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NETWORK ADEQUACY IN MENTAL HEALTHCARE

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Disclaimer

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Honor Pledge

On my honor as a University of Virginia student, I have neither given nor received unauthorized aid on this assignment.

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LIST OF ACRONYMS

ACA: Affordable Care Act of 2010
BH: Behavioral Health
CAA: Consolidated Appropriations Act of 2021
CDC: Centre for Disease Control and Prevention
CMS: The Centers for Medicare & Medicaid Services
COVID-19: Corona Virus Disease of 2019
CoCM: Collaborative Care Model
FEHB: Federal Employees Health Benefits Program
FEIO: Healthcare & Insurance/Federal Employee Insurance Operations
GAO: Government Accountability Office
HHS: The United States Department of Health and Human Services
HPSAs: Health Professional Shortage Areas
HRSA: Health Resources and Services Administration
MHP: Mental Health Professional
MHPAEA: Mental Health Parity and Addiction Equity Act of 2008
OPM: U.S Office of Personnel Management
PIC: Penn Integrated Care Program
QHP: Qualified Health Plans
RCTs: Randomized Control Trials
SUD: Substance Use Disorders
USPSTF: United States Preventive Services Task Force
WHO: World Health Organization

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EXECUTIVE SUMMARY

This report will focus on assessing policy alternatives for the United States Office of Personnel Management (OPM) to advise carriers to increase network adequacy in mental healthcare on a federal level. Network adequacy refers to the sufficiency and accessibility of healthcare providers, facilities, and services within a health insurance plan's network to meet the healthcare needs of its enrollees. The principle of network adequacy is fundamental because it guarantees that people with health insurance can access the care they require when they need it, free from obstacles like long wait times, extensive travel distances, or expensive out-of-network fees. The lack of mental health providers in insurance plan networks, particularly in certain geographic regions or for specific specialty treatments, is one of the major obstacles to receiving mental healthcare. This can result in long wait periods for appointments and trouble locating a mental health physician that accepts a certain insurance plan. Furthermore, some insurance plans may impose restrictions on the number of visits or types of treatment covered for mental health services or require prior authorization, which can make it more challenging for people to obtain the care they require. Addressing these access barriers is crucially important to promote health equity and make progress toward better health outcomes in the United States.

First, the literature points to the implementation of a Collaborative Care Model (CoCM) as a method to alleviate healthcare costs for patients and promote equity of access to mental health services across healthcare coverage. The second policy option is updating provider directories which explicates the relationship between ghost networks and disrupted access to timely assistance; it is an alternative to the status quo of not having a standardized process to address inaccurate provider directories. The final strategy for improving access to mental health providers includes increased reimbursement and expanded coverage for nurse practitioners, clinical psychologists, and mental health social workers. This option ensures that mental health providers are equitably reimbursed and are on a level playing field as medical providers. However, there is limited empirical evidence to assess the efficiency and feasibility in terms of implications on premiums of this intervention within the context of the federal guidelines.

These findings inform the three policy options proposed in this report. Each alternative will be assessed against a set of evaluative criteria: (1) Cost-effectiveness (2) Equity (3) Sustainability. This report ultimately recommends Alternative 1, to utilize reimbursement models that combine care for mental health, substance use disorders, and physical health, such as the Collaborative Care Model (CoCM). This option ranked the highest for cost-effectiveness after a comparative analysis of the literature. CoCM is also in line with the current policy background as more legislation supporting the integration of mental health and physical health is being introduced. Finally, Alternative 1 is highly effective in reducing wait times and increasing accessibility amidst a shortage in behavioral health staff. This may be the ideal time to investigate and advise carriers on the benefits of CoCM for increased accessibility of behavioral health services, given the current federal government's interest in health equity and better mental health outcomes, while experiencing a shortage of behavioral health workforce.

PROBLEM STATEMENT

Many federal employees face barriers to accessing behavioral health services due to a lack of providers offering timely mental health services (Zhu et al. 2017). A national shortage of mental health providers is ascribable to the increased demands during the COVID-19 pandemic and the low reimbursement rate in-network (Nagata et al., 2022; Miller et al., 2022). 57.4% of health insurance plans in the United States of America had limited access to psychiatrists as opposed to 38.7% of plans with limited access to primary care physicians (Zhu et al. 2017). The Federal Employees Health Benefits (FEHB) Program, administered by the United States Office of Personnel Management (OPM), currently lacks network adequacy standards for behavioral health, which exacerbates the issue.

CLIENT OVERVIEW

The United States Office of Personnel Management (OPM) is an independent federal agency that administers the U.S. civilian service. OPM offers support to federal agencies, directs human resources, administers healthcare and insurance programs, manages retirement benefits, and governs merit-based hiring practices and inclusivity in the civil services (About Us - OPM.gov, 2019).

OPM oversees the most extensive employer-sponsored group health insurance program in the world known as the Federal Employees Health Benefits (FEHB) Program. The FEHB program covers the health insurance of over 8 million federal employees, retirees, former employees, family members, and former spouses (FEHB Handbook, 2019). The program is unique to federal employees and serves as a competitive advantage in terms of insurance premiums. The plans under FEHB meet the Affordable Care Act's minimum value standard for the benefits. The minimum value standard is established at 60% of the total allowed cost of benefits anticipated to be incurred while enrolled under the plan (Minimum Value and Affordability | Internal Revenue Service, 2017). Studies have shown that 78% of the Qualified Health Plans (QHP) under the ACA included restrictive networks that offered limited to no coverage out of the network and nonemergency care outside the network is generally not covered (Sloan & Carpenter, 2019). The client, in an administrative role, provides guidance or recommendations to assist in the decision-making process. This can include offering expert knowledge or perspectives on a particular topic, providing insights based on experience, or offering suggestions for potential solutions to a problem. The goal of the administrative role is to help insurance plans make informed decisions using the FEHB Carrier Letter Initiatives for Plan Year 2024.

INTRODUCTION

In 2020, mental illnesses among adults peaked at 21% i.e., 52.9 million adults were suffering from mental ailments (SAMHSA, 2021). Despite the growing need for mental and substance use disorder care, adequate behavioral health services have plummeted significantly, during the pandemic. They are gradually rebounding to a pre-pandemic extent when compared to rapid rebounding in other primary healthcare services (TrendWatch: The Impacts of the COVID-19 Pandemic on Behavioral Health | AHA, 2022). Despite having coverage, 36% of insured adults experiencing moderate to severe symptoms of depression and anxiety did not receive adequate care in 2019 (Pestaina, 2022). Network adequacy of mental healthcare is part of a larger policy discussion that entails addressing behavioral health workforce shortage, insufficient health care to aid people in crisis, rise in mental health treatment needs for the youth, and the need for better incorporation of primary health and behavioral health care systems (Pestaina, 2022).

BACKGROUND

According to the World Health Organization (WHO), an estimated 1 in 8 or 970 million people around the world experience a mental health condition at some point in their lives (WHO, 2022). In the United States, the National Alliance on Mental Illness (NAMI) reports that approximately 1 in 5 adults or 21% of the adults experienced a mental illness in 2020, and nearly 10 million adults have a serious mental illness that significantly interferes with their daily activities (NAMI, 2023). Despite the increasing prevalence of mental health disorders, access to mental healthcare remains a challenge for many individuals. Access to mental healthcare is a critical component of overall healthcare, as mental health conditions can have a profound impact on individuals and communities. The availability of appropriate and sufficient mental health practitioners, facilities, and services to meet the needs of people seeking mental health care is referred to as network adequacy in the context of mental healthcare. Employees who suffer from mental illnesses may need to see a specialist or provider with specific expertise in treating their condition. However, many insurance plans have limited networks of providers, which can make it difficult for patients to find a provider who is covered by their insurance. In addition to the challenges of finding an in-network provider, many patients may also face additional barriers to accessing mental health services, such as long wait times, lack of availability of appointments, and stigma associated with seeking treatment for mental health concerns (Bethune, 2021). These barriers can make it difficult for individuals with mental health concerns to access the care they need, leading to inadequate treatment and poorer health outcomes.

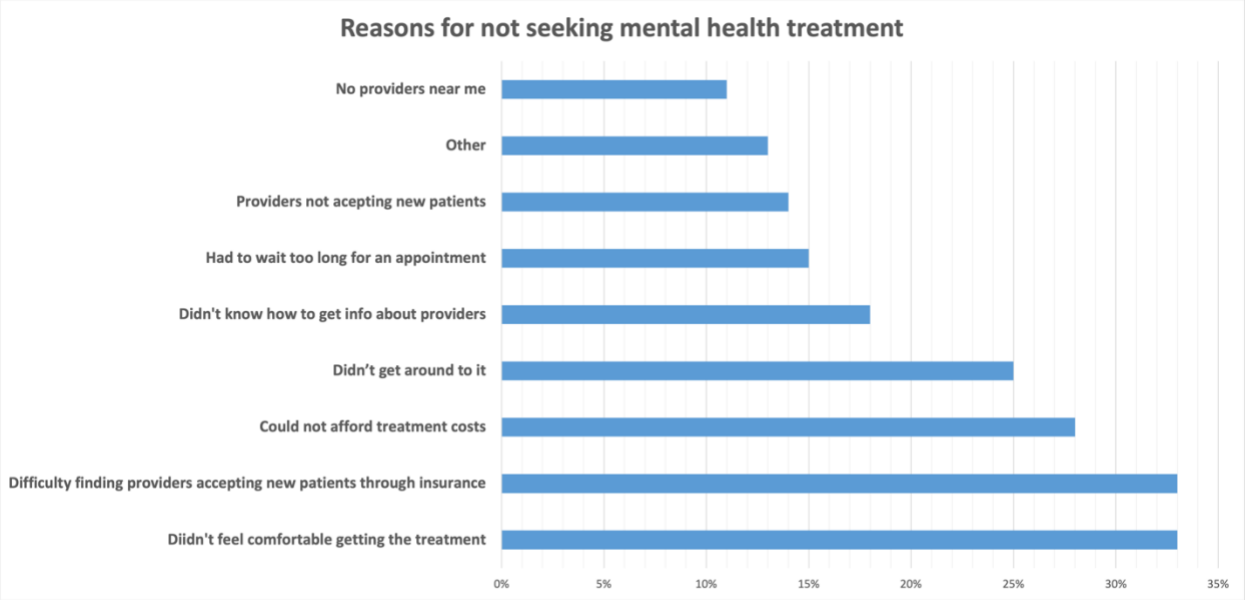
Additional barriers to accessibility include lower reimbursement rates for mental health providers. A 2017 report by Milliman evaluated the disparities in reimbursement rates for behavioral health services in comparison to primary care services. In 2017, the average reimbursement rate for primary care providers was 23.8% higher than behavioral health providers coupled with higher out-of-network use rates for behavioral health office visits which

were 5 times (500%) higher than primary care visits (Melek et al., 2017). The disparities suggest an inequitable reimbursement model for mental health services which subsequently compels patients to resort to paying for out-of-network services as providers prefer being out of network.

The FEHB employee benefits survey in 2021 showed that the main reason for not seeking treatment for mental health concerns was the difficulty in finding a provider that was in-network (FEHB, 2022).

The graph below exemplifies the need for better policies and regulations that encourage adequate mental health networks.

Figure 1: Reasons for not seeking mental health treatment by FEHB enrollees.



Source: 2021 Federal Employee Benefits Survey Report

CAUSES & CONSEQUENCES OF NETWORK INADEQUACY IN MENTAL HEALTHCARE

Causes

Mental health resources often face the issue of narrow networks as mental health is still not well understood and stigmatized. The pandemic led to an increase in adverse mental health conditions, on a nationwide level, due to isolation and job loss (Czeisler et al., 2020). Furthermore, the demand for care from psychiatrists increased over the past 15-20 years, despite a decline in the per capita number of psychiatrists (Bradley et al., 2021). Increasing adversity necessitates better network adequacy standards in mental healthcare.
There are several potential causes of inadequate networks for mental healthcare. Some of the most common reasons include:

Pandemic:

The COVID-19 pandemic and the recession have adversely impacted the mental health of many individuals and have exposed people to poor mental health outcomes like anxiety or depression due to job loss and isolation (Pestaina, 2022). Surveys conducted by the CDC (Centers for Disease Control) observed an extremely large percentage (40.9%) of the respondents reporting at least one adverse mental health condition like anxiety, trauma- and stressor-related disorder and increased or started substance abuse as a method of coping with the stress induced due to the pandemic (Czeisler et al., 2020). Isolation as a preventive measure, addressing the spread of the disease, led to a loss of 22 million jobs and increased unemployment to over 20%, pushing down the share of working women below 50% (Kassens et al., 2021). Since the onset of the pandemic, employees have been facing anxiety and depression due to job loss and a recession.

Shortage of Behavioral Health Providers:

Another cause of inadequate networks is the shortage of behavioral health providers. Psychiatrists are usually out of network and expensive. Moreover, there is a national shortage of behavioral health providers making it even more difficult to find a provider on time and within a distance (Pollitz, 2022). The shortage of mental health providers has been largely seen in rural areas of the U.S. (Morales et al., 2020). Areas that face a shortage of BH providers are called Mental Health Professional Shortage Areas (HPSAs). Designated HPSAs are required by the Health Resources & Services Administration (HRSA) to initiate health centers. HPSAs face a multitude of barriers including a lack of insurance, providers who do not accept the insurance, and high out-of-network costs that are not feasible (Holliday et al., 2019). Health plan networks also play a key role in determining if the patients will seek the necessary treatment, as out-of-network claims can be denied or covered at a lower rate (Pollitz, 2022). A shortage of providers has also been exacerbated by the pandemic.

Flawed Models:

A study estimates that 28% of the U.S. population is impacted by diagnosable mental illnesses yet only 8% seek treatment (Scarbrough, 2018). Non-treatment of mental illnesses can lead to decreased productivity in employees, which contributes to the accelerated cost of treating comorbidities. Insurance companies often fail to address the increasing costs and demands of better access to mental health care and treat mental health claims differently from other medical claims even though the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 is in place (Keith, 2001). The business models of health insurance cater to the needs of doctors and healthcare institutes by reducing the number of in-network providers and accounting for the increasing costs of mental healthcare. Despite the growing need for mental and substance use disorder care, the services have plummeted significantly during the pandemic. According to CMS, *"the proliferation of narrower networks … presents several potential consumer protection concerns including whether a narrow network has sufficient capacity to serve plan enrollees, or whether providers may be too geographically dispersed to be reasonably accessible."* (Patient Protection and Affordable Care Act; HHS (Health and Human Services) Notice of Benefit and Payment Parameters for 2023, p. 685, 2022*).* The CMS describes recent trends in the marketplace as the "proliferation of narrower networks". Insurance companies can design provider networks in a way that they can control the number of providers and the extent of providers to reduce costs, which is also known as shrinkflation (Pollitz, 2022). Such narrow network models apply to FEHB and disrupt the lives of many federal employees. Thus, the above-mentioned flawed models of health insurance indicate a dire need for better coverage that expands to mental illnesses and substance use disorders.

Consequences

The utilization of behavioral health resources has increased since the implementation of The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. This indicates a long overdue need for mental health services that existed due to the stigmatization of mental health (Hargraves, 2018).

It has been more than 25 years since the first federal mental health parity act was passed yet adequate coverage for mental health resources remains inconvenient for many employees who are enrolled in health insurance plans (Pestaina, 2022). Currently, the U.S. follows no national standard for network adequacy and the standards vary from state to state and types of coverage. Although The National Association of Insurance Commissioners (NAIC) developed a Health Benefit Plan Network Access and Adequacy Model Act in 2015, the act includes no national standard and very few states follow the network adequacy model mentioned in the act.

The lack of network adequacy standards for mental health resources has made it difficult for employees to access timely mental healthcare. Time-distance standards are used to determine the proximity of the providers within the network, geographically. A recent survey conducted by Kaiser Family Foundation and CNN revealed that 13% of the individuals had not received

mental healthcare on time due to a struggle to find a provider that accepted their insurance within their area (Lopes et al., 2022). The unavailability requires the individual to travel for extended periods to seek care (Goodman, 2022). Another standard that has been neglected is maintaining a minimum provider-to-enrollee ratio. The state of Illinois requires metro counties to provide a health plan that ensures that the enrollee does not have to travel more than 30 minutes from his/her/their residence to receive mental health care or outpatient care for substance use disorder. Lack of these standards results in additional work leaves that can subsequently harm the employees' performance reviews. Studies have suggested that job loss during the pandemic and isolation have been imperative to the development of mental illnesses and substance abuse (Umucu et al., 2021). Job losses can further lead to economic insecurity that has also been aggravated by the recession induced by the pandemic (Pestaina, 2022). The U.S. Surgeon General recognized the issue of the current mental health crisis among the youth and one of the reasons was the economic instability of the parents which trickled down to their children (Richtel, 2022).

Approximately 57% of employees with moderate depression and 40% of those with severe depression obtain treatment to manage their symptoms (Dewa et al., 2011).

The lack of satisfaction with the FEHB program can lead to employees pursuing another healthcare plan and the subsequent liquidation of the FEHB program. Another consequence could be that federal employees leave their jobs due to debilitating mental health.

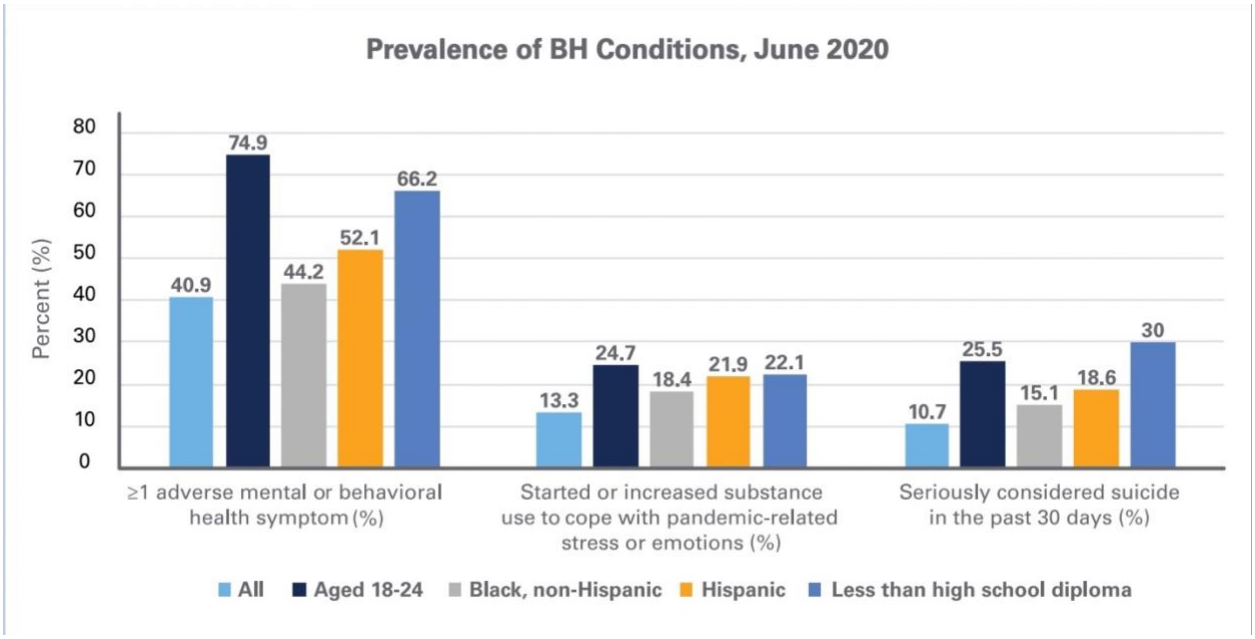
Equity Implications

Racial Equity

Impeded access to mental health resources disproportionately affects underrepresented federal employees (Rubin, 2020). Black and Brown individuals were more likely than White individuals to report symptoms of anxiety and depression during the pandemic. Communities of color experienced higher rates of COVID-19 transmission and deaths along with disproportionate vulnerability to stressors like unemployment and food insecurity. This exposed communities of color to debilitating mental health and inaccessibility due to residing in HPSAs. The decline was evident amongst Black, Hispanic, and Asian communities along with having lower access to mental healthcare (Thomeer et al., 2022). The barriers to mental healthcare access for underrepresented groups included financial, geographic, cultural as well as linguistic obstacles due to the lack of diversity in the mental health sphere (Kormendi & Brown, 2021). Black and Hispanic individuals were also more likely to suffer severe episodes of mental illnesses that go untreated for a longer period relative to White individuals (Williams et al., 2007). The 2021 Federal Employees Benefits Survey analyzed the question, “How often have you felt like you have been treated with less respect than others when seeking health procedures/services?”, based on race. Participants who identified as white were less likely to report any discrepancies in treatment than participants of other racial groups.

In recent years, children and youth have also shown a major increase in mental health concerns attributed to the use of digital media, gun violence, academic pressure, and the pandemic (Richtel, 2022). Moreover, Black, Hispanic, and Asian American students also experienced higher rates of mental health concerns due to income insecurity of parents and anti-Asian racism that increased during the pandemic (Panchal et al., 2021).

Figure 2: Prevalence of behavioral health conditions demographically in the U.S post-pandemic



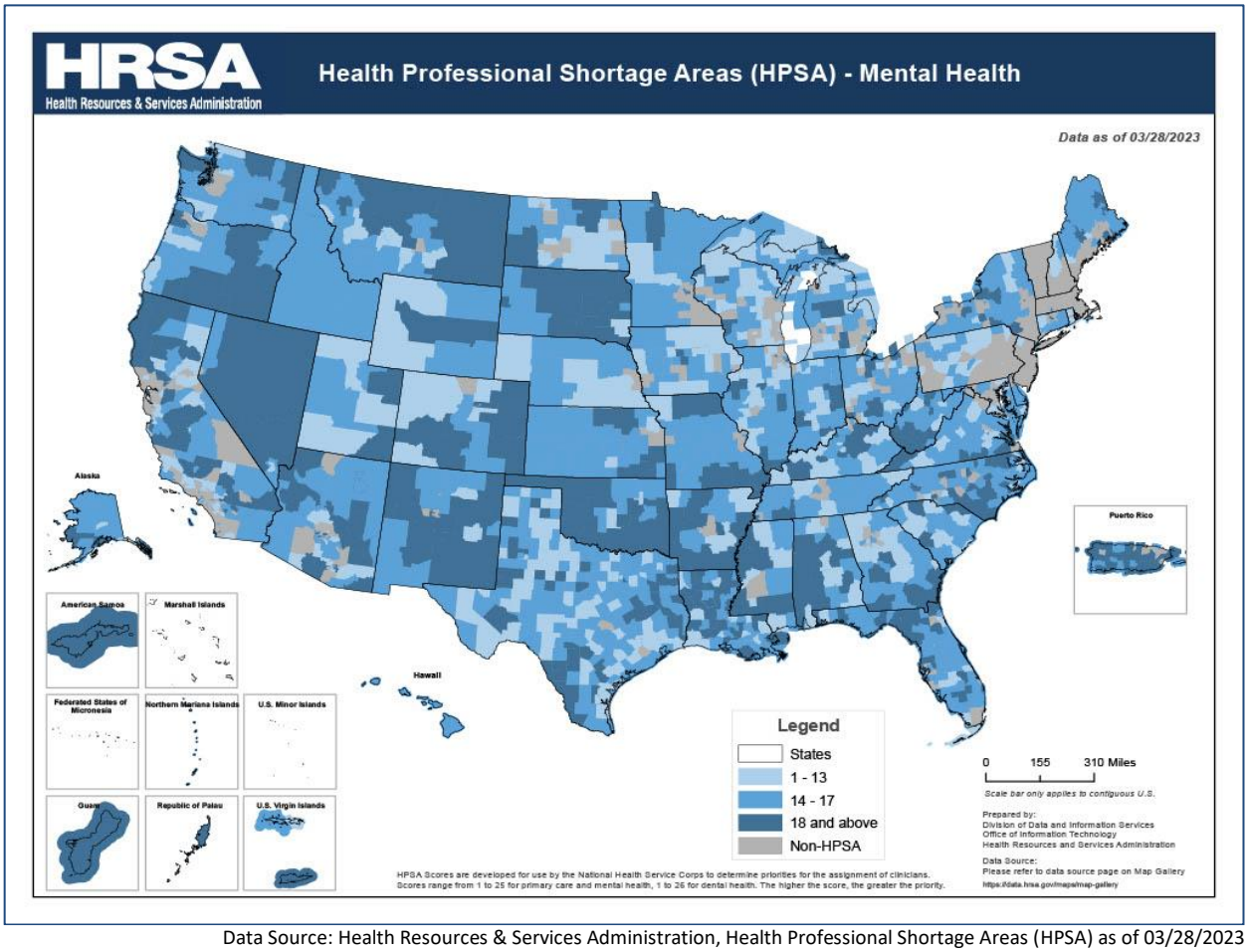
Source: TrendWatch: The impacts of the COVID-19 pandemic on behavioral health, AHA, n.d

Geographic Equity

Inequitable accessibility of behavioral health services has led to implications geographically. Network inadequacy arises when certain areas or regions have limited mental health care in urban and rural areas. Rural and remote areas often face challenges in accessing mental health services due to the scarcity of mental health providers and facilities in those regions. About 6.5 million people, or one-fifth of the rural population in the US, suffer from a mental illness (SAMHSA, 2022). Despite the fact that serious mental illness and most psychiatric disorders affect US adults equally regardless of whether they live in rural or urban areas, rural areas experienced significant shortages and accessibility issues (Anthony et al., 2019). Adults in remote regions face barriers to accessing mental health treatment as they receive services less frequently or from providers who have not received specialized training (Morales et al., 2020). In some urban areas, there is a concentration of underrepresented minority communities with limited access to mental health services. These communities face challenges in finding mental health providers who are culturally competent and sensitive to their unique needs, resulting in

inadequate care and treatment gaps (Rice & Harris, 2021). In some regions, there may be a shortage of mental health providers due to workforce limitations, such as a lack of mental health professionals or facilities. This can result in long wait times, limited availability of appointments, and reduced access to timely and appropriate mental health care. Such areas are known as Mental Health Professional Shortage Areas (HPSAs). The following figure represents a map of the proportion of communities that live in an HPSA.

Figure 3: Health professional shortage areas for mental health in the U.S.



Data Source: Health Resources & Services Administration, Health Professional Shortage Areas (HPSA) as of 03/28/2023

LITERATURE REVIEW

A constantly evolving array of literature on network adequacy standards for mental health evaluates programs and regulations that are already in place and aids in understanding why the current policies are inefficient. This literature review will explore three potential policy approaches to improve access and address the shortage of behavioral health professionals: (1) Collaborative Care Model, (2) Standards to Update Provider Directories, and (3) Maintaining Parity in Reimbursement Models. The literature review includes a summary of previous research on the effectiveness of different approaches to ensure adequate access to mental health services, such as minimum provider-to-patient ratios or maximum travel times for patients. It also includes an analysis of the challenges and limitations of existing network adequacy standards, as well as potential solutions and recommendations for future research in this area. There are major gaps in the literature in terms of evidence-based alternatives. After reviewing the body of literature, it is evident that most health insurance plans have relied on telehealth expansion and state-based network adequacy standards. Moreover, the literature is majorly based on physical health rather than mental health and only a few studies have been done on federal employees.

Below I evaluate the body of literature on network adequacy issues in mental healthcare and suggest methods to alleviate network adequacy issues in the Federal Employees Health Benefits (FEHB) Program.

Collaborative Care

The Collaborative Care Model (CoCM) is an area of research that integrates mental health treatments into primary care. Several randomized control trials (RCTs) have proved the efficiency of the collaboration of mental health care into primary health care to treat mild to moderate levels of anxiety and depression (Miller et al., 2013; Woltmann et al., 2012; Wolk et al., 2021). The main elements of a CoCM team include a primary care physician, a mental health professional (MHP), and a supporting psychiatrist. A study conducted by the Penn Integrated Care Program (PIC) suggested that patients suffering from depression and who were enrolled in collaborative care achieved a 32.6% remission rate of depression (Wolk et al., 2021). 39.5% of the patients suffering from anxiety disorders also achieved remission from anxiety. A study suggests the implementation of preventative depression screening to be effective to curb the further effects of depression as well as a statistically significant reduction in self-reported depression scores (Siniscalchi et al., 2020). Including a depression screening during a primary care visit can largely benefit patients in discovering early-onset depression or anxiety and seeking treatment from the supporting psychiatrist in the model. It might help alleviate mild to moderate behavioral health disorders and reduce employees' productivity loss due to depression. However, CoCM is a novel model with many RCTs referencing it lately. Therefore, the literature is sparse and elusive.

Transparency and Flexibility

FEHB might also adopt standards that require better data management and transparency of provider directories. Existing literature suggests that the shortage of mental health providers is a huge barrier to mental healthcare, especially in children (Dolotina & Turban, 2022). A shortage can be perceived as "phantom networks" that consist of providers who are incorrectly listed as being in-network but do not accept new patients or do not exist in the patient's network and often is a consequence of inaccurate lists.

According to the Government Accountability Office (GAO) report on mental health access, many covered stakeholders in the survey faced challenges due to limited access to in-network mental health providers (United States Government Accountability Office, 2022). Inaccurate directory information worsened access issues and made it difficult for stakeholders to find mental health providers within the network. The report also mentioned that 22% of the phone numbers were non-existent and 21% of the psychiatrists were not accepting new patients. Zhu and colleagues studied the barriers to accessing mental healthcare due to the existence of phantom networks using 2018 Oregon Medicaid medical claims data. The study found that an enormous share of the network directory listings (58.2%) did not see Medicaid patients and 67.4 percent of mental health prescribers were phantom networks. The inaccessibility through phantom networks worsens conditions like depression and can cause many people to lose faith in the existing healthcare system (Dolotina & Turban, 2022). States can also implement different regulations that can curb ghost networks by proper management of databases of providers. For instance, California implemented new regulations in 2017 that required insurers to update their provider list more frequently (J. B. Wishner & Marks, 2017). However, it is unclear how efficiently these regulations worked. The 2016 Medicaid and CHIP managed care final rule requires data and reports that state network adequacy reviews on time distance standards, provider participation reports that are collected through surveys and member complaints, grievances, and appeal logs that are related to the barriers faced by members to access timely mental healthcare.

The literature demonstrates that the most extensive methods for the consideration of mental health staff based on full-time equivalent, in the provider network rather than merely weighing the number of total providers in the network can aid in combatting the shortage of mental health staff (Bradley et al., 2021). Currently, twenty-eight states and the District of Columbia permit behavioral health nurse practitioners to diagnose, treat and prescribe medications to patients without formal authority from physicians or psychiatrists, increasing the scope of practice and providing a solution to the problem of shortage of staff (Spetz, 2020). Some studies assert that making in-network credentialing less cumbersome and flexible will increase more providers to be in-network and therefore increase the number of providers in the network (Bradley et al., 2021). It should be noted that much of the literature surrounds medical care and not specifically mental healthcare. Therefore, the suggestions are extrapolated and generalized to mental healthcare.

Disparity in Reimbursement Models

Network adequacy standards seem straightforward yet are difficult to put into practice. A wide variety of policies suggest that network adequacy refers to frameworks that provide an adequate number of providers in an area without unreasonable delay to mental healthcare (Zhu et al., 2022). Though most of the literature is on network adequacy standards of physical health, one can argue that the standards need to be applied to mental health too per the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) that ensures large group health plans cannot impose mental health benefits that were less favorable than medical/surgical benefits. Studies refer to CMS's strategies to maintain network adequacy, including minimum provider-to-enrollee ratio, time distance standards, a minimum number of providers who accept new patients, and hours of operation (Ludomirsky et al., 2022). Understanding state-based regulations on network adequacy is also important as states may have various quantitative network adequacy measures like time-distance and provider-to-enrollee ratio.

Even though quantitative standards are in place for many health insurance programs, there are gaps in these regulations (Zhu et al., 2022). In order to increase network adequacy, plans that incentivize and strengthen the behavioral health system financially fare better (Pestaina, 2022; Bagalman et al., 2022; Bradley et al., 2021). The President's Mental Health Strategy provides financial incentives as well as workforce development initiatives to strengthen the behavioral healthcare workforce (Bagalman et al., 2022). However, Ettner and Schoenbaum, 2006, study the inefficiency of pay for performance incentives for mental healthcare providers. There is not enough literature that has analyzed incentivizing mental healthcare providers and it is not clear whether incentives will increase performance. Another strategy in the First State of the Union Address by President Biden reinstated the expansion of parity by including three behavioral health visits per year without cost-sharing (The White House, 2022). Further evaluation of reimbursement rate disparity between behavioral health and other medical services is required to increase expansion. Evaluating medical management criteria is another option that involves looking closely at the medical necessity criteria that are used to provide mental healthcare as each state has a different policy (Pestaina, 2022). Moreover, much of the discourse around financial incentives suggests inequity between the payment models that are in place for medical care and behavioral health. Enforcing MHPAEA has proven to be challenging in different states due to inadequate resources from the federal government, lack of awareness of federal parity law in several states, and inefficient market surveillance (Volk et al., 2022).

Expansion of Telehealth

With the advent of the pandemic, telehealth resources are high in demand and convenient. Some studies found that the increasing use of telehealth services that peaked during the pandemic will continue in the foreseeable future (Bradley et al., 2021). For instance, a study published by the American Psychological Association noted that 75% of the respondents depended upon remote services including therapy using telephone and videoconferencing. A

study conducted by Milbank Memorial Fund found that telehealth resources were as effective as in-clinic treatment options for mental health disorders like anxiety and depression and were more cost-effective than in-person treatment (Lazur et al., 2021). There is literature that refutes the claim of increasing the use of telehealth in the future. A study conducted by Molfenter and colleagues in 2021 found that there was no statistically significant difference in the intention to use telehealth post-COVID-19 between administrators and individuals who provided treatment (p-value = 0.16). During the pandemic, several state Medicaid programs expanded coverage by lifting restraints on reimbursement rates for telehealth visits, thus encouraging many out-of-network providers to be in-network (Zhu et al., 2021). It is also important to research how various providers experienced telehealth services during the pandemic to further extrapolate evolving standards over a long period (Bradley et al., 2021). Another meta-analysis on telehealth interventions in college students indicated inconsistencies in methodology and did not account for the heterogeneity, thus making the results unreliable (Davies et al., 2014).

Takeaways from the Literature

The literature reviewed above is essentially based on primary healthcare rather than mental healthcare, thus limiting the suggestion of alternatives. The research so far provides three alternatives that could be implemented individually. Firstly, the FEHB program could investigate improving mental healthcare access by introducing the standards using the Collaborative Care Model (CoCM). The integration could potentially lead to an equitable reimbursement model for primary care providers and behavioral health providers. The program also increases the licensing potential for nurse practitioners and clinicians as a first line of treatment. Yet this policy option needs to be further explored in a comparative analysis of different federal health insurance programs. Alternatively, the FEHB program could discern HHS and CMS measures to inoculate the providers into adopting standards that are advantageous to OPM employees. Secondly, providing financial incentives to behavioral health providers could also alleviate the problem of high out-of-pocket costs for patients across health insurance programs. The policy approaches that could address financial incentives directly include increasing reimbursement rates as a method of maintaining parity in the reimbursement model for primary care and behavioral healthcare. Finally, the expansion of transparency and flexibility standards could reduce barriers to accessibility amongst enrollees, but there is limited empirical evidence to assess the efficacy and feasibility of this intervention within the context of the FEHB guidelines. Moreover, OPM cedes authority to expand the scope of practice for allied mental health professionals to the states.

In the future, developing economic systems to forecast the effects of these prospective policy solutions and examining how these network adequacy policy alternatives fit into the larger socio-political factors at play in the U.S. are possible strategies. Considering the current federal government's interest in health equity and OPM's activities to pursue standards to retain adequate networks, this may be the ideal time to investigate and advise carriers to prepare for implementing integrated models of health systems.

EVALUATIVE CRITERIA

The following criteria will be used to evaluate policy alternatives that aim to address the shortage of mental health providers and increase the accessibility of mental health services, thereby aligning with FEHB's mission of "advancing health equity and offering comprehensive health insurance benefits to federal employees, annuitants, their families, and other eligible persons and groups" (U.S. Office of Personnel Management Healthcare and Insurance, 2022).

Cost-Effectiveness

This criterion measures the cost as well as the effectiveness of each alternative. The practicum examines the cost of each alternative in terms of premium rates required of the enrollees, as it is important for any evidence-based policy recommendation. The effectiveness criterion assesses whether the policy option addresses the inaccessibility of mental health care by measuring the decrease in appointment wait times for people seeking care. Policy alternatives will be ascribed to relative scores **ranging from 1-3**, with 3 being the highest and 1 being the lowest score based on the dollar amount of cost-effectiveness according to the ability to address accessibility in the context of decreasing wait times (i.e., time taken to receive an appointment with a psychiatrist). All cost calculations can be found in the appendix. Furthermore, as this alternative will be vital to predicting the effectiveness of overall goals to achieve optimal appointment wait time while minimizing costs, it will be given the highest weightage of 50%.

Equity

It is critical that the alternatives considered equitably serve OPM's disadvantaged populations. Ensuring comprehensive coverage for underserved populations is an important part of FEHB's recent carrier letter and has been a point of emphasis for mental health and substance use disorder treatments (U.S. Office of Personnel Management Healthcare and Insurance, 2022). To measure equity, I evaluate the policy options based on how well it addresses limited accessibility to mental health resources driven by income differential, racial disparity, and geographic disparity. This criterion will make use of approximations for the effects of comparable initiatives on socioeconomic, geographic, and racial equity. The equity criterion will be operationalized using a point system, **with a maximum of 1 point allowed for each of the three criteria components, for a maximum possible score of 3**. This criterion will be weighted at 30% of the total score.

Sustainability

The last criterion measures the sustainability of the alternative which will be measured through an analysis of the economic and societal factors impacting the effectiveness of the alternative

over time. A shortage in psychiatrists has been projected in the year 2030 by Health Resources and Services Administration (HRSA) due to constant demand and a declining supply of psychiatrists (approximately 12,530 psychiatrists) (HRSA, 2022). Sustainability will also measure the ability of the policy option to address this impending shortage. Policy alternatives will be assigned relative scores **on a scale of 1-3**, with 3 being highly sustainable. This criterion will be weighted at 20% of the total score.

Figure 4: Supply and Demand of Psychiatrists in the Future

Date created: April 7, 2023

Source: Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections. Available at https://bhw.hrsa.gov/data-research/review-health-workforce-research

ALTERNATIVES & EVALUATION

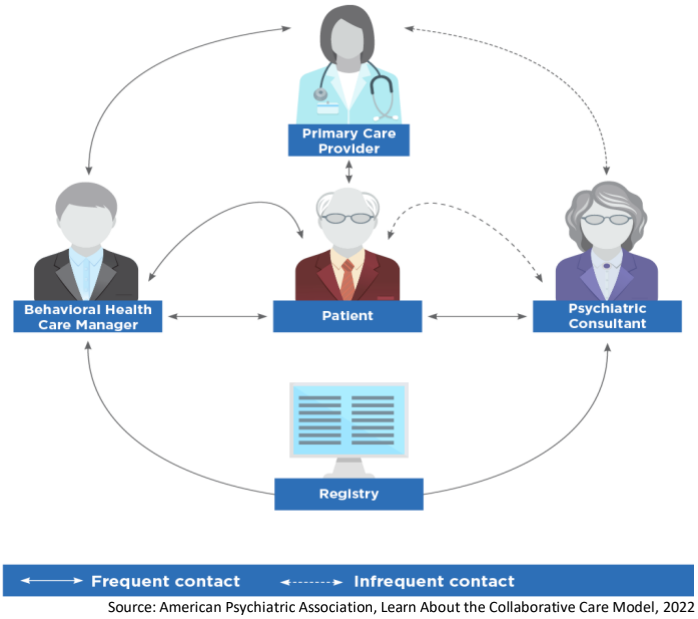
The alternatives will be evaluated based on how well they address the shortage of mental health providers and the expansion of mental healthcare to improve access to mental healthcare for FEHB enrollees and their covered family members.

The first policy option of incorporating Collaborative Care Models has great potential to improve the quality of care for patients with mild to moderate anxiety and depression, and its successful implementation can lead to improved patient outcomes and reduced healthcare costs. The second policy option is updating provider directories which explicates the relationship between ghost networks and disrupted access to timely assistance; it is an alternative to the status quo of not having a standardized process to address inaccurate provider directories. The final strategy for improving access to mental health providers includes increased reimbursement and expanded coverage for nurse practitioners, clinical psychologists, and mental health social workers which ensures that mental health providers are equitably reimbursed and are on a level playing field as medical providers.

Policy Option 1: Collaborative Care Model (CoCM)

The Collaborative Care Model (CoCM) integrates mental health treatments into primary care. Several randomized control trials (RCTs) have proved the efficiency of the collaboration of mental health care into primary health care to treat mild to moderate levels of anxiety and depression (Miller et al., 2013; Woltmann et al., 2012; Wolk et al., 2021). OPM has already initiated the first step by requiring the utilization of reimbursement models that integrate health, mental health, and substance use disorder care, such as the Collaborative Care Model in carrier letters (FEHB Program Carrier Letter 2019-01; FEHB Program Carrier Letter 2023-04). As a part of this policy option, OPM not only needs to encourage their carriers to pursue CoCM, but also needs to verify uptake which utilizes a primary care physician, a mental health professional (MHP), and a supporting psychiatrist who can perform at the top of their license The oversight role of OPM could include verification in the form of a health insurance plan survey conducted by the Federal Employee Insurance Operations (FEIO) office within the Healthcare & Insurance division. Additionally, including a depression screening during a primary care visit can primarily benefit patients in discovering early-onset depression or anxiety and seeking treatment from the supporting psychiatrist in the same care team. It can also alleviate mild to moderate behavioral health disorders and reduce employees' productivity loss due to depression caused by comorbidities. The model has also been shown to reduce total healthcare costs for patients by lowering redundant costs required for mental health concerns (Unützer, 2013).

Figure 5: Working of Collaborative Care Model



Source: American Psychiatric Association, Learn About the Collaborative Care Model, 2022

Cost Effectiveness:

Several systematic reviews have addressed the cost-effectiveness of the Collaborative Care model for individuals with depression in a primary care setting using a randomized control trial (Wright et al., 2016; Unutzer et al., 2008; Gilbody et al., 2006; Glied et al., 2010). A study conducted by Druss and colleagues in 2011 estimated the average per-patient costs for the group that received Collaborative care model treatment as $932. The effectiveness of the alternative measures the increase in referrals that led to a reduction in the appointment wait times for patients. The median wait time for a psychiatric appointment was estimated to be 42 days or six weeks (Steinman et al., 2015). In a collaborative care model, a licensed MHP overseen by a mental health intake coordinator calls the patient (or the patient may call the center directly) within 24 to 48 hours and conducts a structured evaluation over the phone utilizing Behavioral Health Laboratory proprietary software which reduces the appointment wait time by a significant margin (Wolk et al., 2021). The patient is referred to a psychologist or a psychiatrist based on the telephone assessment within 19 minutes which is interpreted as having a significantly lower average wait time to receive an appointment (Pomerantz et al., 2008). The cost-effectiveness criterion assesses the cost per patient receiving mental health treatment/ reduction in appointment wait time. This alternative effectively receives a score of **22.2**, which means that this alternative is highly cost-effective relative to the other policy options[1]. Therefore, this alternative is highly effective in reducing wait times for appointments and is assigned an overall score of **3** on the cost-effectiveness scale.

[1] Lower the score, higher the cost-effectiveness.

Equity:

One of the earliest studies in CoCM, Partners in Care (PIC), demonstrated a reduction in racial and ethnic disparities in health outcomes. In this study, geographical regions were specifically chosen to include a substantial proportion of Latinx and African American populations (Wells et al., 2004). Some studies on the Collaborative Care model aimed to target historically underserved communities and towards increasing accessibility for the underserved areas (Uebelacker et al., 2009; Powers et al., 2020). There is empirical evidence that evaluates the equitable outcomes of the collaborative care model (Jackson-Triche et al., 2020). As these studies particularly expand upon communities of color and increase accessibility in terms of geographic location, this option gains 0.5 points for racial equity and 0.5 points for geographic equity. Lastly, because this expansion covers the cost of allied mental health resources for insured individuals, it would increase equitable access to mental healthcare across socioeconomic statuses. Hence, this policy option receives 1 point for socioeconomic equity, amounting to a total of 2 out of 3 points for equity.

Sustainability:

A notable aspect of this alternative is that the model would have a care team that collaborates and thus reduces wait time for referrals from the physician to the psychiatrist or an allied mental health professional, increasing accessibility in the long run. A study in Australia showed that integrated care for depression and diabetic eye disease successfully reduced wait times for patients (Tahhan et al., 2020). Acknowledging the shortage of mental health professionals and the increasing demand for mental health services during the COVID-19 pandemic, members of Congress have released draft legislation in the Senate that requires health plans to have integrated services for mental health and physical health (Harvey, 2022). Moreover, when some of the strain and pressure on providers are alleviated through collaboration, it could improve recruitment and retention of mental health providers, allowing patients to get the help they need within a reasonable amount of time. CoCM might also shift the burden of resources to the physical health sector, where there might not be as many prevalent workforce shortages as opposed to the behavioral health sector, thereby addressing the projected workforce shortage in 2030 (Pietras & Wishon, 2021). This suggests that this alternative will continue to reduce wait times despite the rising need for mental health specialists. Therefore, option 1 ranks high on sustainability.

Policy Option 2: Provider Directories

The second approach involves implementing guidelines that maintain updated provider directories within the FEHB Program. Inaccurate provider directories impair both the health and the financial well-being of consumers considering the important function that provider directories and provider networks play in linking consumers to care (Burman et al., 2023). Most importantly, the time-consuming administrative cost of navigating through inaccurate directory listings and contacting centers to identify in-network providers is discouraging for the enrollees in the FEHB Program (Ray et al., 2015). Such inaccuracy of provider networks and barriers to

locating a provider leads to delayed care (Haeder et al., 2020). Additionally, research indicates that these burdens fall disproportionately on vulnerable communities (Blumenberg & Agrawal, 2019; Brown et al., 2016).

Updating provider directories frequently to avoid phantom networks and prevent surprise billing of patients is necessary to maintain network adequacy. Importantly, consumers can make informed decisions about which healthcare providers to see and avoid unexpected out-of-network charges when provider directories are kept up to date. According to FEHB Carrier Letter 2022-12, if an individual receives treatment from an incorrectly listed provider, the carrier can only charge costs that do not exceed the cost-sharing amount for in-network providers (FEHB Program Carrier Letter 2022-12). The provision suggests that the first step towards maintaining accurate provider directories has already been taken into consideration and the next step would be to require frequent revisions. As a part of contract oversight, OPM can direct carriers to update provider directories and report back to OPM.

CMS reported that about 45% of the provider directories had inaccuracies such as erroneous phone numbers and providers not being located at the address (CMS, 2017)

Cost Effectiveness:

A report by the Council for Affordable Quality Healthcare mentioned that the average cost per month for directory maintenance by several plan contracts was $998.84 (CAQH, 2019). This amount would vary upon the region with the Northeast having an average cost of about $1245.60 and Western states having an average cost of approximately $808.18. The report also mentioned that the reported cost savings from a nationwide single standard for directory maintenance would be $1.1 billion. OPM has required all carriers to maintain accurate provider directories, following the Consolidated Appropriations Act, 2021 (CAA) (Public Law 116-260), which suggests producing accurate directories using a standard for updating the directory every 90 days. Furthermore, as of 2022, patients who receive care from a provider who was wrongly listed as in-network in an insurer's directory cannot be charged more than they would have for in-network care. Encouraging insurance plans to maintain an accurate directory does not cost anything to OPM, but carriers may incur some costs, that would be passed along in terms of the premium being paid by the enrollee. According to a conversation with the Office of the Actuaries at OPM[2], this spike in premium would be offset by the benefits of keeping updated provider directories and having fewer phone calls to the customer care center by a patient to confirm that the provider is in-network. To measure the effectiveness of the alternative, we can observe that updating provider directories every 90 days increased accessibility and reduced appointment wait times from 42 days to 15 days which was the appointment wait time standard in California and the CMS appointment wait time standard for Federal Marketplace

[2] Brenna Scheideman & Rebecca Kander, Zoom discussion, March 17, 2023

Plans, 2023 (Burman & Haeder, 2022; Pollitz, 2022). The cost-effectiveness criterion measures cost of updating directories per provider/reduction in appointment wait time. This alternative gains **37 points**. As there is not enough evidence to conclude what the effect of provider directories would be per person, I assume that the points would be lower than 36.997. Therefore, this alternative is assigned a score of **3** on the cost-effectiveness scale which prompts high cost-effectiveness. It can be concluded that the net benefits of maintaining an accurate provider directory are more than the net costs of the alternative.

Equity:

Patients who rely on inaccurate provider directories may be unable to find healthcare providers who are in their network, leading to delays in care or out-of-network costs that they may not be able to afford. This can disproportionately affect low-income and underserved communities who may already face barriers to accessing care. However, there is not enough empirical evidence to suggest that this alternative might lead to an equitable outcome instead of an equal outcome across geographic areas and racial groups. Therefore, this alternative gains 1 point in accordance with the assumption that it addresses equitable access to mental healthcare for all people who are insured, regardless of their socioeconomic status, who otherwise must search laboriously for a provider in-network and be startled by a bill that is from an out-of-network provider.

Sustainability:

Maintaining updated provider directories is critical for patients to have access to required care and for health plans and providers to collaborate successfully. However, maintaining the accuracy of provider directories can be difficult due to several challenges, including frequently changing provider information, problems with the quality of the data, and restrictions in the current data management systems. Carriers that have business processes and systems in place can significantly reduce wait times perpetuated by the need to find a provider who is in the network. This policy option does not directly address the 2030 shortage of psychiatrists, but accurate provider directories could further increase the perceived shortage of psychiatrists who are not in the network but are listed incorrectly as in the network leading to inflated health bills. Therefore, due to the uncertainty, this alternative ranks medium on the sustainability index.

Policy Option 3: Parity in Reimbursement Models

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and its regulations provide standards for nonquantitative treatment limitations (NQTLs) such as specifying geographic limits, and network adequacy. The status quo is that FEHB plans are required to apply the same financial requirements (coinsurance, co-payments, deductibles, and out-of-pocket maximums) and treatment limitations (visit and day limits) to both out-of-network medical and surgical benefits and out-of-network mental health

and substance use disorder benefits. Even though parity rules do not fully address provider dollar reimbursement, the U.S. faces an exceptionally low provider reimbursement rate for mental health providers which subsequently leads to providers opting out of the network to get paid more (Rapfogel, 2022). The Department of Labor (DOL) guidance noted that health insurance plans often followed reimbursement models that paid in-network mental health providers at the Medicare rate while paying medical health providers two times the Medicare rate (Walsh et al., 2022). The agency also cited differences between the methodology used to calculate reimbursement rates for practitioners who provided medical treatment and behavioral health practitioners violating the parity statute (Walsh et al., 2022).

Due to the higher out-of-network payments, which incentivize providers not to enter contracts with insurers, networks are becoming narrower, and patients have limited access to care as a result of these low in-network payments for mental health providers. This preference has also been associated with a shortage of ancillary mental health professionals like nurse practitioners, clinicians, and mental health social workers, who often act as the first line of treatment.

This policy alternative seeks to maintain parity between the reimbursement rate models for mental health treatments and other medical treatments. Increasing rates at which allied professionals are reimbursed can be a suitable option for this problem as it can bring more providers to the network. The alternative could help in ensuring equitable reimbursement rates for behavioral health nurse practitioners and clinical psychologists, subsequently encouraging allied professionals to pursue a career in behavioral health. OPM would guide the carriers in the form of a carrier letter after a review by the actuary department that will further inform the impact on the premium paid by the enrollees.

"Although behavioral health has been a top bipartisan policy issue for more than a decade, behavioral health providers are often reimbursed at lower rates than non-behavioral health providers: compared with Medicare-allowed amounts, average 2017 in-network physician reimbursement rates for behavioral health office visits were lower than for primary care office visits and medical/surgical specialist office visits" (Coe et al., 2021)

Cost Effectiveness:

The cost associated with achieving parity would be increasing reimbursement rates for behavioral health providers by 31.58% as mental health professionals make 76 cents for a dollar being reimbursed to primary care physicians (Rapfogel, 2022). In order to incentivize service providers to accept Medicaid for those affected by the opioid epidemic, Virginia boosted its payment rates for SUD services for Medicaid patients in 2017. This was a very successful initiative, as there was a 69% increase in Medicaid patients seeking treatment for opioid use disorders and a 25% drop in opioid-related visits to emergency rooms (Virginia Department of

Medical Assistance Services, Virginia Department of Behavioral Health and Developmental Services, & the Farley Health Policy Center. Virginia Medicaid Continuum of Behavioral Health Services, 2018). The study shows that it increased access to seeking mental healthcare as providers were reimbursed equitably and it positively impacted premiums for enrollees. A study conducted by Alexander & Schnell shows an increase in the likelihood that a Medicaid client reported a doctor visit in the previous two weeks by 0.3 percentage points for every $10 increase in Medicaid compensation per visit (Alexander & Schnell, 2019). The effectiveness can be measured by scaling this experiment to accommodate the cost per mental health care visit per appointment wait time. Many mental health practitioners might accept insurance because of the large discrepancy between demand and supply for such providers coupled with higher reimbursement rates. This iteratively leads to a decrease in appointment wait times due to the larger availability of mental health providers. According to the conversations with the Office of the Actuaries at OPM and the cost analysis, ensuring parity did lead to a sizeable increase in premiums to be paid by the enrollees, therefore this alternative is more expensive than the other two policy options. The cost-effectiveness criterion measures the cost per person seeking mental health treatment/reduction in appointment wait time. The average cost per person seeking treatment was evaluated using the Blue Cross Blue Shield (BCBS) Standard Option cost-sharing by FEHB enrollees. I selected the BCBS Standard option because it was the most popular option among FEHB enrollees. The cost share for enrollees was 35% of the plan allowance (Federal Employees Health Benefits Program Brochure, 2023). The average cost of a session with a psychiatrist fell within the range of $100 to $300, for which I took an average of $200. The total average cost, including the deductible and the increase in reimbursement, was about $1150. With a reduction of 15 days, this alternative gained **41.07 points**. Hence, this alternative scored **1** on the cost-effectiveness scale for being expensive relative to the other two policy options.

Equity:

The equity component involved in this alternative addresses the equitable outcome for mental health professionals that is often associated with a stigma that mental health professionals would be paid less in their profession causing a subsequent reduction in pursuing a career as a mental health professional. The alternative should cater to the needs of underserved populations in both urban and rural settings known as Healthcare Providers Shortage Areas (HPSAs), albeit the increase in reimbursement rates for providers serving in HPSAs would be negligible to detect a shift. Therefore, this criterion would gain 1 point for socioeconomic outcomes for those in underserved areas by an iterative increase in the number of mental health providers.

Sustainability:

Reimbursing behavioral health providers on par with other medical providers can lead to more medical students pursuing psychiatry in the long run which helps address the expected 2030 shortage in behavioral health providers. This can then reduce wait times and increase

accessibility intentionally as more providers are present in the profession. Therefore, this policy option ranks high on the sustainability index.

Outcomes Matrix

	Cost Effectiveness - 50%	Equity (/3) - 30%	Sustainability - 20%	Total Score (Weighted)
Collaborative Care Model	Highly Cost Effective (3)	0.5+0.5+1 = 2	High (3)	0.5*3+0.3*2+0.2*3 = **2.7**
Provider Directories	Highly Cost Effective (3)	1	Medium (2)	0.5*3+0.3*1+0.2*2 = **2.2**
Parity in Reimbursement Models	Cost Ineffective (1)	1	High (3)	0.5*1+0.3*1+0.2*3 = **1.4**

RECOMMENDATION

This report recommends that OPM pursue advisory strategies to implement Alternative 1:

Encourage carriers to implement Collaborative Care Model

After considering the above analysis and outcomes matrix, I recommend Alternative 1, Collaborative Care Model. While Alternative 1 is a developing model, I believe that it is a suitable choice for several reasons. Firstly, Alternative 1 has a lot of empirical evidence that suggests the viability of the option. Secondly, the option is in line with the policy background as more policies supporting the integration of mental health and physical health are put into action. Finally, Alternative 1 is highly effective in reducing wait times and increasing accessibility amidst a shortage in mental health staff.

IMPLEMENTATION

Implementing the collaborative care model will involve various stakeholders, including primary care providers, mental health specialists, care managers, patients, and carriers. The primary care providers will play a crucial role in identifying and referring patients who need mental health care. Mental health specialists will provide consultations and treatment recommendations to primary care providers. Care managers will be responsible for coordinating care and monitoring patient outcomes. Carriers are the primary party in charge of implementing the plan into effect, and they will oversee determining insurance premium prices that reflect the integrated care that customers receive.

Steps and Sequencing

As the oversight role for federal employee health benefits, the Office of Personnel Management (OPM) plays a crucial role in encouraging carriers to implement collaborative care models. The following are some steps that OPM can take:

Training and Education: OPM can educate carriers on the benefits of collaborative care models and the evidence supporting their effectiveness. Forms of education can include webinars, conferences, and other educational resources.

Collaborative care in contracts: OPM can require carriers to implement collaborative care models as part of their contracts. OPM can necessitate the inclusion of specific language in the

contracts that outline the requirements for collaborative care, a detailed description of how carriers implement the model, and the penalties for noncompliance.

Develop performance metrics: OPM can work with carriers to develop performance metrics for collaborative care models. OPM can use these metrics to evaluate the effectiveness of the model and incentivize carriers to improve their performance.

Provide financial incentives: OPM can provide financial incentives to carriers implementing collaborative care models. As highlighted in the President's first State of the Union address, incentives such as bonuses, grants, or other financial rewards can be awarded to carriers that meet or exceed performance metrics for collaborative care (The White House, 2022).

Share best practices: OPM can facilitate sharing best practices among carriers that have successfully implemented collaborative care models using conferences, webinars, or other collaborative forums.

Monitor compliance: OPM can monitor compliance with collaborative care requirements through regular audits and reviews. Effective monitoring ensures that carriers are implementing collaborative care models as required and meeting performance metrics.

Perspectives of Stakeholders

Since the collaborative care model can increase patients' access to mental health care and outcomes, patients are likely to favor it. The increased workload and requirement for training may worry some primary care physicians. If the approach is seen as a threat to the autonomy of mental health professionals, they may be reluctant to adopt it. Payers may be in favor of the approach if they believe that better management of mental illness would result in cost savings. The client should explain the advantages of the collaborative care model and include all stakeholders in the planning and implementation phase to reduce resistance. Also, the client should take the lead and resolve any issues or conflicts that come up during the implementation process.

Challenges to Implementation

The collaborative care model's successful adoption may be hampered by several risks. These concerns include a lack of resources, stakeholder resistance, and poor team member communication and information collaboration. The customer should create backup plans and set aside enough funds for the implementation process to meet these risks. The client should also establish clear communication channels and facilitate ongoing feedback and evaluation to address any issues that may arise.

In conclusion, the collaborative care model is an effective approach to improving network adequacy in mental health care. To implement this model successfully, the

client should involve all stakeholders, prioritize training and education, redesign workflows, and establish quality monitoring systems. The client should also anticipate potential risks and develop contingency plans to ensure seamless implementation.

CONCLUSION

Network adequacy issues in mental healthcare continue to pose significant challenges for patients, providers, and policymakers. The analysis and research conducted in this report have highlighted the importance of implementing a collaborative care model and explored alternatives such as updating provider directories to prevent ghost networks and ensuring parity in reimbursement models for behavioral health providers and medical providers.

The collaborative care model has shown promising results in improving patient outcomes, reducing costs, and increasing access to mental healthcare services. Updating provider directories can ensure patients have accurate information about in-network providers, reducing the risk of being unknowingly directed to out-of-network providers. Parity in reimbursement models can ensure that behavioral health providers receive fair compensation for their services, reducing the incentive to opt out of insurance networks and increasing the availability of mental healthcare services.

After careful consideration of the alternatives considering the criteria, I recommend that OPM encourages its carriers to implement Collaborative Care Model. Policymakers need to take steps to incentivize healthcare providers to adopt these models, and insurance companies should develop reimbursement models that incentivize providers to work collaboratively. The goal is to ensure that patients receive the high-quality mental healthcare services they need and deserve, regardless of where they live or their insurance.

REFERENCES

About Us : About Us - OPM.gov. (2019). U.S. Office of Personnel Management. https://www.opm.gov/about-us/

AHRQ. (2020). *What is Integrated Behavioral Health? | The Academy*. Ahrq.gov. https://integrationacademy.ahrq.gov/about/integrated-behavioral-health

Akiyama, J., Kohut, R., Lee, C., Ohadugha, C., To, T., Cameron, S., Huffman, R., & Trent, P. (2015). *Network Adequacy for Mental Health Patients How North Carolina Measures Up*. https://www.ncpsychiatry.org/assets/docs/network%20adequacy%20and%20mental%20health%20report%20dec%202015.pdf

Alexander, D., & Schnell, M. (2019). The Impacts of Physician Payments on Patient Access, Use, and Health. *THE BULLETIN on HEALTH*, *3*(3). https://doi.org/10.3386/w26095

Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.cd006525.pub2

Bethune, S. (2021, October 19). *Demand for mental health treatment continues to increase, say psychologists*. Https://Www.apa.org. https://www.apa.org/news/press/releases/2021/10/mental-health-treatment-demand

Blumenberg, E., & Agrawal, A. W. (2019). *Getting Around When You're Just Getting By: Transportation Survival Strategies of the Poor*. Journal of Poverty. https://www.tandfonline.com/doi/abs/10.1080/10875549.2014.951905

Brown, E. J., Polsky, D., Barbu, C. M., Seymour, J. W., & Grande, D. (2016). Racial Disparities In Geographic Access To Primary Care In Philadelphia. *Health Affairs*, *35*(8), 1374–1381. https://doi.org/10.1377/hlthaff.2015.1612

Building Your Program Consumer- Operated Services. (n.d.). https://store.samhsa.gov/sites/default/files/d7/priv/sma11-4633-buildingyourprogram-cosp.pdf

Burman, A., Haeder, S. F., & Yi, W. (2023). Provider Directory Inaccuracy and Timely Access for Mental Health Care. *AJMC*, *29*. https://www.ajmc.com/view/provider-directory-inaccuracy-and-timely-access-for-mental-health-care

Busch, S. H., & Kyanko, K. A. (2020). Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills. *Health Affairs*, *39*(6), 975–983. https://doi.org/10.1377/hlthaff.2019.01501

Camacho, E. M., Davies, L. M., Hann, M., Small, N., Bower, P., Chew-Graham, C., Baguely, C., Gask, L., Dickens, C. M., Lovell, K., Waheed, W., Gibbons, C. J., & Coventry, P. (2018). Long-term clinical and cost-effectiveness of collaborative care (versus usual care) for people with mental–physical multimorbidity: cluster-randomised trial. *The British Journal of Psychiatry*, *213*(2), 456–463. https://doi.org/10.1192/bjp.2018.70

CAQH. (2019). *The Hidden Causes of Inaccurate Provider Directories*. https://www.caqh.org/sites/default/files/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf?token=kx9rkgqJ

Choi, S. K. Y., Boyle, E., Cairney, J., Gardner, S., Collins, E. J., Bacon, J., & Rourke, S. B. (2016). Adequacy of Mental Health Services for HIV-Positive Patients with Depression: Ontario

HIV Treatment Network Cohort Study. *PLOS ONE*, *11*(6), e0156652. https://doi.org/10.1371/journal.pone.0156652

CMS. (2022, January 5). *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023*. Federal Register. https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023

Coe, E., Enomoto, K., Carlos Pardo Martin, & Nikhil Seshan. (2021, February 24). Unlocking whole person care through behavioral health. McKinsey & Company; McKinsey & Company. https://www.mckinsey.com/industries/healthcare/our-insights/unlocking-whole-person-care-through-behavioral-health

Czeisler, M. É., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M. D., Robbins, R., Facer-Childs, E. R., Barger, L. K., Czeisler, C. A., Howard, M. E., & Rajaratnam, S. M. W. (2020). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *MMWR. Morbidity and Mortality Weekly Report*, *69*(32), 1049–1057. https://doi.org/10.15585/mmwr.mm6932a1

Davies, E. B., Morriss, R., & Glazebrook, C. (2014). Computer-Delivered and Web-Based Interventions to Improve Depression, Anxiety, and Psychological Well-Being of University Students: A Systematic Review and Meta-Analysis. *Journal of Medical Internet Research*, *16*(5), e130. https://doi.org/10.2196/jmir.3142

Dewa, C. S., Thompson, A., & Jacobs, P. E. (2011). The Association of Treatment of Depressive Episodes and Work Productivity. The Canadian Journal of Psychiatry, 56(12), 743–750. https://doi.org/10.1177/070674371105601206

Dolotina, B., & Turban, J. (2022). *Phantom Networks Prevent Children And Adolescents From Obtaining The Mental Health Care They Need | Health Affairs Journal*. Health Affairs. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00588

Druss, B. G., von Esenwein, S. A., Compton, M. T., Zhao, L., & Leslie, D. L. (2011). Budget Impact and Sustainability of Medical Care Management for Persons With Serious Mental Illnesses. *American Journal of Psychiatry*, *168*(11), 1171–1178. https://doi.org/10.1176/appi.ajp.2011.11010071

Ensuring Accurate Health Plan Provider Directories AB 236 (Holden). (n.d.). https://health-access.org/wp-content/uploads/2023/02/HA-Factsheet_AB-236_FNL.pdf

Erica Hutchins Coe, Lamb, J., & Rivera, S. (2017, May). *Hospital networks: Perspective from four years of the individual market exchanges*. McKinsey & Company; McKinsey & Company. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/hospital-networks-perspective-from-four-years-of-the-individual-market-exchanges

Ettner, S. L. (2006a, February 2). *The Role of Economic Incentives in Improving the Quality of Mental Health Care*. Chapters; Edward Elgar Publishing. https://ideas.repec.org/h/elg/eechap/3572_27.html

Ettner, S. L. (2006b, February 2). *The Role of Economic Incentives in Improving the Quality of Mental Health Care*. Chapters; Edward Elgar Publishing. https://ideas.repec.org/h/elg/eechap/3572_27.html

Ettner, S. L. (2006c, February 2). *The Role of Economic Incentives in Improving the Quality of Mental Health Care*. Chapters; Edward Elgar Publishing. https://ideas.repec.org/h/elg/eechap/3572_27.html

Ettner, S. L. (2006d, February 2). *The Role of Economic Incentives in Improving the Quality of Mental Health Care*. Chapters; Edward Elgar Publishing. https://ideas.repec.org/h/elg/eechap/3572_27.html

Ettner, S. L., & Schoenbaum, M. (2006, February 2). *The Role of Economic Incentives in Improving the Quality of Mental Health Care*. Chapters; Edward Elgar Publishing. https://ideas.repec.org/h/elg/eechap/3572_27.html

Federal Employees Health Benefits (FEHB) Program: An Overview. (2016). https://www.everycrsreport.com/files/20160203_R43922_79db80060fb82fa3e6335ee92c630794a3360202.pdf

FEHB Handbook. (2019). U.S. Office of Personnel Management. https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/fehb-handbook

FEHB Program Carrier Letter All FEHB Carriers. (2022). https://www.opm.gov/healthcare-insurance/healthcare/carriers/2022/2022-12.pdf

Federal Employees Health Benefits Program brochure. (2023). Opm.gov. https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/BrochureJson?brochureNumber=71-005&year=2023

FEHB, U. S. O. (2022). 2021 Federal Employee Benefits Survey Report. https://www.opm.gov/policy-data-oversight/data-analysis-documentation/employee-surveys/2021-federal-employee-benefits-survey-report.pdf

FINAL REPORT THE MENTAL HEALTH & PREPARING FOR THE FUTURE SUBSTANCE USE DISORDER OF ARTIFICIAL INTELLIGENCE PARITY TASK FORCE. (2016). https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.PDF

Finance Committee Unveils Mental Health Care Integration Discussion Draft | The United States Senate Committee on Finance. (2022, November 10). Senate.gov. https://www.finance.senate.gov/chairmans-news/finance-committee-unveils-mental-health-care-integration

GAO. (2022). *United States Government Accountability Office*. https://www.gao.gov/assets/gao-22-104597.pdf#page=16

Gilbody, S., Bower, P., & Whitty, P. (2006). Costs and consequences of enhanced primary care for depression. *British Journal of Psychiatry*, *189*(4), 297–308. https://doi.org/10.1192/bjp.bp.105.016006

Gillette, B. (2023, February 20). *New Bill Would Lower Costs, Improve Outcomes for Mental Health Care*. AMP; AMP. https://www.armoneyandpolitics.com/costs-outcomes-mental-health-care/

Glied, S., Herzog, K., & Frank, R. (2010). Review: The Net Benefits of Depression Management in Primary Care. *Medical Care Research and Review*, *67*(3), 251–274. https://doi.org/10.1177/1077558709356357

Goldman, H. H., & Grob, G. N. (2017). *Defining "Mental Illness" In Mental Health Policy | Health Affairs Journal*. Health Affairs. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.25.3.737

Goodman, B. (2022, October 6). *Long waiting lists, long drives and costly care hinder many kids' access to mental health care*. CNN; CNN. https://www.cnn.com/2022/10/06/health/youth-parents-mental-health-kff-poll-wellness/index.html

H.R.133 - 116th Congress (2019-2020): Consolidated Appropriations Act, 2021. (2019). Congress.gov. https://www.congress.gov/bill/116th-congress/house-bill/133

Haeder, S. F., Weimer, D. L., & Mukamel, D. B. (2020). Going the Extra Mile? How Provider Network Design Increases Consumer Travel Distance, Particularly for Rural Consumers. *Journal of Health Politics, Policy and Law*, *45*(6), 1107–1136. https://doi.org/10.1215/03616878-8641591

Hargraves, J. (2018, August). *The Impact of the Mental Health Parity and Addiction Equity Act on Inpatient Admissions*. HCCI; HCCI. https://healthcostinstitute.org/hcci-research/the-impact-of-the-mental-health-parity-and-addiction-equity-act-on-inpatient-admissions

Harvey, T. (2022, November 10). *Finance Committee Unveils Mental Health Care Integration Discussion Draft | The United States Senate Committee on Finance*. Senate.gov. https://www.finance.senate.gov/chairmans-news/finance-committee-unveils-mental-health-care-integration

Haun, M. W., Oeljeklaus, L., Hoffmann, M., Tönnies, J., Wensing, M., Szecsenyi, J., Peters-Klimm, F., Krisam, R., Kronsteiner, D., Hartmann, M., & Friederich, H.-C. (2023). Primary care patients' experiences of video consultations for depression and anxiety: a qualitative interview study embedded in a randomized feasibility trial. *BMC Health Services Research*, *23*(1). https://doi.org/10.1186/s12913-022-09012-z

Heller, S. (2023, January 30). *President Biden Signs End-of-Year Legislation Including Telehealth, Medicare & Medicaid, Mental Heal*. Mondaq.com; Crowell & Moring. https://www.mondaq.com/unitedstates/healthcare/1275710/president-biden-signs-end-of-year-legislation-including-telehealth-medicare--medicaid-mental-health-pandemic-preparedness-and-other-health-care-provisions

Holliday, S. B., Holliday, S. B., Hepner, K. A., Hepner, K. A., Pincus, H. A., & Pincus, H. A. (2019). *Addressing the Shortage of Behavioral Health Clinicians: Lessons from the Military Health System*. Rand.org. https://www.rand.org/blog/2022/05/addressing-the-shortage-of-behavioral-health-clinicians.html

Horner, L., Kim, J., Dormond, M., Hardy, K., Libersky, J., Lipson, D. J., Hossain, M., & Lechner, A. (2021, May). *Promoting Access in Medicaid and CHIP Managed Care: Strategies for Ensuring Provider Network Adequacy and Service Availability | Guidance Portal*. Hhs.gov. https://www.hhs.gov/guidance/document/promoting-access-medicaid-and-chip-managed-care-strategies-ensuring-provider-network

HRSA. (2022, August 31). *Behavioral Health Workforce Projections | Bureau of Health Workforce*. Hrsa.gov. https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health

Implementation Guide | University of Washington AIMS Center. (2021). Uw.edu. https://aims.uw.edu/collaborative-care/implementation-guide

Increased Medicaid Reimbursement Rates Expand Access to Care. (2019). NBER. https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care

Inflation Calculator | Federal Reserve Bank of Minneapolis. (2013). Minneapolisfed.org. https://www.minneapolisfed.org/about-us/monetary-policy/inflation-calculator

insideout. (2019, June 6). *Learning & Development - ATA*. ATA. https://www.americantelemed.org/resource/learning-development/

Jackson-Triche, M. E., Unützer, J., & Wells, K. B. (2020). Achieving Mental Health Equity. *Psychiatric Clinics of North America*, *43*(3), 501–510. https://doi.org/10.1016/j.psc.2020.05.008

Johns Hopkins Medicine. (2023, February). *Mental Health Disorder Statistics*. Hopkinsmedicine.org. https://www.hopkinsmedicine.org/health/wellness-and-prevention/mental-health-disorder-statistics#:~:text=Many%20people%20suffer%20from%20more%20than%20one%20mental,%28major%20depression%2C%20bipolar%20disorder%2C%20or%20dysthymia%29%20each%20year.

Kassens, A. L., Taylor, J., & Rodgers III, W. M. (2021, May 11). *Mental Health Crisis during the COVID-19 Pandemic*. The Century Foundation. https://tcf.org/content/report/mental-health-crisis-covid-19-pandemic/?agreed=1

Keith, N. (2001). Legislative and judicial solutions for mental health parity: S. 543, reasonable accommodation, and an individualized remedy under Title I of the ADA. *The American University Law Review*, *51*(1). https://pubmed.ncbi.nlm.nih.gov/11963952/

King, R. (2022, December 20). *From telehealth to Medicare cuts: Here are the health policies in Congress' $1.7T omnibus*. Fierce Healthcare. https://www.fiercehealthcare.com/providers/telehealth-medicare-cuts-here-are-health-policies-congress-17t-omnibus

Kormendi, N. M., & Brown, A. D. (2021). Asian American mental health during COVID-19: A call for task-sharing interventions. *SSM - Mental Health*, *1*, 100006. https://doi.org/10.1016/j.ssmmh.2021.100006

Last, B. S., Buttenheim, A. M., Futterer, A. C., Livesey, C., Jaeger, J., Stewart, R. E., Reilly, M., Press, M. J., Peifer, M., Wolk, C. B., & Beidas, R. S. (2021). A pilot study of participatory and rapid implementation approaches to increase depression screening in primary care. *BMC Family Practice*, *22*(1). https://doi.org/10.1186/s12875-021-01550-5

Lazur, B., Sobolik, L., & King, V. (2021, March 12). *Telebehavioral Health: An Effective Alternative to In-Person Care | Milbank Memorial Fund*. Milbank Memorial Fund. https://www.milbank.org/publications/telebehavioral-health-an-effective-alternative-to-in-person-care/

Levine, D. (2018). *What's the Answer to the Shortage of Mental Health Care Providers?* US News & World Report; U.S. News & World Report. https://health.usnews.com/health-care/patient-advice/articles/2018-05-25/whats-the-answer-to-the-shortage-of-mental-health-care-providers

Lopes, L., Kirzinger, A., Sparks, G., Brodie, M., & Stokes, M. (2022, October 6). *KFF/CNN Mental Health In America Survey - Findings*. KFF. https://www.kff.org/report-section/kff-cnn-mental-health-in-america-survey-findings/

Ludomirsky, A. B., Schpero, W. L., Wallace, J., Lollo, A., Bernheim, S., Ross, J. S., & Ndumele, C. D. (2022). *In Medicaid Managed Care Networks, Care Is Highly Concentrated Among A Small Percentage Of Physicians | Health Affairs Journal*. Health Affairs. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.01747

Mark, T. L., Olesiuk, W., Ali, M. M., Sherman, L. J., Mutter, R., & Teich, J. L. (2018). Differential Reimbursement of Psychiatric Services by Psychiatrists and Other Medical Providers. *Psychiatric Services*, *69*(3), 281–285. https://doi.org/10.1176/appi.ps.201700271

Mattocks, K. M., Elwy, A. R., Yano, E. M., Giovannelli, J., Adelberg, M., Mengeling, M. A., Cunningham, K. J., & Matthews, K. L. (2021). Developing network adequacy standards for VA Community Care. *Health Services Research*, *56*(3), 400–408. https://doi.org/10.1111/1475-6773.13651

McCall-Hosenfeld, J. S., Mukherjee, S., & Lehman, E. B. (2014). The Prevalence and Correlates of Lifetime Psychiatric Disorders and Trauma Exposures in Urban and Rural Settings: Results from the National Comorbidity Survey Replication (NCS-R). *PLoS ONE*, *9*(11), e112416. https://doi.org/10.1371/journal.pone.0112416

Melek, S., Davenport, S., & Gray, T. (2017). *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement A deeper analytical dive and updated results through 2017 for 37 million employees and dependents*. https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx

Mental Health Care Health Professional Shortage Areas (HPSAs). (2021, November 11). KFF. https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Mental Health in the Workplace. (2022). https://www.cdc.gov/workplacehealthpromotion/tools-resources/workplace-health/mental-health/index.html

Miller, C. J., Grogan-Kaylor, A., Perron, B. E., Kilbourne, A. M., Woltmann, E., & Bauer, M. S. (2013). Collaborative Chronic Care Models for Mental Health Conditions. *Medical Care*, *51*(10), 922–930. https://doi.org/10.1097/mlr.0b013e3182a3e4c4

Miller, L. H., Parks, J., Yowell, R., Penaskovic, K., Reed, R., & Kannarkat, J. (2022). The Impact of COVID-19 on Financing of Psychiatric Services. Psychiatric Clinics of North America, 45(1), 161–177. https://doi.org/10.1016/j.psc.2021.11.014

Minimum Value and Affordability | Internal Revenue Service. (2017). Irs.gov. https://www.irs.gov/affordable-care-act/employers/minimum-value-and-affordability

Molfenter, T., Heitkamp, T., Murphy, A. A., Tapscott, S., Behlman, S., & Cody, O. J. (2021). Use of Telehealth in Mental Health (MH) Services During and After COVID-19. *Community Mental Health Journal*, *57*(7), 1244–1251. https://doi.org/10.1007/s10597-021-00861-2

Morales, D. A., Barksdale, C. L., & Beckel-Mitchener, A. C. (2020a). A call to action to address rural mental health disparities. *Journal of Clinical and Translational Science*, *4*(5), 463–467. https://doi.org/10.1017/cts.2020.42

Morales, D. A., Barksdale, C. L., & Beckel-Mitchener, A. C. (2020b). A call to action to address rural mental health disparities. *Journal of Clinical and Translational Science*, *4*(5), 463–467. https://doi.org/10.1017/cts.2020.42

Nagata, J. M., Ganson, K. T., Bonin, S. L., Twadell, K. L., Garcia, M. E., Langrock, O., Vittinghoff, E., Tsai, A. C., Weiser, S. D., & Abdel Magid, H. S. (2022). Prevalence and Sociodemographic Correlates of Unmet Need for Mental Health Counseling Among Adults During the COVID-19 Pandemic. Psychiatric Services, 73(2), 206–209. https://doi.org/10.1176/appi.ps.202100111

NAMI. (2023). *Mental Health By the Numbers | NAMI: National Alliance on Mental Illness*. Nami.org. https://nami.org/mhstats#:~:text=21%25%20of%20U.S.%20adults%20experienced%20mental%20illness%20in,million%20people%29.%20This%20represents%201%20in%2020%20adults.

Network Adequacy. (2022). Naic.org. https://content.naic.org/cipr-topics/network-adequacy

Office of Personnel Management, U. S. (2019). *FEHB Program Carrier Letter*. https://www.opm.gov/healthcare-insurance/healthcare/carriers/2019/2019-01.pdf

Office of Personnel Management, U. S. (2023). *FEHB Program Carrier Letter : Letter Number 2023-04*. https://www.opm.gov/healthcare-insurance/healthcare/carriers/2023/2023-04.pdf

Panchal, N., Chidambaram, P., Garfield, R., Cox, C., & Kamal, R. (2021, May 26). *Mental Health and Substance Use Considerations Among Children During the COVID-19 Pandemic*. KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023. (2022, January 5). Federal Register. https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023

Pestaina, K. (2022, August 18). *Mental Health Parity at a Crossroads*. KFF. https://www.kff.org/private-insurance/issue-brief/mental-health-parity-at-a-crossroads/

Pollitz, K. (2022, February 4). *Network Adequacy Standards and Enforcement*. KFF. https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/#

Pomerantz, A. S., Shiner, B., Watts, B. V., Detzer, M. J., Kutter, C., Street, B., & Scott, D. (2010). The White River model of colocated collaborative care: A platform for mental and behavioral health care in the medical home. *Families, Systems, & Health*, *28*(2), 114–129. https://doi.org/10.1037/a0020261

Pomerantz, A., Cole, B. H., Watts, B. V., & Weeks, W. B. (2008). Improving efficiency and access to mental health care: combining integrated care and advanced access. *General Hospital Psychiatry*, *30*(6), 546–551. https://doi.org/10.1016/j.genhosppsych.2008.09.004

Powers, D. M., Bowen, D. J., Arao, R. F., & Jürgen Unützer. (2020, July 23). *Rural clinics implementing collaborative care for low-income patients can achieve comparable or better...* ResearchGate; American Psychological Association.

https://www.researchgate.net/publication/343176713_Rural_clinics_implementing_collaborative_care_for_low-income_patients_can_achieve_comparable_or_better_depression_outcomes#:~:text=Collaborative%20care%20%28CoCM%29%20is%20an%20evidence-based%20approach%20that,implementation%20in%208%20rural%20clinics%20treating%20low-income%20patients.

Rapfogel, N. (2022, May 26). *The Behavioral Health Care Affordability Problem*. Center for American Progress. https://www.americanprogress.org/article/the-behavioral-health-care-affordability-problem/

Ray, K. N., Chari, A. V., Engberg, J., Bertolet, M., & Mehrotra, A. (2015). Disparities in Time Spent Seeking Medical Care in the United States. *JAMA Internal Medicine*, *175*(12), 1983. https://doi.org/10.1001/jamainternmed.2015.4468

Rice, A. N., & Harris, S. C. (2021). Issues of cultural competence in mental health care. *Journal of the American Pharmacists Association*, *61*(1), e65–e68. https://doi.org/10.1016/j.japh.2020.10.015

Richmond, VA. (2018). *"Virginia Medicaid Continuum of Behavioral Health Services."* Https://Www.dmas.virginia.gov/Media/1414/2019-Continuum-Proposal-Report.pdf.; Virginia Department of Medical Assistance Services, Virginia Department of Behavioral Health and Developmental Services, and the Farley Health Policy Center.

Richtel, M. (2022). Surgeon General Warns of Youth Mental Health Crisis. *The New York Times*. https://www.nytimes.com/2021/12/07/science/pandemic-adolescents-depression-anxiety.html

Rubin, R. (2020). Pandemic Highlights Behavioral Health Disparities. *JAMA*, *323*(24), 2452. https://doi.org/10.1001/jama.2020.10318

SAMHSA. (2022). *Rural Behavioral Health*. Samhsa.gov. https://www.samhsa.gov/rural-behavioral-health

Satiani, A., Niedermier, J., Satiani, B., & Svendsen, D. P. (2018). Projected Workforce of Psychiatrists in the United States: A Population Analysis. *Psychiatric Services*, *69*(6), 710–713. https://doi.org/10.1176/appi.ps.201700344

Scarbrough, J. A. (2018). The Growing Importance of Mental Health Parity. *American Journal of Law & Medicine*, *44*(2-3), 453–474. https://doi.org/10.1177/0098858818789432

Schneider, A. (2022, May 16). *Standards for Provider Network Adequacy in Medicaid and the Marketplaces* (A. Corcoran, Ed.). Center for Children and Families. https://ccf.georgetown.edu/2022/05/16/standards-for-provider-network-adequacy-in-medicaid-and-the-marketplaces/

Search of: Collaborative Care | Depression and anxiety - List Results - ClinicalTrials.gov. (2023). Clinicaltrials.gov. https://clinicaltrials.gov/ct2/results?cond=Depression+and+anxiety&term=Collaborative+Care&cntry=&state=&city=&dist=

September 2022 ISSUE BRIEF 1 HHS ROADMAP FOR BEHAVIORAL HEALTH INTEGRATION. (n.d.-a). https://aspe.hhs.gov/sites/default/files/documents/84a701e0878bc26b2812a074aa22a3e2/roadmap-behavioral-health-integration.pdf

September 2022 ISSUE BRIEF 1 HHS ROADMAP FOR BEHAVIORAL HEALTH INTEGRATION. (n.d.-b). https://aspe.hhs.gov/sites/default/files/documents/84a701e0878bc26b2812a074aa22a3e2/roadmap-behavioral-health-integration.pdf

Sherbourne, C. D., Wells, K. B., Duan, N., Miranda, J., Unützer, J., Jaycox, L., Schoenbaum, M., Meredith, L. S., & Rubenstein, L. V. (2001). Long-term Effectiveness of Disseminating Quality Improvement for Depression in Primary Care. *Archives of General Psychiatry*, *58*(7), 696. https://doi.org/10.1001/archpsyc.58.7.696

Siniscalchi, K. A., Broome, M. E., Fish, J., Ventimiglia, J., Thompson, J., Roy, P., Pipes, R., & Trivedi, M. (2020). Depression Screening and Measurement-Based Care in Primary Care. *Journal of Primary Care & Community Health*, *11*, 215013272093126. https://doi.org/10.1177/2150132720931261

Sloan, C., & Carpenter, E. (2019, December 11). *2020 Exchange Plan Networks Are the Most Restrictive Since 2014*. Avalere Health; Avalere Health. https://avalere.com/press-releases/2020-exchange-plan-networks-are-the-most-restrictive-since-2014

Spetz, J. (2020, December 22). *California's Nurse Practitioners: How Scope of Practice Laws Impact Care - California Health Care Foundation*. California Health Care Foundation. https://www.chcf.org/publication/californias-nurse-practitioners/

Steinman, K. J., Shoben, A. B., Dembe, A. E., & Kelleher, K. J. (2015). How Long Do Adolescents Wait for Psychiatry Appointments? *Community Mental Health Journal*, *51*(7), 782–789. https://doi.org/10.1007/s10597-015-9897-x

Sullivan, T. (2021, October). *Senate Passes Legislation on Mental Health for Health Care Professionals*. Policy & Medicine. https://www.policymed.com/2021/10/senate-passes-legislation-on-mental-health-for-health-care-professionals.html#:~:text=HHS%20may%20also%20award%20grants%20for%20mental%20and,for%20their%20own%20mental%20and%20behavioral%20health%20concerns.

Tahhan, N., Ford, B. K., Angell, B., Liew, G., Nazarian, J., Maberly, G., Mitchell, P., White, A. J. R., & Keay, L. (2020). Evaluating the cost and wait-times of a task-sharing model of care for diabetic eye care: a case study from Australia. *BMJ Open*, *10*(10), e036842. https://doi.org/10.1136/bmjopen-2020-036842

The Mental Health Parity and Addiction Equity Act (MHPAEA) | CMS. (2013). Cms.gov. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

The White House. (2022, May 31). FACT SHEET: Biden-Harris Administration Highlights Strategy to Address the National Mental Health Crisis - The White House. The White House; The White House. https://www.whitehouse.gov/briefing-room/statements-releases/2022/05/31/fact-sheet-biden-harris-administration-highlights-strategy-to-address-the-national-mental-health-crisis/

Thomeer, M. B., Moody, M. D., & Yahirun, J. (2022). Racial and Ethnic Disparities in Mental Health and Mental Health Care During The COVID-19 Pandemic. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-022-01284-9

TrendWatch: The Impacts of the COVID-19 Pandemic on Behavioral Health | AHA. (2022). American Hospital Association. https://www.aha.org/guidesreports/2022-05-31-trendwatch-impacts-covid-19-pandemic-behavioral-health

U.S. Office of Personnel Management Healthcare and Insurance. (2022). *FEHB Program Carrier Letter All FEHB Carriers*. https://www.opm.gov/healthcare-insurance/healthcare/carriers/2022/2022-12.pdf

Uebelacker, L. A., Smith, M., Lewis, A. W., Sasaki, R., & Miller, I. W. (2009). Treatment of depression in a low-income primary care setting with colocated mental health care. *Families, Systems, & Health*, *27*(2), 161–171. https://doi.org/10.1037/a0015847

Umucu, E., Reyes, A., Nay, A., Elbogen, E., & Tsai, J. (2021). Associations between mental health and job loss among middle- and low-income veterans and civilians during the COVID-19 pandemic: An exploratory study. *Stress and Health*, *38*(2), 410–416. https://doi.org/10.1002/smi.3099

Unützer, J. (2013). *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes ▪ Implementation of evidence-based collaborative care in Medicaid -and in integrated care programs for individuals dually eligible for Medicare and Medicaid-could s IN BRIEF*. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-irc-collaborative-5-13.pdf#:~:text=More%20than%2070%20randomized%20controlled%20trials%20have%20shown

Unutzer, J., Katon, W. J., Fan, M.-Y., Schoenbaum, M. C., Lin, E. H. B., Della Penna, R. D., & Powers, D. (2008). Long-term cost effects of collaborative care for late-life depression. *The American Journal of Managed Care*, *14*(2), 95–100. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3810022/

Volk, J., Schwab, R., Kona, M., & Walsh-Alker, E. (2022, October 13). *A Review of State Efforts to Enforce Mental Health Parity*. RWJF. https://www.rwjf.org/en/library/research/2022/10/states-struggle-to-ensure-equal-access-to-behavioral-health-services-amid-mental-health-crisis.html

Walker, T. (2019, November 17). *The Cost Burden of Maintaining Provider Directories*. Managed Healthcare Executive; Managed Healthcare Executive. https://www.managedhealthcareexecutive.com/view/cost-burden-maintaining-provider-directories

Walsh, M. J., Becerra, X., & Yellen, J. (n.d.). *2022 MHPAEA Report to Congress Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage*. https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf

Weiner, S. (2018). *Addressing the escalating psychiatrist shortage*. AAMC. https://www.aamc.org/news-insights/addressing-escalating-psychiatrist-shortage

Weiner, S. (2022, August 9). *A growing psychiatrist shortage and an enormous demand for mental health services*. AAMC. https://www.aamc.org/news-insights/growing-psychiatrist-shortage-enormous-demand-mental-health-services#:~:text=Already%2C%20more%20than%20150%20million%20people%20live%20in

Wells, K., Sherbourne, C., Schoenbaum, M., Ettner, S., Duan, N., Miranda, J., Unützer, J., & Rubenstein, L. (2004). Five-Year Impact of Quality Improvement for Depression. *Archives of General Psychiatry*, *61*(4), 378. https://doi.org/10.1001/archpsyc.61.4.378

WHO. (2022, June 8). *Mental disorders*. Who.int; World Health Organization: WHO. https://www.who.int/news-room/fact-sheets/detail/mental-disorders

Williams, D. R., González, H. M., Neighbors, H., Nesse, R., Abelson, J. M., Sweetman, J., & Jackson, J. S. (2007). Prevalence and Distribution of Major Depressive Disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites. *Archives of General Psychiatry*, *64*(3), 305. https://doi.org/10.1001/archpsyc.64.3.305

Wishner, J. B., & Marks, J. (2017, March 16). *Ensuring Compliance with Network Adequacy Standards: Lessons from Four States*. Urban Institute. https://www.urban.org/research/publication/ensuring-compliance-network-adequacy-standards-lessons-four-states

Wishner, J., & Marks, J. (2017). *Ensuring Compliance with Network Adequacy Standards: Lessons from Four States ACA Implementation-Monitoring and Tracking*. https://www.urban.org/sites/default/files/publication/88946/2001184-ensuring-compliance-with-network-adequacy-standards-lessons-from-four-states_0.pdf

Wolk, C. B., Last, B. S., Livesey, C., Oquendo, M. A., Press, M. J., Mandell, D. S., Ingram, E., Futterer, A. C., Kinkler, G. P., & Oslin, D. W. (2021). Addressing Common Challenges in the Implementation of Collaborative Care for Mental Health: The Penn Integrated Care Program. *The Annals of Family Medicine*, *19*(2), 148–156. https://doi.org/10.1370/afm.2651

Woltmann, E., Grogan-Kaylor, A., Perron, B., Georges, H., Kilbourne, A. M., & Bauer, M. S. (2012). Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty, and Behavioral Health Care Settings: Systematic Review and Meta-Analysis. *American Journal of Psychiatry*, *169*(8), 790–804. https://doi.org/10.1176/appi.ajp.2012.11111616

Wright, D. R., Haaland, W. L., Ludman, E., McCauley, E., Lindenbaum, J., & Richardson, L. P. (2016). The Costs and Cost-effectiveness of Collaborative Care for Adolescents With Depression in Primary Care Settings. *JAMA Pediatrics*, *170*(11), 1048. https://doi.org/10.1001/jamapediatrics.2016.1721

Zhu, J. M., Charlesworth, C. J., Polsky, D., & McConnell, K. J. (2022). Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access In Oregon Medicaid. *Health Affairs*, *41*(7), 1013–1022. https://doi.org/10.1377/hlthaff.2022.00052

Zhu, J. M., Polsky, D., Johnstone, C., & McConnell, K. J. (2022). Variation in network adequacy standards in Medicaid managed care. *The American Journal of Managed Care*, *28*(6), 288–292. https://doi.org/10.37765/ajmc.2022.89156

Zhu, J. M., Zhang, Y., & Polsky, D. (2017). Networks In ACA Marketplaces Are Narrower For Mental Health Care Than For Primary Care. *Health Affairs*, *36*(9), 1624–1631. https://doi.org/10.1377/hlthaff.2017.0325

APPENDIX

Cost - Effectiveness Calculations for Policy Option 1: Collaborative Care Model (CoCM)

The average cost of CoCM per person per year: **$932 per year per patient receiving care**

The average number of days required to receive an appointment with a mental health professional: **42 days**

CoCM patient's average number of days required to receive an appointment with a mental health professional: 19 minutes or **0.01319 days**

Calculation for points: 932/ (42-0.01319) = **22.2**

Points assigned compared to the other two policy options: **3 (Highly cost-effective)**

Cost - Effectiveness Calculations for Policy Option 2: Provider Directories

The average cost of updating provider directories: **$998.94 per year for provider**

Additionally, updating provider directories can lead to more accessibility for patients, therefore increasing the number of patients per provider. As the number of patients that would increase per provider due to updated provider directories is uncertain, I assume there would be a decrease in the current average cost of updating provider directories per patient.

The average number of days required to receive an appointment with a mental health professional: **42 days**

The average number of days required to receive an appointment with a mental health professional after updating provider directories: **15 days**

Calculation for points: 998.94/ (42-15) = **37**

The points would be lower than 37

Accounting for the uncertainties, points assigned compared to the other two policy options: **3 (Highly Cost-effective)**

Cost - Effectiveness Calculations for Policy Option 3: Parity in Reimbursement Models

Cost range of attending per session with a psychiatrist for FEHB enrollees with Blue Cross Blue Shield plan (Participating Providers)[3]: **35% of the plan allowance**

Average cost per session with a psychiatrist: ($100 + $300)/2 = **$200**

Average cost range of attending per session with a psychiatrist for FEHB enrollees with Blue Cross Blue Shield plan: 35%*200 = **$70**

The average cost of attending 8-12 with a psychiatrist: 70*10 = $700 per year + $350 deductible = **$1050 per year**

The increased average cost of attending 8-12 with a psychiatrist: $1050 per year +$10 per visit = **$1150 per year for patient receiving care**

Average number of days required to receive an appointment with a mental health professional after increased reimbursement: **14 days** **(two-week appointments)**

Calculation for points: 1150/(42-14) = **41.07**

Points assigned compared to the other two policy options: **1 (Cost-ineffective/Expensive) and might lead to a sizeable impact on the premium as carriers transfer the burden of the impact onto the enrollee**.

[3] According to a conversation with Padma Shah, Teams discussion, April 19, 2023, Blue Cross Blue Shield Standard Option was the popular option among federal employees in the FEHB Program.