of the PHQ-9 Tool for Depression
- Use of the GAD-7 Tool for Anxiety
- Experience of Care and Health Outcomes (ECHO) Survey
- Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence
- Gains in Patient Activation (PAM) Scores at 12 Months
- Excessive Use of Emergency Room Visits
- Inconsistent Use of Antidepressant Medication
- Member satisfaction with provider and with outcome

Prioritize the patient-provider matching process. Lack of insight into wait times, combined with minimal quality information or patient reviews, can make finding the right behavioral health provider incredibly frustrating for members. Employers should push for specific improvements to provider directories to aid with this process, starting with the addition of "length of time to appointment" to the list of search criteria. This gives employees seeking help a realistic timeframe for when they can expect to receive care from a specific provider. Certain companies that CPR reviewed have demonstrated the ability to do this, leading the way for others to follow. It is equally important to demand some provider-specific quality indicators in the provider directory as well. Ask specifically if your health plan displays provider-level quality data or if they have considered integrating with third-parties, like HealthGrades or ZocDoc, who collect patient reviews for behavioral health providers that can inform your members about patient satisfaction. The addition of easy online scheduling is another differentiating factor that substantially improves a patient's ability to access care.

Employers will find that many mental health companies are attempting to reduce the reliance on provider directories altogether and incorporate patient-provider matching capabilities into their services for an employee. This may be the most immediate way to reduce frustration with the process and get members in need to the right provider efficiently. Some companies, like Lyra Health, use a data-driven algorithm to personalize high-quality provider options based on a patient's assessment and offer easy online scheduling to expedite the process. Others offer high-touch concierge support, like Joyable, who will identify appropriate provider options from a member's health plan network and do all initial outreach on their behalf.

> "We make eight phone calls on average to match users with the right provider. If you put yourself in the shoes of someone who needs support, that first call is hard enough to make, the second one is harder, and the chance you get to eight is pretty low.
>
> **James Powell, VP of Business Development, Joyable**

Ask detailed questions about provider network management: Demand transparency into how providers are screened, monitored, or removed from the network. Are there specific quality thresholds a provider must meet? Which quality measures are being used to evaluate performance? Does your vendor partner audit providers on a regular, proactive basis or wait to respond to a member complaint? How many providers did your partner remove from its network last year? Zero may not be the right answer for this metric. CPR found that many health plans, EAPs, or other partners who manage a network investigate or audit providers based on member complaint instead of proactively monitoring on a regular and ongoing basis. CPR recommends that health plans conduct site visits or audits of 25% of providers each year.

> "We've pulled data from dozens of different sources to evaluate and analyze whether a provider is trained in and using evidence-based medicine correctly. Only about 15% of the several hundred providers that apply every month end up meeting our quality standards."
>
> **Sean McBride, Head of Partnerships, Lyra Health**

Set performance guarantees for member satisfaction and outcomes. In reviewing a subset of mental health companies, CPR found that most report generally high member satisfaction results but only a few standardly offer performance guarantees for member satisfaction and outcomes. Employers should pay attention to whether their partners are willing to put some portion of payment at risk based on member satisfaction, utilization, or outcomes. Most express a willingness to do this if there is employer demand.

PUSHING FOR A HOLISTIC, INTEGRATED APROACH

As the behavioral health landscape evolves, employers and other health care purchasers are increasingly focused on integration. There are numerous opportunities that could help ensure a more holistic approach to managing common mental health conditions and reduce friction for their members, including a focus on primary care coordination, data sharing, and delivery reform models, CPR identified several priorities within this category.

BARRIERS AND EMPLOYER PAIN POINTS

To carve in or to carve out behavioral health services: CPR's workgroup revealed different perspectives on the pros and cons of offering behavioral health coverage through their medical carrier (i.e., carving in) or contracting with a separate behavioral health services vendor (i.e., carving out). According to a survey by Willis Towers Watson,[12] 70% of employers opted to carve in behavioral health services in 2017. Potential advantages of this model include enhanced coordination between primary care and behavioral health providers, integrated benefit design and clinical management for MHPAEA compliance purposes, and more robust data sharing capabilities.

Some feel the carved in model lends itself to less siloed care, citing how there can be confusion over who is responsible for paying for an inpatient admission with a behavioral health component when there are two distinct entities managing care. However, other employers felt it was easier to push for innovation, set high bars for performance, and customize behavioral health communications for its members when working with a dedicated behavioral health carrier using a carved out model. Employers may also find differences in their ability to integrate with other program elements meaningfully depending on which route they take. Certain health plans have established relationships with behavioral health partners, EAPs, or telehealth providers, for example.

> "We don't see ourselves as being on an island. We integrate with wellness portals, EAPs, navigators, health systems, disability vendors, and carriers to make Joyable the behavioral health resource. **Certain partners want to offer Joyable anytime there is a new diagnosis, which is often accompanied by a behavioral health need.** This is an obvious integration point to us."
>
> **James Powell, VP of Business Development Joyable**

A firewall between behavioral health and medical data: Employers in CPR's workgroup identified data sharing among behavioral health carriers, medical carriers, and third-party vendors as a challenge. The amount of data mental health partners make available to others in an employer's ecosystem varies (i.e., bi-directional data exchanges between health plans, telehealth providers, digital therapy programs, and EAPs). Many identified Federal and state laws requiring patient consent as a major barrier to the free flow of behavioral health-related data.[13] Currently, only twelve states do not have state-specific regulations requiring specific member consents before sharing behavioral health data with a third party. As a result, CPR found that examples of data integration are largely occurring on a case-by-case basis and at the request of employer-customers. However, it is also worth noting that integrated case management is more regularly offered showing a commitment to integrating clinical management on a patient's behalf, even if patient data can only be shared with consent.

Lack of coordination between primary care and behavioral health care: Studies show that primary care providers deliver the bulk of depression treatment in the United States, prescribing nearly 80% of antidepressants and caring for 60% of the patients who receive treatment and yet there is little standardization in how this care is managed or measured.[14] While CPR found certain health plans encourage or attempt to incentivize screening for depression and anxiety during primary care office visits, it is not a standard requirement. Additionally, health plans are not typically measuring the percentage of primary care providers who are co-located with behavioral health specialists despite evidence that an integrated model can increase access for members.[15]

Delivery models that spur an integrated approach have been slow to take off: Despite projections that the Affordable Care Act would spur an increase in delivery reform models focused on behavioral health integration, including patient-centered medical homes (PCMHs), health homes or accountable care organizations (ACOs),[16] CPR has found these models have yet to integrate behavioral health as a standard approach and vendors shared limited examples of driving the effort for more integration.

[12] https://www.willistowerswatson.com/en-US/press/2017/03/us-employers-act-to-improve-quality-access-behavioral-health-programs
[13] https://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670434/
[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4771375/
[16] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3568195/

KEY FINDINGS AND RECOMMENDATIONS:

Collaborative Care as a vehicle for behavioral health integration. Collaborative care is the most common form of behavioral health integration today. These models are characterized by the use of standard tools (e.g., PHQ-9) for screening and measurement, a shared care plan between behavioral health specialists and primary care, use of evidence-based techniques, medication management, and accountable care.[17] In their recommendations for improving the mental health marketplace, the American Psychiatric Association identifies expansion of Collaborative Care as a major priority and encourages employers to demand visibility into how health plans are training providers on use of relevant payment codes and their utilization.[18] For example, the National Alliance for Health Care Purchaser Coalitions reported that despite the fact that multiple health plans indicate that they do, in fact, reimburse for these codes, there is "little evidence that they are being promoted or used."[19] Be sure also to ask if your health plan is tracking how many primary care practices in its network have behavioral health specialists co-located, the ability to make a warm referral to an off-site integrated preferred partner, or whether they refer to an off-site provider with limited or no integration, to get a sense of whether this is a priority.

Consider how increased data sharing could enhance your strategy. The rise of digital solutions in mental health is leading to new forms of data collection and patient engagement. CPR found that many vendors, including digital therapy programs, EAPs and telehealth providers, are experimenting with health plan data integration, but they do not offer it in a standard fashion or only make it available upon request by the customer. This means that for all parties to overcome many of the technical barriers to data sharing, they will need customers who identify specific use cases as a priority. Examples include vendors using claims data to trigger targeted outreach or the ability to track which members ultimately received care. Certain vendors are already investing in the automated exchange of clinical data with patient consent and considering how to educate members on the tangible benefits for care coordination and management.

> "There's a very interesting discussion occurring now about the emergence of a data layer. The end user may benefit from having a **digital medical record for mental health to move from one provider to another.** Things like preferences for types of intervention or what has worked in the past can help providers hit the ground running when they meet with someone."
>
> **Tomer Ben-Kiki, CEO**
> **Happify**

Request education for the key providers in your network. Even without technical data integration or changes to the underlying payment model, employers can still make headway in bringing more primary care and medical providers into the fold. CPR found that most health plans, EAPs, and virtual solutions are prioritizing ways to educate providers about behavioral health resources, sometimes working directly with a customer's health plan network on how and when to refer patients in need of services. Doing this at scale is not feasible, as these providers can't track which patient has access to which dedicated behavioral health resource across the entire population without further enhancements to medical records. However, employers who have a relationship with a key health system, primary care practice, onsite or near site clinic, or other key provider group will find that this is an effective way to bring behavioral health resources into the physician's office. Several digital therapy companies indicated they are partnering directly with health systems. For example, myStrength is working with providers to make its digital programs available in behavioral health and substance use disorder inpatient settings.

[17] http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf
[18] http://workplacementalhealth.org/media/WorkPlaceMentalHealthDevSite/Employer-Resources/CWMH-Recommendations-for-Improving-Access-to-Care.pdf
[19] Achieving Value in Mental Health Support, powered by eValue8, August 2018, the National Alliance of Healthcare Purchaser Coalitions

How Can Payment & Delivery Reform Improve Mental Health Care?

PATIENT CENTERED MEDICAL HOMES (PCMH): The PCMH is a redesign of primary care delivery emphasizing population health management, multidisciplinary teams, and care management for at-risk patients. These models are applicable for Medicare or commercial patients and there are "health home" equivalents that accept Medicaid patients.

How do they address behavioral health gaps? PCMHs have potential to serve patients with mild or moderate behavioral health needs, but may not have the capacity to address severe conditions. To be accredited by NCQA and receive financial incentives, PCMHs are required to manage behavioral health needs creating a business case for co-location or deeper integration of behavioral health services into primary care practices.

Examples: University of Pittsburgh Medical Center (UPMC)'s Behavioral Health Home Plus Model and Aetna's Integrated Primary care Behavioral Health Program.

ACCOUNTABLE CARE ORGANIZATIONS (ACOs): ACOs are groups of physicians and hospitals that share financial and medical responsibility for providing coordinated care, with financial incentives to provide high-quality care and to limit avoidable, unnecessary spending.

How do they address behavioral health gaps? ACO models responsible for a patient's overall care should be motivated to improve behavioral health care. However, studies show only 14% of ACOs have fully integrated behavioral health and primary care teams and over one-third of the largest commercial ACO contracts do not include behavioral health services in the total cost of care. CPR encourages employers to include "Depression remission at 6 months" as a core quality measure to evaluate ACO performance and send a strong signal about its importance.

Examples: Oregon's Coordinated Care Organizations and Massachusetts Medicaid's MassHealth program

NEXT STEPS AND ADDITIONAL RESOURCES FOR EMPLOYERS

Understanding the findings and recommendations identified in this report is just the first step on an employer's journey toward higher value mental health care. Since beginning its work on mental health care in 2016, CPR has observed a sizable uptick in the number of vendors focused on higher value behavioral health care. If you are an employer or other health care purchaser consider the following:

- **Download CPR's Toolkit for Evaluating High-Value Mental Health Care and field the evaluation questions with your health plan, EAP, telehealth provider, digital solution, or navigation vendor.** The tool includes employer-driven specifications that outline what you should expect for each criterion to gauge whether your needs are being met. This toolkit can be used to evaluate an existing partner or to source a new partner.

- **Interested in seeing the results of CPR's mental health evaluations to date?** CPR is releasing to CPR member organizations only an inventory of Summary Scorecards based on the piloting of our evaluation tool. If you are interested in becoming a CPR member to gain access to these scorecards and future similar evaluations that CPR will field on its members' behalf, email Ryan Olmstead, Director of Member Services, at rolmstead@catalyze.org.

- **Review these valuable additional resources for a full picture of the current state of behavioral health and other specific actions employers can take:**

    - The National Alliance of Healthcare Purchaser Coalitions recently released a report entitled **Achieving Value in Mental Health Support: A Deep Dive Powered by eValue8** and an accompanying **Mental Health Action Brief** that shine a light on the underlying gaps in mental health care and related benefits administration based on the National Alliance's annual eValue8 survey of health plans. There is an action checklist for employers that help directly address many of the recommendations in this report.

    - The American Psychiatric Association and the Center for Workplace Mental Health also recently released **Recommendations for Improving Access to Mental Health and Substance Use Care** with clear guidance for health plans and behavioral health organizations, employers, and employer coalitions.

APPENDIX: MENTAL HEALTH TREATMENT OPTIONS

As mental health garners increased attention and the dialogue shifts toward more proactive wellness and prevention, the number of treatment options is also on the rise.

OPTION	DESCRIPTION	KEY STATS
Traditional talk therapy	Aimed at helping patients identify and change their emotions, thoughts and behavior. This type of treatment occurs with a licensed or trained therapist in individual or group settings. Psychotherapy falls into five broad categories[i]: psychoanalysis and psycho dynamic therapies focusing on problematic behaviors, behavior therapy, cognitive therapy emphasizing thoughts rather than actions, humanistic therapy and integrative or holistic therapy.[20]	42% of Americans have seen a counselor at some point in their lives. 21% of Millennials express interest in counseling compared to 8% of Baby Boomers[21].
Prescription medications	Another common form of mental health treatment. Because it is generally understood that mental illnesses arise from chemical imbalances in the brain, medications can address and reduce these imbalances. They are typically paired with other treatment options. Common medications used include antidepressants, anti-anxiety medication, mood stabilizers, and antipsychotic medications.	Approximately 8 to 10 percent of the population takes an antidepressant, making antidepressants the third most frequently taken medication in the U.S..[22] Prevalence of antidepressant use increases with age, with 19% of those 65 and older taking them.[23]
Computerized Cognitive Behavior Therapy (cCBT)	Alternative option to cognitive behavioral therapy requiring less direct therapist involvement. cCBT can use interactive digital interfaces to help patients with psychotherapy treatment, allowing for expanded access, via geography and time of day. cCBT can be used as a primary treatment intervention or to supplement traditional cognitive behavior therapy.[24]	Shown to be more effective than usual primary care at improving mental health quality of life, mood, and anxiety symptoms.[25] However, cCBT is also associated with high drop-out rates and little evidence exists about patient preferences and acceptability.[26]
Coaching and Virtual Coaching	A form of support to improve individual's present life and work towards goals for the future. In coaching treatments, the individual with a mental condition is active in their own recovery plan and makes decisions about the pathway. The designated coach provides expertise to support and keep the client on track. Coaching has gained traction due to provider shortages.[27]	Though evidence focusing on coaching in mental health is limited to date there is a growing body of evidence showing positive outcomes for coaching as a complementary mental health intervention.[28]
Sleep Interventions	Certain treatment options target sleep, as lack of sleep negatively impacts an individual's psychological state. Individuals with mental health conditions are more likely to have insomnia and other sleep disorders, thus addressing the quality of sleep and amount of time they are sleeping is important. Sleeping problems are most common in individuals with anxiety, depression, bipolar disorder and ADHD.[29]	Chronic sleep problems impact 50 to 80% of adults in a typical psychiatric practice, compared to 10-18% of adults in the general U.S. population.[30] More than 50% of insomnia cases are related to depression, anxiety or psychological stress.[31]
Resilience Training and Mindfulness Based Cognitive Therapy (MBCT)	Training programs that teach strategies to become stronger because of stress, to learn and adjust from events, and to confront additional stress in the future with less impact. There is a growing popularity for these programs especially in industries that trigger daily stress, including the US military.	Systematic reviews demonstrate mindfulness interventions (MBCT) effectively reduce rates of depressive relapses and depressive symptoms.[32] Research also finds the effects of mindfulness-based therapy does not differ from the effectiveness of traditional CBT or behavioral therapies, or pharmacological treatments.[33]

[20] http://www.apa.org/topics/therapy/psychotherapy-approaches.aspx
[21] https://www.barna.com/research/americans-feel-good-counseling/
[22] https://www.scientificamerican.com/article/the-rise-of-all-purpose-antidepressants/
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[27] http://hopeandhealingcenter.org/support/mental-health-coaching/
[28] https://greatergood.berkeley.edu/images/uploads/Keng-Mindfulness_Review_and_Conceptions.pdf
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[33] https://www.sciencedirect.com/science/article/pii/S0272735813000731?via%3Dihub

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